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The Medical Protection Society 129

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Annual Report of the Council and Accounts for the year ended 31 December 1985

Registered Office
50 Hallam Street, London W1N 6DE
Telephone: 01-637 0541 (International + 44 1 637 0541)
Facsimile: 01-636 0690 (International + 44 1 636 0690)
Telex: 8952848 (MEDPRO G)

Northern Regional Office
30 Park Square, Leeds LS1 2PF
Telephone: 0532-442115 (International + 44 532 442115)
Facsimile: 0532-453615 (International + 44 532 453615)

The Medical Protection Society

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Deputy Secretary	W G Duncan Murray MD MFOM DIH
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Financial Controller	R C Law FCA FCT
Registrar	A Gough FAAI
Administrative Officer	B A Brooking *MBE* JP BA MA MBIM
Professional Advisers	
Solicitors	Messrs Le Brasseur & Bury 71 Lincolns Inn Fields, London WC2A 3JF
Auditors	Messrs Robson Rhodes, 186 City Road, London EC1V 2NU
Bankers	Barclays Bank PLC (Cocks Biddulph branch) 16 Whitehall, London SW1A 2EA
Stockbrokers	Messrs J M Finn & Co, Salisbury House, London Wall, London EC2M 5TA
Insurance Brokers	Harrison Horncastle Insurance Brokers Limited, The Harrcastle Building, The Minories, London E1 8AT

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Annual Report of the Chairman of the Council

To be presented at the Annual General Meeting, which will be held on the 8th October, 1986 at 50 Hallam Street, London, W1.

This has been a year of consolidation and planning for the future. We continue to recruit over 50% of the United Kingdom medical and dental graduates. With this continuing increase in membership, the increasing incidence of problems in the practice of medicine and dentistry and the increasing amount of litigation, the Medical Secretariat has been increased by the appointment of four new members, whom we warmly welcome. Dr Owen comes from a background of general practice and Doctors Steele, Miller and Payne from the hospital service.

Although litigation involving our members receives a great deal of publicity and costs a great deal of money, this does not provide the bulk of the work of the Secretariat. Their time is largely taken up in providing advice, counsel and assistance to our members who have become enmeshed in the problems of practice today. It is this role of the Society which distinguishes us from an insurance company. Insurance companies provide indemnity. We provide a good deal more, as shown on page 10 (Benefits of Membership).

We are a mutual society of doctors and dentists who work together for the benefits of members and not commercial providers of indemnity. It is this concept which underlies our subscription policy as it is, rather than as a 'premium' paid according to risk. With the rapidly-increasing subscriptions there are, not surprisingly, to be heard more frequent calls for the subscription policy to be amended. This comes particularly from those who regard themselves, rightly or wrongly, as being a low-risk group. Such calls are listened to, of course, and considered carefully but, at the present time, are not convincing. In many cases they would be manifestly unfair in that those who would have to pay most would be least able to afford it. The costs of administering such a scheme would be very great. The restriction of practice would not be within the spirit of freedom which the profession enjoys today. The difficulties of placing members in an appropriate 'risk category' would be enormous — e.g. how would one assess the part-time clinical medical officer who gave dental general anaesthetics?

The intense interest in the press and television about the question of litigation in medicine and the voice of consumer-orientated groups continues to increase and does nothing to decrease the work of the Society. One particular point widely and vehemently made is that the Society forbids its members to explain to the patient or his relatives what has gone wrong or even to speak to them at all. It cannot be stressed too much that this is not so. All the Society asks is that the member does not admit legal liability until all the facts are elicited. Ten minutes explanation, which may admittedly be difficult, may well save many months or even years of worry.

D W Sumner
Chairman of Council

Obituaries

Herbert Lionel Thomas John Hardwick FDS MRCS LRCP

It is with great sadness that we report the death of Lionel Hardwick, a former Vice President and Treasurer of the Society, at the age of 81 years. He was one of that select band of true gentlemen, the 'old school'.

He entered the Royal Dental Hospital qualifying LDS in 1929, later taking his Conjoint from Charing Cross Hospital. He made his mark on the Royal Dental Hospital becoming part-time Dean and was totally involved in dental affairs and education. These interests were balanced by the demands of a private practice. With the creation of a Fellowship in Dental Surgery he was elected a Fellow at its inception in 1948.

It was a fortunate day for the Medical Protection Society when he was elected to Council in 1948. His talents were recognised and he was made Vice-Treasurer from 1958-63 later becoming Treasurer, a post in which he served with great distinction, and on his retirement as Treasurer he was created a Vice-President of the Society in 1976.

Professor Robert Milnes Walker *CBE* MS FRCS

The death of Professor Milnes Walker who had, until his retirement, held the chair of surgery at the University of Bristol, is recorded with great regret. He was a Vice-President and Member of Council of the Society from 1947 until 1975 and played a full part in its affairs.

His meticulous consideration of surgical cases invariably produced wise and sound advice to the benefit of the individual member. His quiet, serene manner and breadth of knowledge and understanding, coupled with his excellence in teaching, were always most welcome attributes, advancing the wider interests of the Society.

Advice to members

The Council and Secretariat of the Society advocate a policy of full and proper communication with patients. In circumstances where complications and errors arise it is proper that objective, factual information, with appropriate clinical reassurance, is provided. Adequate explanations, ideally from the responsible consultant or principal, assist in reducing fear and uncertainty which may give rise to complaints and claims.

However, it may be inappropriate to speculate or to cast blame unless, and until, all relevant facts are carefully established by proper and thorough inquiry, not least because an inappropriate remark could prejudice the interests of other members of the clinical team, both medical and non-medical, who have a right to be consulted and afforded an opportunity to comment and to seek advice.

- **Report promptly to the Society any mishap affecting a patient or circumstances which could give rise to a complaint or claim. (See 'Incident Reports' below).**
- **Make and keep accurate, contemporaneous notes. They should be legible, objective and written in the knowledge that they might, one day, be read out in court.**
- **Ensure that anyone to whom a task is delegated is competent, understands what is required and is encouraged to seek help if in difficulty.**
- **Criticism is easy with hindsight; avoid criticism of colleagues unless and until full facts are made available in response to a formal request.**
- **Be ready and willing to provide factual information and appropriate assurance and guidance to patients at all times, but do not admit *legal* liability without reference to the Society.**
- **Show professional courtesy at all times.**
- **Do not incur legal expense without the Society's prior approval.**
- **Ensure prompt payment of the annual subscription, preferably by bankers' direct debit.**
- **Advise the Society of any change of address — particularly important if moving to a country where a different rate of subscription applies.**
- **Do not hesitate to contact the Society with any membership or subscription query.**

Incident reports

Factual reports of incidents such as complaints, treatment mishaps or other medico-legal problems should be prepared as soon as possible after the event. These reports should be addressed to the Society, for the attention of the legal advisers. **Copies should not be filed in the patient's case notes** but should be retained by members in secure, personal files. Such reports may be legally privileged documents.

The report should be a plain, narrative statement of the facts without comment, opinion or speculation. When patient management is criticised, no matter how unreasonably, members should seek the advice of the Society at an early opportunity, and before statements are made or submitted.

Content

Members are asked to provide the following details when writing to the Society:

- **name, address, qualifications and current appointment**
- **a *curriculum vitae* for those in training posts**
- **the name, age, gender and occupation of the patient**
- **the names and appointments of other practitioners involved**
- **details of the member's personal involvement and dealings with the patient — symptoms, signs, investigations and treatments as a narrative of fact**
- **photocopies of the relevant clinical records with the authors of entries identified**
- **the Society membership number.**

Rates of subscription
(from 1st January 1987)

Members in the United Kingdom and the Republic of Ireland

A leaflet giving details of rates of subscription has been included with this Report.

Members Overseas

The rates of subscription for members who subscribe through Schemes of Co-operation in Australia, Hong Kong, Malaysia, New Zealand, Singapore and South Africa will be notified to them by the Schemes of Co-operation.

Members who subscribe direct to the Society from these and other countries overseas will receive details from the Society's registered office.

Members are reminded that the annual subscription is normally an allowable expense for income tax purposes.

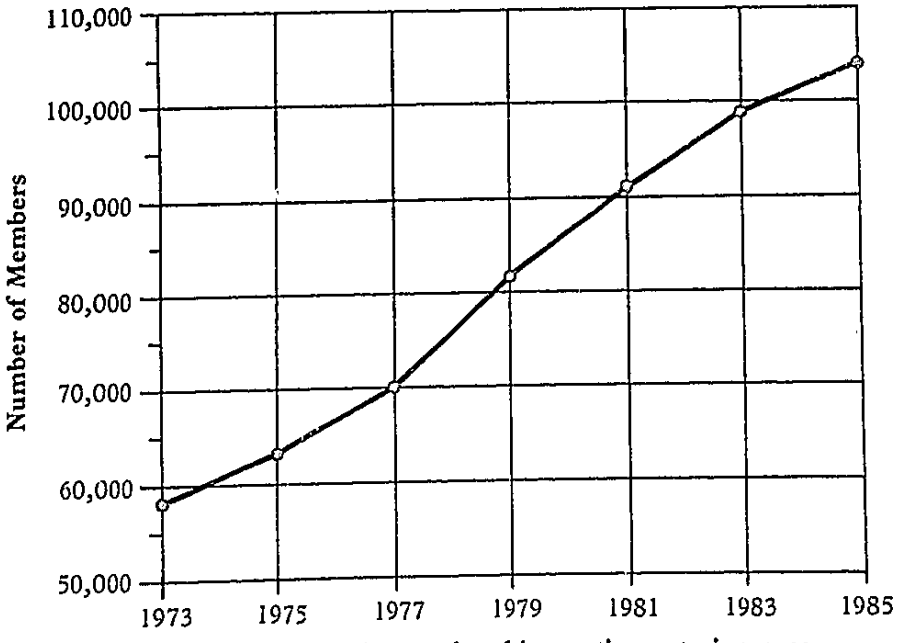
Prompt payment of subscription; changes of address

The Society can only assume responsibility for legal costs and damages on behalf of a practitioner who was a member at the time of the incident in question. This responsibility cannot be accepted if membership has lapsed through non-payment of the annual subscription. **Payment by direct debit, whether by instalments or annual payment, is possible in the United Kingdom and the Republic of Ireland and is normally the most reliable method. Full details may be obtained on application to the Registrar.**

Reminders that the subscription is overdue and ultimately the notice that membership has been terminated may not be received because of a failure to notify the Society of the member's current address.

Members without a permanent residence should always provide the Society with a reliable forwarding address, which could well be their bank.

The Growth of Membership for the Years 1973-1985



The Society's membership continues to increase, both in the United Kingdom and overseas.

Benefits of Society membership

A wide range of matters directly related to professional practice may be undertaken on behalf of a member at the discretion of Council in accordance with the provisions of the Society's Memorandum and Articles of Association (reproduced on pages 74 to 76). The benefits of membership include the following matters, but the list is not exhaustive.

1. Complete indemnity in all cases undertaken by the Society within the provisions of the Articles of Association against legal costs incurred on behalf of a member and costs and damages which may be awarded to the other side in cases where adverse verdicts result, including settlements out of court. This indemnity also covers the personal representatives of a deceased member.

2. Advice and assistance with regard to any question or matter affecting a member's professional character or interests including, when appropriate, the initiation or defence of proceedings.

3. Advice and assistance in connection with matters arising from the practise of the member's profession, including matters of law and ethics and, when necessary, the opinion and assistance of the Society's solicitors.

4. Initiation or defence of proceedings involving questions of professional principle, affecting the general membership.

5. Defence of a member in proceedings brought in respect of an act or omission by:

(a) a partner, assistant or *locum tenens* who is a member of this or of any other protection society with which there is a reciprocal arrangement

(b) a subordinate medical or dental officer whether or not a member of any protection society

(c) an assistant or subordinate who is not a registered medical or dental practitioner, such as a nurse, dispenser, physicist, radiographer, physiotherapist, or dental auxiliary, etc. The Council will not normally accept responsibility under this paragraph where a claim in respect of a non-medical or non-dental assistant or subordinate arises as a result of the engagement of the member in an activity outside the normal range of medical or dental practice, e.g. as the proprietor of a nursing home or laboratory.

Members are urged to check the qualifications of employees and where appropriate to suggest that they subscribe to any available indemnity scheme, e.g. that of the Royal College of Nursing.

6. Defence of proceedings taken against a deceased member's estate in respect of a professional act or omission during his lifetime.

7. Advice and assistance, with legal representation when necessary, at Courts Martial, Boards of Inquiry, Tribunals, Disciplinary Hearings, Coroners' Inquests, Fatal Accident Inquiries, etc.

8. Assistance with arbitration proceedings, for settling disputes and difficulties between members of the Society and others.

9. Consideration, origination and support of improvements and decisions in the law which are conducive to any of the Society's objects.

10. Provision of educational material on matters of interest to members.

Overseas membership; practice in Canada

Membership of the Society is open to practitioners overseas if they possess a qualification which is registrable with the United Kingdom General Medical Council or General Dental Council and are on the appropriate Register of the country in which they practise.

The Society has for many years provided assistance to members practising overseas with the exception of the United States of America. During the last year the Society has been forced, because of the vast increase in awards of damages and the very high cost of litigation, also to exclude Canada.

Members who change their country of practice must notify the Society promptly. Subscription rates vary greatly throughout the world and the correct subscription must be paid to ensure that the full benefits of membership are available. Members who intend to practise in countries in the Middle East are advised to contact the Society before finalising their arrangements because the assistance which the Society may be able to provide is greatly circumscribed by local law, culture and custom.

Ship surgeons

A ship surgeon is liable to be sued in overseas courts, including those of the United States of America or Canada, by a patient treated on board ship. Members contemplating employment of this nature should contact the Secretary to ascertain the benefits of membership available to ship surgeons before finalising their arrangements with the shipping company concerned.

Ship surgeons are not provided with indemnity in respect of legal proceedings in the United States of America and Canada.

Non-clinical practitioners

A practitioner shall be regarded as employed in non-clinical work if, and only if, such work (except in the case of some *bona fide* emergency) is in the opinion of the Council of the Society in no way concerned with diagnosis or therapy or advising thereon. Examples of this category of membership include administrative staff of the DHSS and Dental Estimates Board, and medical statisticians. The range of duties of district community physicians and specialists in community medicine may or may not include an element of clinical practice, and therefore such practitioners are not necessarily eligible. Members wishing to be considered for non-clinical membership should apply to the Secretary giving full particulars of their responsibilities.

Compounded life membership

Members who have paid 40 annual subscriptions are entitled to the full rights and privileges of membership for life without further payment irrespective of whether or not they are still engaged in active practice.

Retired life membership

Retired life membership is granted without subscription, but those wishing to avail themselves of the benefits of this privilege must, on retirement, make immediate application to the Society, notify all changes of address, and if practice (temporary or permanent) is resumed, notify the Society and pay the appropriate annual subscription. Retired life members may seek the Society's assistance in respect of any matter arising from a casual attendance at a *bona fide* emergency and will continue to receive copies of the Annual Report. Retired life membership is not granted to those whose membership is terminated by notice for failure to pay subscriptions.

Schemes of co-operation

Members resident in an area where a Scheme of Co-operation exists are strongly advised to maintain membership through the local association, which provides valuable additional benefits. The Society's schemes of co-operation are:

Medical

Australia

Queensland
The Medical Defence Society of Queensland,
A M A House, 88 L'Estrange Terrace,
Kelvin Grove, Brisbane,
Queensland 4059.
Tel: (07) 356 7103 and 356 2241

South Australia
Medical Defence Association of
South Australia,
Newland House,
80 Brougham Place, North Adelaide, 5006
Tel: (08) 267 4355

Tasmania
Medical Protection Society of Tasmania,
153 Davey Street
Hobart, Tasmania 7000
Tel: (002) 23 7535

Victoria
Medical Defence Association of Victoria,
Pelham House, 165 Bouverie Street,
Carlton 3053, Victoria
Tel: (03) 347 4904 and 347 2842

Western Australia
Medical Defence Association of
Western Australia,
PO Box 263, West Perth 6005,
Western Australia.
Tel: 481 0977, Telex 95669, Fax 481 3686

Hong Kong

The Hong Kong Medical Association,
Duke of Windsor Social Service Building,
5th Floor, 15 Hennessy Road,
P.O. Box 1957, Hong Kong.
Tel: 5-278285, 5-278891, 5-278915

Malaysia

Malaysian Medical Association,
4th Floor, M M A House,
124 Jalan Pahang, P.O. Box S-20
5300 Kuala Lumpur, Malaysia.
Tel: (03) 2980617 and 2928972

New Zealand

New Zealand Medical Association,
26 The Terrace, PO Box 156,
Wellington 1, New Zealand.
Tel: (04) 724 741

Singapore

Singapore Medical Association,
Housemen Quarters,
c/o Singapore General Hospital,
College Road, Singapore 0316

South Africa

The Medical Association of South Africa,
PO Box 20272, Alkantrant 0005,
Pretoria, South Africa.
Tel: 47-6101

Dental

Australia

Queensland
Australian Dental Association
(Queensland Branch),
61 Brookes Street, Bowen Hills,
PO Box 455, Fortitude Valley,
Brisbane, Queensland 4006.
Tel: (07) 52 9866 and 52 9006

South Australia
Australian Dental Association
South Australian Branch Incorporated,
288 Greenhill Road,
PO Box 95, Glenside 5065,
South Australia.
Tel: (08) 79 7878

Tasmania
Australian Dental Association
Tasmanian Branch Incorporated,
130 Main Road, New Town,
Tasmania 7008
Tel: (002) 29 5917

Victoria
Australian Dental Association
Victorian Branch
PO Box 434,
Toorak 3142, Victoria
Tel: (03) 240 8318

Western Australia
Australian Dental Association
(Western Australia Branch),
A D A House, 14 Altona Street,
West Perth 6005, Western Australia.
Tel: (09) 321 7880

Northern Territory
Australian Dental Association
(Northern Territory Branch),
PO Box 4496, Darwin NT 5794

Hong Kong

Hong Kong Dental Association,
Duke of Windsor Social Service Building,
8th Floor, 15 Hennessy Road, Hong Kong.
Tel: 5-285327

Malaysia

Malaysian Dental Association,
No. 26C, Jalan Sultan 52/4,
P O Box 237, 46720 Petaling Jaya
Selangor, Malaysia.
Tel: (03) 7569012

New Zealand

New Zealand Dental Insurance Society Ltd.,
PO Box 28084, Remuera, Auckland 5,
New Zealand.
Tel: (09) 542 778

Singapore

Singapore Dental Association,
Alumni Medical Centre,
4A College Road, Singapore 0316.
Tel: 2202588

Advice from Council

Clinics which advertise to the public

Members who are in contract with, or work for, private clinics which advertise to the public, such as those offering cosmetic surgery or hair-transplant services, are reminded that they should observe carefully the advice published by the General Medical Council (see "Professional Conduct and Discipline: Fitness to Practise", 1985 GMC). Members are advised to exercise objective clinical judgments which are entirely uninfluenced by contractual relationships with, or pressures from, a third party.

Doctors who manage, direct or perform clinical work for organisations which offer private medical services should satisfy themselves that such organisations provide adequate clinical and therapeutic facilities for the services advertised. Members are also advised that they should not, under normal circumstances, undertake any treatment or procedure for which they have not received a recognised formal training, in accordance with the relevant, approved standards of the country in which they practise.

Ritual or religious circumcision

Members who undertake to perform ritual or religious circumcisions are reminded of the need to exercise a high standard of skill and care, both in the performance of the surgery and in the pre-operative and post-operative management, including sedation and recovery.

Council has received some disturbing reports of sole operator-sedationists practising with inadequate staff and facilities, to the detriment of patients. Such practices invite not only civil litigation but also inquiry by the Medical Council as to whether the facts amount to serious professional misconduct by reason of a disregard or neglect of the doctor's professional duties to his patients. If the patient should die there is, additionally, the possibility of criminal proceedings being instituted against the practitioner.

Fraud and the Society's role

The Council of the Society consider it to be an improper use of resources to fund the defence of members who are guilty of fraud or theft. Each request for assistance is carefully examined. The Council recognise that there may be difficulties in the interpretation and understanding of claim forms and that well-intentioned practitioners may fall foul of the law without any criminal intent to defraud. In such exceptional circumstances the Society has discretion to undertake a member's defence in the criminal courts.

Members are reminded that a criminal conviction may lead to further inquiry by the General Medical or Dental Council with the attendant consequences, including the possibility of suspension or erasure from the professional Register.

Shortfalls in resources

In our 1984 Annual Report (No. 92, p. 22) we gave advice to members about medico-legal implications of shortcomings in resources. Council remains concerned about the effects on patient care of economies imposed in response to financial constraints, both at local and national level. We repeat our advice that where these are considered by members to impose unacceptable risks to patient care representations should be made, at once, to those responsible for managing the service. It is advantageous if views are put collectively, through appropriate medical and dental advisory committees, and confirmed in writing.

Such action by members will help to ensure that, if it can be demonstrated that avoidable harm to patients was a direct consequence of unheeded professional advice, the Society is well placed to argue that the legal and financial consequences should be borne by health authorities and not by the Society.

An acquiescence (whether stated or silent) in economies which lower standards of patient care may leave members vulnerable to criticism. If members consider that circumstances arising from management decisions pose unacceptable risks they should consider carefully whether or not to proceed with treatments and, always, should make a detailed record in the clinical notes.

Armed forces, Crown Immunity and the doctor or dentist

A doctor or dentist serving in the armed forces who treats service personnel will, in certain circumstances, be protected by Crown Immunity from legal actions. For the immunity to apply the

doctor or dentist must act within the scope of his official military duties and the patients must be service personnel who are either on duty or on military premises when treated.

Crown Immunity was considered in a recent case in the Court of Appeal. A soldier had received a head injury when off duty in barracks. An army doctor treated the soldier in the barracks but, later, transferred the patient to a civilian hospital where he died. The doctor was adjudged negligent in forwarding inaccurate and misleading details as a result of which the civilian hospital was not fully informed of the soldier's injuries. The Court of Appeal had to consider whether or not the soldier's family could sue the doctor or whether Crown Immunity protected him. It was held that the soldier suffered the consequences of the negligence away from military premises and that Crown Immunity was not available to protect the doctor.

Additionally, Service medical and dental officers would **not** be protected by Crown Immunity for treating civilian members of the families of service personnel, nor for the treatment of civilians generally — for example by undertaking sessional medical or dental work in a civilian setting when 'off duty'. In all circumstances which are unprotected by Crown Immunity, doctors and dentists are personally liable for their negligent acts and omissions and the Society therefore strongly recommends that doctors and dentists in the armed forces should maintain membership of the Society.

Drug and other research: harm to volunteers

The Society will only indemnify members, and pay compensation in accordance with the benefits of membership, for harm suffered in the course of research and clinical trials in circumstances where that harm was the consequence of members' negligence. Injury or harm which occurs without negligence will not be compensated by the Society.

Many research and trial volunteers will expect to receive compensation for injury without the need to prove fault — i.e. on a 'strict liability' or 'no fault' basis. Council advises members who engage or participate in research and trials to ensure that provision is made for *ex gratia* payments to volunteers who suffer harm. Members who practise in the National Health Service may wish to know that a longstanding agreement exists between the Chief Medical Officers in the United Kingdom and the Royal College of Physicians of London to consider on its merits, for *ex gratia* payments by the Health Departments, each case in which a genuine volunteer suffers injury as a result of having taken part in clinical research investigations.

Commercial concerns which sponsor drug trials should be asked to confirm in writing that they will conform to the current guidelines of the Association of the British Pharmaceutical Industry. Research projects should be scrutinised by an approved ethics committee of the health authority and/or university. 'Guidelines on the Practice of Research Ethics Committees' has been published by the Royal College of Physicians of London.

Passport applications, statutory certificates etc.

Members who are asked to countersign passport application forms are reminded that it is necessary to certify that they have been **personally** acquainted with the applicant for at least 2 years. It is not sufficient for the passport applicant to have been a patient of the practice or hospital for 2 or more years and for the member to have worked there for 2 or more years.

Members' attention is also drawn to the following extract from the General Medical Council publication 'Professional Conduct and Discipline: Fitness to Practise':

> *"A doctor's signature is required by statute on certificates for a variety of purposes on the presumption that the truth of any statement which a doctor may certify can be accepted without question. Doctors are accordingly expected to exercise care in issuing certificates and similar documents, and should not certify statements which they have not taken appropriate steps to verify. Any doctor who in his professional capacity signs any certificate or similar document containing statements which are untrue, misleading or otherwise improper renders himself liable to disciplinary proceedings."*

Assistants, partners and deputies

In law any practitioner is responsible for his professional acts and omissions, and the fact that a principal may also be liable for the acts of his assistant in no way decreases the assistant's personal responsibility. Partners are jointly and severally liable in legal actions brought against the partnership and it is essential that each partner and every assistant be a member of a recognised protection or defence society.

Before engaging a *locum tenens,* members are advised to satisfy themselves as to his credentials, that he is a registered practitioner and that he is a member of a recognised protection or defence society. The Medical and Dentists Registers provide the only legal evidence of registration under the relevant Acts.

Whilst it is not the practice of the Society to assist members to negotiate the precise terms of partnership and assistantship agreements, it is always willing to give general advice on these matters and has produced a booklet ***'Considering Partnership'*** in question and answer form, for the guidance of members interested in entering general practice. The Society cannot intervene in disputes between partners or between principals and assistants where the other party or parties to the dispute are also members of the Society unless specifically requested by all concerned, but is willing to assist with arbitration if requested by the parties so to do.

From past experience the Society knows that it is of the utmost importance that prospective partners, principals and assistants should be properly advised in the first instance before committing themselves to arrangements which may have consequences not immediately apparent in the early stages. For example, a junior partner should not commit himself to the purchase of a house and the consequent expense unless and until the partnership arrangements have been finally settled and embodied in a proper agreement.

Practice nurses

Members are advised to employ only registered or enrolled nurses in their practices and to check nursing qualifications with the appropriate registration authorities. It is an offence under the Nurses, Midwives and Health Visitors Act, 1979 for any person to state, or to do any act calculated to suggest, that a person is a registered or enrolled nurse if this is known to be incorrect.

It is both an ethical and a legal duty to ensure that nurses (and any other employees) are properly trained for, and competent to perform, any procedures which are delegated to them. Appropriate training and instruction must be provided before procedures are delegated. It is in members' interests to ensure that nurses whom they employ subscribe to The Royal College of Nursing (see Benefits of Membership 5(c), page10).

Limited registration

Holders of limited registration are reminded that it is their responsibility to ensure the continuation and renewal of their registration with the General Medical Council. Failure to ensure that registration is in order for the post held can lead to a request for a detailed explanation and may result in an appearance before the Overseas Committee of the GMC. This could lead to a refusal to renew registration.

Registration for practice in Ireland

The Medical Council of Ireland has asked that the following notice be drawn to the attention of members:
"Doctors who qualify from a medical school in the United Kingdom and are registered on the principal list of the General Medical Council are required by statute to obtain registration with the Medical Council of Ireland, 8 Lower Hatch Street, Dublin 2, before commencing the practice of medicine in the Republic of Ireland." Registration with the General Medical Council of Great Britain and Northern Ireland no longer confers the privilege of practice in the Republic of Ireland.

New Law

The Hospital Complaints Procedure Act, 1985

Complaints procedures have existed for many years in the National Health Service and elsewhere. In 1985 Parliament enacted The Hospital Complaints Procedure Act which places upon the Secretary of State a duty to give directions to health authorities (health boards in Scotland) to secure that arrangements are made to deal with complaints concerning hospital patients and that steps are taken to publicise the arrangements which have been made. The Act itself does **not** set up a complaints procedure, nor does it specify how complaints procedures should be drawn up or operate. It remains to be seen what changes, if any, will be made to the various complaints procedures already operating within the NHS, and the manner in which they are publicised to patients and their relatives.

The Health Service Commissioner ('Ombudsman') is not able to investigate complaints about clinical judgment but the scope of his powers and the operation of the procedure for the investigation of complaints about clinical judgment (set out in DHSS Circular HC(81)5) are currently under scrutiny by a Select Committee of the House of Commons.

'RIDDOR': The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1985

New statutory regulations applicable to Great Britain came into force in April 1986 which modify the law governing the reporting of accidents resulting in death or major injuries arising from work. The regulations also require the reporting to the Health & Safety Executive, or other appointed authorities, of specified diseases, poisonings and dangerous occurrences. The regulations (Statutory Instrument 1985 No. 2023, HMSO) amend and repeal previous regulations and consolidate the law. A list of reportable diseases and occurrences is set out in the Society's publication ***'Statutory Notifications'***, available to members upon application. The statutory duty of notification is now imposed on employers rather than on doctors, a notable change from the old law.

A booklet of information for doctors on the new arrangements has been published by the Health & Safety Executive from whom copies are available (HSE, St. Hugh's House, Stanley Precinct, Bootle, Merseyside L20 3QY).

Misuse of Drugs

New statutory regulations came into force in April 1986 which modify the Misuse of Drugs Act 1971 and regulations made under that Act. They enable the United Kingdom to become signatory to the United Nations Convention on psychotropic substances 1971, make changes to the list of drugs controlled under the Act and make additional drugs subject to the requirements of the Misuse of Drugs (Safe Custody) Regulations 1973. Details of the changes were circulated to U.K. doctors in a letter (CMO(86)2) from the Chief Medical Officer, Department of Health and Social Security.

A completely new schedule of 33 benzodiazepine drugs is added by the regulations, but these drugs require no statutory safe custody requirements, no special prescription requirements and no record keeping requirements for practitioners.

Certificates of still-birth and early infant death

New statutory regulations have been approved by Parliament and came into operation on 1st January 1986 to amend the **Registration of Births, Deaths and Marriages Regulations 1968** in relation to the certification of still-births and the cause of death of live-born children dying within the first twenty-eight days of life. The new Regulations are **The Registration of Births, Deaths and Marriages (Amendment) (No. 2) Regulations 1985** (S I. 1133 of 1985) and **The Registration of Births, Still-births and Deaths (Welsh Language) (Amendment No. 2) Regulations 1985** (S.I. 1134 of 1985). They prescribe separate forms of certificates for use in cases of still-births and of deaths occurring within the first twenty-eight days of life.

"Still-born" and "Still-birth" are defined as follows by section 41 of the Births and Deaths Registration Act 1953:

> *"Still-born child means a child which has issued forth from its mother after the twenty-eighth week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other sign of life, and the expression "still-birth" shall be construed accordingly".*

A child which has breathed or shown any other sign of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles is considered as live-born for registration purposes irrespective of the number of weeks' duration of the pregnancy.

Books of the Still-birth Certificate forms are supplied free of charge for the use of registered medical practitioners and registered midwives. Books of neonatal death certificate forms are supplied free of charge for the use of registered practitioners only. Both forms of certificate provide for the cause of death to be stated under the categories (a) Main diseases or conditions in fetus, (b) Other diseases or conditions in fetus, (c) Main maternal diseases or conditions affecting fetus, (d) Other maternal diseases or conditions affecting fetus, (e) Other relevant causes.

The books of certificates are accompanied by a printed document described as **"Notes for Medical Practitioner"** followed by the words **"Statutory Provisions Relating to Medical Certificates of Cause of Death".** It is important that practitioners who may be required to complete these certificates should appreciate that **the printed notes are not a part of the Regulations and have no statutory force.** They are designed only for guidance and assistance in completing the forms and do not have to be rigidly followed if not considered appropriate to the circumstances of the particular case. **When completing the certificates care should be taken to adhere to facts.**

Expressions of opinion which might be only speculation and likely to cause needless anxiety or distress to the parents of the child should be avoided.

Data Protection Act, 1984

The Data Protection Act 1984 regulates the use of automatically-processed information relating to individuals and the provision of services in respect of such information. Although the Act itself does not use the word 'computer', it is to computer-based data that it applies and it does not regulate manually-stored information.

The Act gives statutory definitions of terms such as "data", "personal data", "data subject", "data user" etc. and it is important to recognise that close attention must be paid to these complex definitions, and that the plain, ordinary English meanings of the words are irrelevant.

The Act gives effect in law to long-established data principles (set out in schedule 1, part 1 of the Act) which govern how personal data held by data users is to be obtained, held, used and kept private and up to date.

The Society does not, in this brief note, attempt to explain the full provisions of the Act, but simply to remind members (many of whom will doubtless be familiar with it) of some of its provisions and operation. The Act set up the office of The Data Protection Registrar who maintains a Register of data users who hold personal data and of persons carrying on computer bureaux services. Since May 11, 1986 it has been **unlawful** for a person to hold personal data unless registered to do so. The Data Protection Registrar has wide powers to deal with those who contravene the data protection principles, including a power to de-register. The consequences of de-registration are, of course, devastating for those who rely upon computer systems in their daily work. There are rights of appeal from decisions of the Data Protection Registrar to a Data Protection Tribunal. Legal powers also exist to deal with un-registered persons who operate computer equipment which can process information automatically in response to instructions.

Certain exemptions are made under the Act but few of these are likely to be of relevance to members of the Society in the course of their professional duties except for word processors used only for the purposes of producing and editing the text of a document. These are exempt from the provisions of the Act.

The Act gives rights to data subjects (to take effect in November 1987) to be supplied with a copy of information held about them by a data user. It also gives a right to compensation for damage suffered in respect of erroneous information and for the loss or unauthorised disclosure of personal data. Inaccurate data may have to be rectified or erased.

The subject-access provisions of the Act have given rise to much anxiety to doctors and dentists in respect of access to personal health data. A power to make exemptions from the subject access provisions is vested in a government minister and the Department of Health & Social Security is currently considering responses to a consultative document (DA(85)23) on the topic. It remains to be seen what, if any, exemption will be made in respect of computer-based health records. Whilst manual records are exempt from the subject-access provisions, it is likely that pressure will mount for similar rules to apply to them as to computerised records. The Society stresses again the advice given for several years, that medical and dental records should be objective and worthy of independent scrutiny and should not be used to record pejorative comments or other material likely to be embarrassing.

Further information about the Act, and answers to enquiries, may be obtained from the Office of the Data Protection Registrar, Springfield House, Water Lane, Wilmslow, Cheshire DK9 5AX (telephones: enquiries 0625 535777, administration 0625 535711).

Product liability

The term 'product liability' is a loose but convenient shorthand expression for describing the law which determines liability for injury or death caused by defective products. What, for example, are the legal remedies open to a patient who suffers injury from the adverse effects of a medicine or drug, and against whom can such remedies be exercised?

Under the present law in the United Kingdom and other common law countries, a person who is injured by a defective product may have a remedy in contract or in tort. If he purchased the product he can sue the seller in contract for breach of an implied warranty that the goods are reasonably fit for the purpose for which they are bought; negligence does not have to be proved, and is irrelevant. But if the injured person is a third party, such as a member of the purchaser's family who has no direct contractual relationship with the seller, his only remedy is to sue the producer or manufacturer of the goods in tort; here the plaintiff must prove negligence, i.e. breach of a duty of care, on the part of the manufacturer. The standard of care owed by the manufacturer to the ultimate consumer was stated in these terms by Lord Atkin in a celebrated case decided by the House of Lords in 1932:

> *"A manufacturer of products, which he sells in such a form as to show that he intends them to reach the ultimate consumer in the form in which they left him with no reasonable possibility of intermediate examination, and with the knowledge that the absence of reasonable care in the preparation or putting up of the products will result in an injury to the consumer's life or property, owes a duty to the consumer to take that reasonable care".* ***Donoghue v Stevenson*** *(1932) A.C. 562.*

In 1978 the Royal Commission on Civil Liability and Compensation for Personal Injury (the Pearson Report) recommended among other things that producers should be strictly liable in tort for death or personal injury caused by defective products. Strict liability means that negligence would not have to be proved. Subject to any special defences open to the defendant a claim for damages would succeed if it were proved that the product was defective and that the injury complained of was caused by the defect.

The Pearson recommendations have not so far been put into effect. They took into account and were influenced by certain proposals contained in a draft E.E.C. Directive and in the Strasbourg Convention of 1977 which were then under discussion. After another eight years of discussion the E.E.C. Directive was eventually adopted in July 1985. Member States of the European Community are required to adapt their domestic laws to give effect to the Directive by the end of July 1988. What follows is a brief summary of some of the main provisions of the Directive as they may affect medical and dental practitioners.

1 The producer of a product will be strictly liable for damage caused by a defect in the product. "Product" means all movables except primary agricultural products and game. The definition undoubtedly includes all medicines and drugs. "Producer" means the manufacturer of a finished product, the producer of any raw material or the manufacturer of a component part, and any person who holds himself out to be the producer e.g. by putting his own brand name on the product.

2 Where the producer of a product cannot be identified, each supplier of it shall be treated as its producer, unless he informs the injured person within a reasonable time of the identity of the producer or of the person who supplied him with the product.

3 The claimant must prove the damage, the defect and the causal relationship. Presumably the standard of proof and rules of evidence will be in accordance with the domestic law of each Member State.

4 A product is defective when it does not provide the safety which a person is entitled to expect, taking all circumstances into account including the presentation of the product, the use to which it could reasonably be expected to be put and the time when it was put into circulation; but a product will not be considered defective for the sole reason that a better product is subsequently put into circulation.

5 Six specific defences are provided by the Directive. The producer will not be liable if he proves:

(a) that he did not put the product into circulation; or

(b) that, having regard to the circumstances, it is probable that the defect which caused the damage did not exist at the time when the product was put into circulation by him or that the defect came into being afterwards; or

(c) that the product was neither manufactured by him for sale or any form of distribution for economic purpose, nor manufactured or distributed by him in the course of his business; or

(d) that the defect is due to compliance of the product with mandatory regulations issued by the public authorities; or

(e) that the state of scientific knowledge at the time when he put the product into circulation was not such as to enable the existence of the defect to be discovered; or

(f) in the case of a manufacturer of a component, that the defect is attributable to the design of the product in which the component has been fitted or to the instructions given by the manufacturer of the product.

6 The Directive will not apply retrospectively to any products put into circulation before the date when the provisions come into force in individual Member States.

7 Various other provisions of the Directive relate to contributory negligence of the injured person, the limitation period for bringing proceedings, heads of damage for which compensation may be claimed, and other sundry matters.

It would be premature to attempt any detailed comment in advance of proposed legislation by the U.K. Parliament. It is however clear that the Directive has a number of implications and raises a number of questions of direct concern to the pharmaceutical industry and to individual pharmacists, doctors and dentists.

The "supplier" (paragraph 2 above) would include the dispensing general practitioner, the dispensing chemist, the hospital pharmacy and perhaps the doctor or dentist who issues a prescription. Is the G.P. to keep a record of the manufacturer of every drug for which he issues a prescription for a named patient? How is he to identify the manufacturer, perhaps some years later, if he prescribes a drug by its generic rather than its proprietary name, as encouraged by the D.H.S.S.? The definition of a defective product (paragraph 4) must raise a number of questions when applied to drugs. Is it realistic to judge "the safety which a person is entitled to expect" by applying the same criteria to a drug as to a domestic electric appliance? How is it to be proved whether the injury complained of is caused by an alleged defective drug, or by some idiosyncrasy of the patient or interaction with another drug or the patient's diet or natural progression of the illness? There will be scope for much debate during the progress of the Bill through Parliament.

AIDS — Legal and Ethical Aspects

by D J Jeffries BSc MB BS FRCPath
Head of the Division of Virology, St. Mary's Hospital Medical School, London

The Acquired Immune Deficiency Syndrome (AIDS) is caused by a recently-recognised human retrovirus called HTLV3/LAV. This serious condition is diagnosed by the appearance of certain tumours, of which the commonest is Kaposi's sarcoma, and/or opportunist infections such as pneumocystis carinii pneumonia, disseminated cytomegalovirus, oesophageal candidiasis and ulcerative perianal herpes simplex in an individual who has had no known history of natural or iatrogenic immunocompromise. The syndrome is the most severe manifestation of the virus infection; milder disease states occur (e.g. persistent generalised lymphadenopathy) and, at present, the majority of those infected are asymptomatic. It is becoming clear, however, that the virus has the ability to invade the central nervous system and is associated with the development of encephalopathy and progressive dementia in the absence of opportunist infections or other evidence of immunocompromise. In addition to this, virus is known to persist in asymptomatic individuals as well as those who are ill despite evidence of antibody production. Those who have a confirmed positive antibody test must, therefore, be presumed to be infected and capable of transmitting the infection. Only time and continued study will answer important questions such as the long-term effects of viraemia and whether immune responses can eventually overcome virus production and achieve a

non-infectious state of immunity. There is at present no cure for the infection and thus it is important to avoid the spread of the virus. The most important factor in controlling spread of infection is education of the public to understand its modes of transmission. Panic, hysteria and ignorance must be replaced by acceptance and understanding that this worldwide infection is most unlikely to disappear spontaneously. The health-care professions must take the lead in this.

Virus transmission

Extensive investigation of many thousands of cases throughout the world has indicated three routes of infection. Sexual intercourse (homosexual and heterosexual) accounts for most infections. When the virus first appeared the risk of infection could be correlated to the numbers of sexual contacts with risk-group individuals. As it became more prevalent this was less significant and it was obvious that a single contact could result in transmission. The virus is also transmitted by transfer of infected blood, either by transfusion of whole blood or certain blood products, or by inoculation with contaminated needles, particularly in intravenous drug abusers. In addition, it is clear that the virus may be transmitted from mother to offspring. There has been no convincing evidence that HTLV3/LAV can be infectious by any other route and this is supported by the absence of antibody in close family contacts of ill and asymptomatic carriers of the virus and in health care workers caring for infected patients. It would appear that the highest levels of virus are to be found in blood and seminal fluid but it has also been detected in other body fluids, including tears, saliva, milk, female genital tract secretions, urine and cerebrospinal fluid. It has not been detected in vomitus or faeces although any body fluid is likely to contain virus if it is blood-stained. When devising policies for preventing exposure of health-care workers it is sensible to take precautions with all tissues and fluids.

Antibody testing

In the absence of routine methods for detecting infectivity the only currently available tests for exposure to the virus and identification of potentially infectious carriers are antibody assays. These tests have been introduced with commendable speed with the prime objective of screening blood donors and, hence, preventing spread of the virus by transfusion. In achieving this aim it is acknowledged that the first-generation tests are not infallible and that they may produce a low rate of false-positive and false-negative results. To avoid the possibility that individuals may donate blood for the sole purpose of obtaining the antibody test alternative testing sites have been established throughout the U.K. in sexually-transmitted disease (STD) clinics. The availability of the test has led to increasing requests for many different reasons including diagnosis, other screening requirements, research and attempts to reduce the potential for hospital infection.

It must be realised that the demonstration of the presence of antibody to HTLV3/LAV in a blood sample is likely to have profound effects on that individual's life. Apart from the fact that at the present time there is no absolute confirmatory test which can be relied on to eliminate all risk of false-positivity, the psychological sequelae of realising that one may be a lifelong infectious carrier of a potentially-fatal disease may be serious. Without adequate and informed counselling the depression, which may ensue, has led to suicides. The detection of the antibody may have serious implications for employment and schooling. The prejudices previously seen with hepatitis B in the work situation and in schooling have already been repeated with this virus.

There has recently been an indication that people will only be allowed to work in a certain middle-eastern country if they can produce a certificate of HTLV3/LAV negativity. In the United Kingdom a positive antibody test prevents an individual from obtaining life-insurance and in the United States some companies require proof of a negative test before proceeding with a proposal. The fact that the virus is known to transmit from mother to baby makes it unwise for women who are HTLV3/LAV positive to conceive. In addition to this, because of the apparent adverse effect of pregnancy in precipitating disease in women who are HTLV3/LAV antibody positive, consideration should be given to termination. Patients who are receiving haemodialysis would probably be ill-advised to proceed with renal transplantation if they are antibody positive as the administration of immunosuppressive drugs may precipitate frank AIDS.

As the test has so many implications it is extremely important to ensure that these are understood before a sample is taken. The clinician should obtain consent from the patient before initiating the test and also ensure that the patient can receive skilled counselling if the result is positive. This counselling process is likely to be required over a long period of time and will enable the individual to come to terms with what is usually a major life-event. If testing is conducted without informed consent the practitioner is likely to cause unnecessary harm to the patient and may also expose himself to litigation. If skilled counselling cannot be provided it would be prudent to refer the patient to a centre which has adequate facilities.

Before requesting a test for HTLV3/LAV antibody the clinician should consider the benefit to be gained from the result. It should not be overlooked that the test can be of little or no benefit to the

individual patient because there is no cure for those with positive results, albeit that the test might be of some benefit to a wider community or the public at large. The test occasionally has a part to play in diagnosis but only in certain circumstances. It may be very valuable in ascertaining the cause of disease in some low-risk individuals such as babies with multiple infections who are failing to thrive. It is difficult to imagine, however, that it can aid diagnosis of disease occurring in members of the 'high-risk' groups in whom the antibody prevalence is already known to be at a high level. There is a strong case for extending the donor screening to include any situation where tissues or fluids are transferred from one person to another without satisfactory sterilisation. This includes donors of kidneys, corneas, bone-marrow, hearts and spermatozoa.

Other groups to whom the test should be offered are haemodialysis patients and women in 'high-risk' categories attending ante-natal clinics. The extremely low risk of transmission of the virus to health-care workers means that, in view of the major implications of testing to the patients concerned, routine testing for safety reasons is not justified. Indeed, the impossible task of attempting to identify those who may be in 'high-risk' groups, together with the fact that the virus is likely to extend outside those groups, indicates the futility of considering this approach.

Risks to health-care workers

At the time of writing, no health-care worker anywhere in the world is known to have acquired AIDS from occupational exposure. There is one recorded instance of an inoculation injury which resulted in sero-conversion and there is circumstantial evidence that two other workers may have been infected from contaminated needles. This type of exposure must represent the 'worst-case' situation as, although the virus is sometimes found in other fluids, it is mainly associated with blood. Tests on over 650 health-care workers in the United States, all of whom have received significant needle-injuries, have remained negative over a year's follow-up. This must be compared with the recorded rate of transmission (6-30%) of another serum-borne hazard to health-care staff, hepatitis B, in those who have not been immunised. There is no evidence that health-care workers are at risk from infection by any other route. It is clear that the essential precautions to be taken to prevent this virus, which may be present in any patient or any sample, are those designed to prevent inoculation injury or exposure of skin, eyes and lips to blood or other body fluids. The careful disposal of 'sharps' is mandatory and protective clothing should be available if there is a likelihood of contamination with body fluids. Any cuts or open wounds on the hands should be covered with a waterproof dressing and, if there is a likelihood of skin contamination with blood, gloves should be worn. Protective spectacles and a mask should be considered if there is a possibility of splashing to the face.

It can be argued that biohazard labelling of samples from known HTLV3/LAV positive patients will reduce risks by enabling staff to exercise greater care. The danger of this approach is that there is likely to be an assumption that the absence of the label implies lack of infectivity and this is inappropriate with a prevalent and commonly asymptomatic infection.

If inoculation injury occurs staff should be aware of sensible first-aid measures to be taken, particularly the need to encourage bleeding and to wash immediately with soap and water. In the event of splashing into the eye suitable eye irrigation apparatus should be to hand. It is important that they then have access to an occupational-health adviser who can counsel them and, if necessary, arrange for them to receive regular consultations to reassure them and confirm that health is maintained. It is sensible for the staff member to donate a serum sample after the injury and this should be stored frozen as a baseline for any future investigations. It should not be tested without the knowledge and consent of the person concerned.

In view of the likelihood of unfair prejudices to health-care workers, knowledge of positivity should be a matter for strict confidentiality between them and their health adviser. There is no evidence that staff who are HTLV3/LAV antibody positive present a threat to their patients or to other staff. Staff, particularly surgeons and dentists, who are aware that they are positive should pay particular attention to personal hygiene and ensure that any hand lesions are adequately protected.

Dentists

The principles of preventing inoculation injury apply particularly in dentistry. The likelihood of generating aerosols by low and high speed drills, ultrasonic scalers and irrigation/air syringes emphasises the need to wear protective eyewear and a mask when working with known HTLV3/LAV antibody positive individuals. In view of the fact that many infected patients will remain undetected, a case can be made for wearing this protection with all patients. Detailed guidelines for the surgical and dental management of HTLV3/LAV infected patients have been produced by the Department of Health and Social Security in the United Kingdom.

HTLV3/LAV in the community

Studies of close family contacts for those who are known to be carriers of the virus have failed to show evidence of transmissibility by intimate non-sexual contact. There is no evidence of spread within the community by any route other than sexual intercourse, blood or semen transfer or from mother to baby (probably in utero) and possibly by breast feeding. This means that there is no reason to regard those who are known or suspected to be carrying the virus as a potential threat to others in any aspect of community life.

Schools

The absence of evidence of transmission in close family situations emphasises the fact that children at school who are HTLV3/LAV positive do not present a threat to classmates. As many of these children will not be identified it is sensible for staff to be aware of the potential hazard from blood from any child, to cover any open wounds and to know that the virus can be disinfected easily in blood spillages by using household bleach (hypochlorite). Detailed guidelines for staff in educational establishments are being prepared by the Department of Education and Science and the Department of Health and Social Security.

Decontamination of infected materials

It is fortunate that HTLV3/LAV is a delicate retrovirus, very easily destroyed by heat and the standard disinfectants recommended for hepatitis B virus such as hypochlorite, formaldehyde and glutaraldehyde. It appears to be inactivated by heating at 56°C for 30 minutes and boiling and autoclaving are more than adequate for its destruction. It is known to be killed by hypochlorite 1,000 to 10,000 parts per million available chlorine (depending on the degree of blood contamination) and 2% freshly-activated glutaraldehyde. Alcohols and detergents will also remove its infectivity. It is, therefore, a virus which is easily controlled in any health-care setting and it is important that those who are infected, or those who are caring for them in the community, know how to deal with a haemorrhage. The marked sensitivity to heat and detergents means that standard washing of crockery and cutlery is all that is required to inactivate the virus.

Conclusions

The appearance of this epidemic presents a problem which is probably unprecedented in recorded history. The virus differs from those which have caused previous epidemics in its ability to produce a persistent infectious carrier state in most, if not all, of those infected. Evidence of transmission to the next generation indicates that it will be a continuing problem. The best prospect for its control lies in education and consequent alteration of lifestyles and, hopefully, this may be supplemented by immunisation and therapy. It is unlikely to disappear and it is essential that those engaged in health-care come to terms with the fact that they will be required to treat an increasing number of carriers of a low-infectivity virus. If those who are antibody positive are seen to be victims of undue prejudice or if their medical care is sub-optimal they will be much less inclined to co-operate in attempts to bring the epidemic under control. If the health-care professions can be persuaded to accept these facts sooner rather than later it should be possible to educate the public.

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All in a Week's Work

by C A Owen BSc MPhil MB BS MRCGP
Member of Secretariat, The Medical Protection Society

For some of you the arrival of the Annual Report and Accounts this year will evoke a different response from that of previous years. Its content will have greater relevance this year because, for the first time, you needed help with a problem. Maybe it was the writ which you opened with Saturday morning's post and which blighted your weekend off. Possibly you found yourself approached by the police, keen for you to divulge information about a patient which will help them. It could have been an ethical matter which made you decide to telephone us, or the first time anybody complained about you. Until that point of contact with us you may well have wondered about the cost of your yearly subscription, thought it unfair that the doctor whose "negligence" incurred a large damages payment should pay the same amount as you. Well publicised these cases may be but they are by no means the mainstay of our workload. There are many more cases which never reach a court and can be resolved with guidance from a secretariat member. The numbers are large: in the first two months of this year I handled 207 new matters, 83 by telephone and 124 by correspondence, and I am only one of 12 medical colleagues. Of my new matters, complaints against general practitioners totalled 32. Join me for a typical week and see what happens.

In the lull before the storm of Monday's post I tie up some loose ends from Friday. An anaesthetic death, a missed scaphoid fracture and a rectovaginal fistula apparently following repair of a third-degree tear. I wrote last week to the members involved in these cases, inviting them to send me their reports. Now I need to liaise with the health authorities, solicitors and our sister defence societies. The ringing of the telephone cuts across my thoughts. A member, faced with a neonatal death after a difficult forceps delivery, needs advice. This is followed by a more common request for advice regarding the release of a patient's records in litigation. Another doctor wants to know if it is permissible to override the wishes of a mother and examine in hospital her two-year-old to establish an alleged sexual assault by the father.

I gulp my coffee as the 'phone rings again — our solicitors want to finalise details of a conference to be held this Wednesday. Then time for some teamwork as one of my colleagues and I weigh up whether we should advise a member to agree to the investigation of an out-of-time complaint.

We break for lunch, which is also an opportunity to chat to other members of the secretariat. Today it's cricket and whether we need a bigger computer. Back in my office I tackle the day's new correspondence which ranges over the ethics of opening a private health clinic; a general practitioner accused by his former receptionist of unfair dismissal; solicitors alleging a failed sterilization and a policeman requesting from a member the address of a patient suspected of rape. There is usually a time in the day when members of the secretariat can meet and discuss informally any particularly complex problems. This afternoon it concerns a member who has been left with unpaid practice tax bills following the departure of her partner. She has no access to the bank account which is in his name and there is no practice agreement. Suggestions made as to how to turn a seemingly insoluble problem into a more straightforward one, we repair to our respective offices. I take my final call of the day and speak to a practitioner who asks if there are ethical problems in renting part of his practice premises for use as a massage parlour.

Tuesday, and as usual I find myself working on the train surrounded by the now familiar faces on the 7.05. The Suffolk countryside is still dark and there is little to distract me from reading the *BMJ, Current Law* and some internal policy memoranda. In the office the first new matter concerns a South African member considering an action for assault against a patient he alleges tried to run him over. Next is a forensic report on glass removed from a facial wound which confirms that it is of the type used in car windscreens. The plaintiff's solicitors are using this report in a claim for damages against a casualty officer who saw the patient five years ago following a road accident.

Sadly, no biscuits with coffee — just a circulating memo about restrictive covenants in general practice. Commonly an outgoing partner is precluded from resuming practice within a specified radius of his old partnership. I discuss with my secretary how we can more easily organise the 'bring-forward' diary for the long-running cases. Inevitably the telephone punctuates everything: advice on GMC registration; concern over a summons — do I have to go to court and can't you get me out of it? The answers being yes and no respectively!

I manage to have a good session with the ongoing cases which often generate a substantial amount of correspondence and require interaction with increasing numbers of people as the case progresses. Of these matters in progress each secretariat member has about one thousand current cases at any one time. We are always pleased to assist with telephone advice and our switchboard policy is to put

members straight through to one of the members of secretariat whenever possible. Our London and Leeds offices will have around 300 incoming telephone calls each day. Of these, about one-third will be enquiries about membership and subscriptions and one-half will be requests from members for legal, ethical and other advice which will be answered by the medical and dental secretariat. This afternoon the problems are no less diverse than usual. Termination of pregnancy for a 15-year-old without parental consent; advice on confidentiality with respect to an epileptic driver; help in respect of a court appearance tomorrow by a member giving evidence in a case of a man with AIDS who has allegedly bitten two policemen.

Wednesday is the earliest time I have to work on a case from a recent trip to Dublin. A colleague and I spent 48 hours taking statements of evidence from four members, working through current cases with our solicitors in the Republic, meeting a consultant surgeon to discuss his expert medical reports and participating in an undergraduate meeting on medico-legal issues. The case today involves alleged tendon damage during removal of warts. I finalise the draft statement, request an expert orthopaedic opinion, liaise with our solicitors and write to the member involved. Finally, but no less important, I write a précis of the case for its consideration at our next Cases Committee. This comprises about 30 medical and dental specialists who, with our secretariat and solicitors, meet fortnightly to decide defensibility and apportionment of liability in current claims. (Its work was described in our Annual Report for 1980, Number 88, at page 24).

I'm out all afternoon with our solicitors at a conference with counsel. Such a meeting involves the member, a solicitor, a barrister, and one or more medical experts with, of course, the member of secretariat responsible for the case. The purpose is to take advice on how the case should be conducted and to establish the evidence needed at trial.

Thursday morning begins with a telephone call from a general practitioner, anxious about the FPC complaint against him. I discuss the complaints procedure, ask for copies of the correspondence and the complaint and offer advice about a reply. Common reasons for complaints include failures to visit, to treat or to arrange admission or referral to hospital. They should not be dismissed as unimportant even if they seem trivial to the doctor concerned as they can easily 'snowball' into an unpleasant conflict. We meet each morning to distribute the day's post which is more or less divided randomly, though some of us have responsibility for particular geographical areas. My problems today include a consultant obstetrician whose antenatal patient wishes acupuncture in labour and a general practitioner who prescribed eye drops for visual loss later found to be due to a detached retina. With our solicitors I check through one or two details relating to a forthcoming GMC hearing at which a doctor faces the possibility of erasure from the Register for serious professional misconduct.

In the afternoon I advise a member who is having an affair with one of his surgery staff. This is followed by three new matters in quick succession — a police statement in a case of non-accidental injury; a new claim relating to an orthopaedic operation in 1975 and a request for help in drafting a coroner's statement.

My train journey on Friday morning provides a welcome opportunity for reading a number of articles on the pros and cons of patients having access to their general practitioner records. The post brings an anaesthetic death, complicated by a misleading newspaper report of the events surrounding the death. Another member has been accused of sexually assaulting a nurse on hospital premises, despite the fact that he was out with friends when the incident is said to have taken place. Help is required for a case in which a laminectomy was performed, with subsequent neurological deficit. Correspondence relating to a dozen of the current files ensures a busy end to the week. A general practitioner telephones for advice about one of his patients who is standing outside the surgery with a placard of derogatory comments about him. We work out the course of action to be taken and agree that we will update events as they change. At the secretariat meeting we discuss fire arrangements and the escalating costs in cases involving brain-damaged children in the light of a recently reported award of £600,000.

After lunch I deal with an enquiry from a general practitioner who has received a complaint from his patient for an allegedly missed diagnosis of shingles. We decide that he should call and see the patient to try and resolve things at this early stage. Next a surgeon telephones with notification of a claim in respect of damage to a tributary of the femoral vein during stripping of varicose veins.

Before leaving the office I learn that a member whom I helped with a Medical Services Committee hearing has had the complaint dismissed. Although we have never met I feel that I know him well through his letters and telephone calls, his practice, his notes, his hopes and his fears. The complaint was an unreasonable one and I'm greatly relieved that he and his family can put this incident behind them. His file is now closed and it is a fitting end to the week in London.

'Doctor, you have a child!'

by Adrian Whitfield QC

"I knew for a fact that this was no libel,
Spread in the pub by some jealous rival—
By God, 'twas a fact, and well supported;
I was a father before I started!"

The Midnight Court: *Bryan Merryman*
Tr Frank O'Connor

In the last seven years a new form of claim has been accepted by the English courts — a claim that a doctor should pay for the upkeep of the unwanted child. It started in **Scuriaga** v **Powell** [1979] 123 SJ 406, a claim in negligence based on an unsuccessful attempt to terminate a pregnancy. Then came **Thake** v **Maurice** [1986] 1 All ER 497, where the doctor was sued because a baby was born following late recanalisation after vasectomy. The mothers in both those cases had healthy babies, but in **Emeh** v **Kensington AHA** [1985] QB 1012 a particular tragedy struck: after a failed sterilisation there was born a child with congenital abnormalities. The circumstances of, and the arguments in, these and other cases differed: but in each case awards of damages were made to the parents, and each award included a sum to be paid by the responsible doctors (or their protection societies) based on the cost of bringing up the children.

Why are awards made in such circumstances? How are they calculated? Should the unwanted child, subsequently loved, be brought up at the doctor's expense? And what next? These problems concern not only gynaecologists but also any doctor who is consulted by those seeking advice on family planning, pregnancy, abortion or sterilisation.

Liability

Successful actions of the type under discussion have, to date, all been based on allegations of negligence, usually in treatment, such as in the performance of an operation of termination or sterilisation. **Thake**'s case is however a significant example of an award based on a finding of negligent advice. A doctor who advised the couple on a vasectomy gave evidence that he had told the plaintiffs, a married couple, that "the ends have been known very occasionally to heal up". It was the plaintiffs' case that they were not told this and that therefore symptoms of later pregnancy were disregarded until it was too advanced for termination.

It was the plaintiffs' evidence which was accepted, as opposed to the doctor's recollection, and as the latter had given evidence that a clearly understood warning of the possibility of recanalisation was necessary, the finding went against him. It is noteworthy that it did so even though the plaintiffs had called no expert evidence to condemn a failure to warn: in the circumstances departure from the doctor's own professed standard was held to be negligent. More recently, in **Gold** v **Haringey Health Authority** (The Times, June 17, 1986) the judge stated that, in matters of contraceptive counselling (as distinct from therapeutic counselling), it was the opinion of the court, rather than the test of conformity to a practice accepted as proper by responsible medical opinion, which determined the issue of negligence. However, this case is likely to be the subject of an appeal.

Furthermore, the court found that had the couple been warned of the risk of recanalisation they would have realised that the symptoms experienced indicated a possible pregnancy and that, having obtained advice, the mother then could and would have obtained a legal abortion: thus, that the negligence of the doctor was in law responsible for the birth of the child and that he was liable to pay damages.

Now, it is by no means always the case that the pregnancy is discovered too late for termination. It has accordingly been argued that a woman who qualifies for a lawful abortion when an originally unwanted pregnancy or its continuance is discovered is unreasonable if she then refuses to have it terminated, and thus that (while she has a limited claim for pain and suffering) she cannot be heard to claim damages for the upkeep of the child. Such an argument did indeed succeed in front of the trial Judge in **Emeh**, even though the pregnancy was about twenty weeks advanced when the plaintiff discovered it. Not surprisingly, however, the argument was rejected on appeal. The attitude of Slade LJ was expressed in the following terms:

> *"Save in the most exceptional circumstances, I cannot think it right that the court should ever declare it unreasonable for a woman to decline to have an abortion in a case where there is no evidence that there were any medical or psychiatric grounds for terminating the particular pregnancy."*

This in terms says little more than it is almost always reasonable for a woman to decline an illegal abortion, but its tone indicates distaste for the defendant's argument. Purchas LJ went as far as saying that it was

> *"unacceptable that the court should be invited to consider critically in the context of a defence of* novus actus interveniens *the decision of a mother to terminate or not her pregnancy which has been caused by the defendant's negligence".*

The inference one draws is that if by a doctor's negligence a woman becomes or remains pregnant, he must usually pay for the child when it is born, even though a lawful abortion might have been possible.

Quantum

It is not surprising that the calculation of damages has provoked a lot of argument and debate, nor that arguments based on public policy have been raised. Indeed, in the case of **Udale** v **Bloomsbury AHA** [1983] 1 WLR 1098 such arguments succeeded to the extent of preventing the plaintiff recovering all costs of upkeep of a child born after failed sterilisation. However, that part of the decision in **Udale** has not been followed, the case law has by now to some extent established a pattern of awards and unless and until the House of Lords has a chance to consider the public policy arguments, the general position is likely to be as follows:—

Pain and suffering

First, the mother will have an award for the 'pain, suffering and loss of amenities' which she experiences in the unwanted pregnancy and birth. Extra worry will increase this award, if for example through a misunderstanding of her condition she believes that she is ill, or if she has been given drugs for a suspected illness which she thinks may have damaged the fetus. Initially, in **Thake** the trial judge had refused to permit such a claim, saying:

> *"The birth of a healthy child should be set off against their disappointment and the labour pains so that they cancel each other out".*

The Court of Appeal, however, reversed that finding and held that while the joy of having a healthy child should cancel out and prevent the recovery of damages for the "time, trouble and care which is inevitably involved in the upbringing", claims could still be made for "pre-natal distress, pain and suffering".

If, however, the child is not born healthy but is handicapped, the position may well be very different. In **Emeh** where there were disabilities, the award included £10,000 for future

> *"pain, suffering and the loss of amenity including the extra care which has to be given . . . over the years".*

It is not easy to see from the report why the award was so small.

Where the plaintiff is an unmarried mother she may have a claim for the impairment of marriage prospects: **Scuriaga.** On general principles, if the unwanted pregnancy destroys an existing marriage, she should recover damages for that as well.

The mother's loss

Secondly, the plaintiff will have claim for expenses rendered necessary by, and consequent on, the birth. These will include not only the cost of baby clothes and the pram but also any loss of wages until a return to work can reasonably be expected and/or the cost of a childminder.

The child's keep

Thirdly, and most controversially, the parents may have a claim for the cost of the child's keep. This will include the costs of upbringing, projected forward until (say) school-leaving age. So far, this part of the award, which is that most sensitive to the argument that it is against public policy, has been approached somewhat cautiously. Thus, awards have been based on supplementary benefit scales, or credit has been given for child allowance. I have as yet seen no award of more than £11,500 for the cost of keep of an unwanted child. This no doubt is because children whose cases have appeared in the law reports all seem, in the words of one Judge, to have been "born into a humble household". The same Judge went on:

> *"The defendant should not be expected to do more than provide her with necessaries".*

It is rather as if the courts, having decided that it is not against public policy to father the child upon the doctor, nevertheless so far hesitate to heap wealth upon the real parents. Larger awards, however, would doubtless be made if there was evidence of a family lifestyle in which considerable expenditure on children could be expected.

The level of damages

Globally, the largest award of which I am aware to date has been that of a total of just over £39,000 in **Jones v West Berkshire Health Authority** (The Times, July 3, 1986). Included in this sum was the agreed figure of £30,000 for the mother's loss of earnings and cost of keep, £2,750 for pain, suffering and loss of amenity and £7,000 in interest.

Compared with awards in other classes of case, this is very small. In the 1984 Annual Report I gave an example of what was then the large award of £309,529 for incomplete quadriplegia with persistent pain. I concluded that:

"It can be said with some confidence that the level of awards by judges is likely to go on rising".

That prophecy has been fulfilled. Thus, in December 1985 the Times reported an award of £580,470 damages to a tetraplegic, and of that sum £95,000 was for pain, suffering and loss of amenities alone. Further, in March 1986, following an obstetric accident resulting in brain damage, a claim was settled at £600,000, and the plaintiff's counsel was reported as saying that the family had discounted 20% of what they believed a conservative valuation (Times, 11th March, 1986).

However, while claims of the type discussed are comparatively small in size they are nevertheless becoming frequent. Repugnant though it may seem to many, doctors are finding that they have to pay for the cost and keep of a child, who, unwanted before birth, has become a loved and integral member of a family unit long before the writ is issued against them by the devoted parents.

Consent for sterilising operations

Members who undertake sterilising operations are advised to use the special form of consent which the Society publishes in their booklet **"Consent, Confidentiality, Disclosure of Medical Records"** and which was reproduced at page 24 of last year's Annual Report. On this form patients acknowledge that there is a possibility that they might not become or remain sterile.

Failed sterilisation: Histology report not acted upon; (case report)

A woman aged 30 years was admitted to hospital for a sterilisation which was performed by a locum consultant and a registrar, both members of the Society, through a small Pfannensteil incision. Specimens of resected tissue were sent for histological examination but unfortunately no result is documented in the case notes. The locum consultant could not recall what, if any, counselling had been given to the patient. She went home after a four-day admission and four days after she went home a histology report was despatched which stated that, microscopically, numerous sections taken showed fibromuscular and vascular connective tissue only. No fallopian tube lumen or mucosa was seen in the specimen from the right side. The histological report never found its way into the contemporaneous case notes and no action was taken upon it.

The patient was reviewed in the gynaecology outpatient department six weeks after discharge from hospital when the gynaecological registrar noted that the scar was well healed and he discharged the patient. The absence of the histology report was not remarked upon.

Two years later the patient became pregnant and subsequently gave birth to a normal baby. She claimed compensation, alleging negligence in that no operation had been performed on the right fallopian tube and that the histology result had been negligently overlooked. The claim was regarded as being indefensible and negotiations between legal advisers resulted in payment of compensation of £11,000. The importance of adequate follow-up of requests for histological reports is stressed as is the importance of placing such reports in the case notes in time for outpatient attendances.

Intramuscular and Intravenous Injection and Blood Sampling

by T H Taylor MB BS FFARCS
Consultant Anaesthetist, The London Hospital, London E1
Member of the Cases Committee, The Medical Protection Society

Intramuscular and intravenous injections and the removal of blood samples are the commonest invasive procedures undertaken by doctors and they are remarkably free of untoward effects on the patient. Nevertheless, the Society is called upon to advise members on mishaps each year, many of which are avoidable. The excuse for this article, which reiterates many previous warnings, is that it is based on actual cases reported to the Society in the past few years, which although often trivial in themselves, cause considerable inconvenience and distress both to the patients and the practitioners involved.

Aseptic technique

All injection procedures should be carried out in an aseptic manner. This does not mean a full 'surgical' technique but implies that the hands are washed and that a 'no touch' technique is employed in respect of the needle. The patient's skin should be cleaned at the puncture site with a suitable spirit-based sterilising agent. Although this seems so obvious that it should not need stating, some cases of infection following injections or blood sampling arise each year. The defence of these cases is not difficult if the practitioner is known to be meticulous in his approach to the patient in this respect.

Positioning of patients

No doctor should ever forget that the thought of an injection frightens patients and that the young adult is the person most likely to faint at the sight of the needle. If such a patient falls and receives an injury during the course of an injection it is difficult to defend a charge of negligence, unless appropriate precautions were taken. Therefore patients must be placed in a safe position, either lying down or firmly supported in a chair before the operator approaches, and sufficient time should be allowed after the injection for recovery to take place before the patient is allowed to move.

The safe site for intramuscular injections

Intramuscular injections are often given by nurses but doctors not infrequently administer drugs by this route. Before doing so care must be taken that the correct preparation of the drug is used and that a safe site is selected for the injection, for puncture of a large vessel may cause considerable discomfort if not permanent damage, and nerves can be irreparably damaged by injected drugs. The site with an adequate bulk of muscle to accommodate the injected fluid that seems to produce the minimum number of problems is the lateral aspect of the thigh. The gluteal region is dangerous because of the proximity of the sciatic nerve, which is a wide (2 cms) structure and may be damaged in thin individuals even if the upper, outer third of the buttock is used. Again in thin individuals, the deltoid region high up on the shoulder has little muscle bulk and the circumflex nerve may be at risk.

The suitable vein

When taking a blood sample it is necessary to use the largest available vein, so that the blood flows easily into the syringe. If aspiration has to be used, it is likely that some damage may occur to the blood elements. Likewise, it is important to have the correct sample bottle already labelled so that the blood is put rapidly into the appropriate anti-coagulant and gently mixed. Care should be taken that the labelling is correct before sending the sample to the laboratory. Some authorities suggest that it is safer to label the bottle after the specimen has been put into it.

The safe site for intravenous injections

The large veins commonly used are those in the ante-cubital fossa, and the lateral side is safest anatomically. Remember that the median nerve and brachial artery are just deep to the ante-cubital vein on the medial aspect of the midpoint of the elbow. The needles used for samples can mechanically damage these structures, and this possiblity is even greater when the largest needles are used to remove blood for transfusion. The median nerve itself can be transfixed, or more rarely, if the anterior interosseous branch arises abnormally high on the lateral side of the median nerve it alone can be damaged, with consequent limitation of flexion of the thumb. Injected irritant drugs that

escape outside the vein can also cause sequelae. The brachial artery lies deeper, beneath the bicipital aponeurosis on the medial side of the median nerve, but it can be entered in error, and if the artery is damaged and the subsequent bleeding unrecognised there can be considerable extravasation into the anterior compartment of the arm, which may have long-term consequences. Several such cases have been reported to the Society following blood donor sessions. It is doubly unfortunate when volunteers suffer harm from their altruism, and these donors are sometimes compensated by an *ex gratia* payment even though the mishap is not necessarily due to negligence by the operator.

The drug and its dangers

Before injecting any drug, but especially into a vein, it is essential that the prescriber is completely familiar with the actions of the drug, both the desirable and the adverse. All manufacturers produce a comprehensive data sheet for their products and may include an information leaflet with the drug in the original packaging. Otherwise information can easily be found in the "Datasheet Compendium", published each year by the Association of the British Pharmaceutical Industry (ABPI), and in formularies such as the British National Formulary (BNF). These books are available free to any doctor who requires them for reference, but they are not consulted as much as they should be, for no doctor can be expected to remember all the information there is available on drug actions, interactions and complications.

The care after an injection

After injecting a drug the doctor must wait a sufficient time with the patient to ensure that there are no ill-effects, the most life-threatening of which is a severe, acute anaphylactic response. It is usually assumed that this observation should be for about twenty minutes, although there can be no hard and fast rule. This duty can be delegated to another qualified person in most circumstances. Thus, if the injection has been of a contrast medium for an intravenous pyelogram, known to produce an allergic response in some individuals, if no untoward signs emerge in about five minutes the care could pass to the radiographer, provided always that he or she knows where help may be obtained and has sufficient knowledge of when to call the help. It should not be necessary to repeat here the instruction to have the means of resuscitation to hand before giving such an injection. If the required articles and drugs were not readily available in the room it could be difficult to resist an allegation of negligence. Examples of these mishaps have been before the Society in the past year.

Extravasation of intravenous fluids

Many drugs, or the vehicles in which they are dissolved, cause pain on injection, and also damage the intima of the vessel, leading to a severe phlebitis. More seriously, extravasation of irritant drugs may cause necrosis and severe scarring of surrounding tissues. The manufacturer's data will give information about those drugs peculiarly prone to these complications. Should extravasation occur with a drug known to cause tissue damage, immediate remedial steps should be taken to minimise the effect. These may include dilution with saline or other solutions, perhaps with the addition of hyalase, and the local injection of hydrocortisone, as well as the usual measures directed to the comfort of the patient. Many drugs are so irritant that they should only be administered by means of a slow intravenous infusion, sited in the largest possible vein to achieve maximum blood flow, making sure that the infusion is running freely. Such irritant drugs should never be given directly into a vein, or through a sharp indwelling needle.

Ankle lesion following extravasation of intravenous fluids.
This photograph illustrates the consequence of extravasation of intravenous fluids into the tissues surrounding the ankle of a child.

The back of the hand

Even an infusion placed in the back of the hand is dangerous for the administration of irritant agents, since extravasation in this site can lead to severe damage to the extensor tendons of the fingers and little tissue separates these structures from the vein. In this situation a minimal extravasation will cause the maximum damage. The Society has dealt with a number of claims for extravasation damage, including some on the hand, the commonest drugs involved being thiopentone, diazepam and

certain cytotoxic drugs, but also from 8.4% bicarbonate administered during resuscitation. In a conscious patient pain would serve as a warning, perhaps allowing the injection to be stopped before a large quantity of drug had escaped into the tissues. Although the loss of a small quantity of the drug may be excusable, clearly if a considerable volume is injected without the operator noticing, either through carelessness or because the injection site is not visible, it is negligent. It is particularly hard, however, to be sued for the damage caused by extravasated bicarbonate solution given to a patient who had suffered a cardiac arrest and was successfully resuscitated. We resist these claims vigorously, but perhaps it would be wise to abandon the use of this strong solution in favour of a larger volume of a weaker and less irritant one, especially as in the circumstances of an arrest it may be particularly difficult to set up a satisfactory infusion. The use of sodium bicarbonate as a routine in these circumstances is currently the subject of criticial review.

Pain at the injection site

There are many patients in whom it is very difficult or even impossible to 'find the vein' successfully, either due to obesity or previous extensive use of the veins. This is particularly worrying in the emergency situation when urgent treatment is required, for example of an epileptic fit. In these circumstances particular care should be taken to palpate the area before attempting to insert the needle and to check that an artery has not been entered inadvertently, since virtually all drugs cause some damage when given into an artery and the majority can damage the vessel severely enough to cause the loss of an arm. In the conscious patient, pain on injection is an important sign and has to be distinguished from the pain caused by some drugs on intravenous injection, the possibility of which will be mentioned by the manufacturers on their data sheet. This pain begins locally and passes proximally, whereas pain on arterial injection tends to be more severe and it is felt by the patient to pass distally. When the patient is unable to communicate in this way the dangerous anatomical sites should not be chosen for the injection, the vessel should be checked by palpation and the colour of the blood aspirated should be noted as arterial blood is always bright red, except in severely cyanosed individuals. Furthermore, the syringe fills passively without aspiration when in an artery, but rarely does so in an un-occluded peripheral vein.

The disposal of the needle and syringe

Lastly, remember that for the protection of the operator and of those who have to dispose of used syringes and needles, great care should be taken to place them in a safe 'sharps' receptacle immediately after use. Injury by a used needle and subsequent contamination with a patient's blood could be the source of infection and serious disability. It is inadvisable to attempt to re-sheath a used needle, since this has been shown to be a common cause of 'needle-stick' injuries. Such injuries have been incriminated as the source of infections, including those by HTLV3/LAV virus and the hepatitis viruses.

Extravasation of cytotoxic drugs; (case report)

A 41-year-old woman attended hospital in Ireland on a monthly basis for intravenous chemotherapy following a mastectomy for carcinoma of the breast. The consultant physician delegated the administration of the drugs to the house officer. Because the patient's veins were difficult to cannulate, a locum consultant anaesthetist set up an intravenous infusion using a 'butterfly' needle in the dorsum of the left hand. The medical house officer was to administer the drugs later that day.

Whilst working in theatre the surgical house officer, a member of the Society, received a call from the sister in charge of the ward who explained that the medical house officer was not available, the patient had not received her chemotherapy and she was crying and becoming anxious. The surgical house officer was requested to attend the ward to administer the drugs. He went to the ward, found the intravenous infusion running satisfactorily and proceeded to give Adriamycin via the drip. After injecting 1 ml he noticed that the infusion had 'tissued'. He stopped the injection immediately, removed the infusion and applied pressure to the area. The patient developed a chemical burn on the back of her left hand with resultant pain and scarring.

Experts consulted by the Society expressed reservations about the use of a 'butterfly' needle for the administration of chemotherapy as they have a reputation for 'tissuing'. If a 'butterfly' needle could be inserted then so could a small gauge intravenous cannula, which could have been passed further into the vein, so reducing the risk of 'tissuing'. It was considered that a vein in the back of the hand was not the most appropriate site for the administration of cytotoxic drugs. It was felt that the anaesthetist must accept the major portion of the liability on both these counts.

It was considered to be in the best interests of all concerned to negotiate a settlement out-of-court. The patient's claim for compensation was settled for IR £17,000 plus costs. 20% of this sum was borne by the Society on behalf of the house officer and 80% was borne by the locum anaesthetist's protection organisation.

Problems in Laboratory Medicine

by Bernard Knight MD MRCP FRCPath DMJ Barrister
Professor of Forensic Pathology, University of Wales College of Medicine
Member of the Cases Committee, The Medical Protection Society

Though laboratory disciplines, compared with other more clinical specialities, carry a lesser risk of allegations of malpractice, they are by no means immune. In addition to these negligence hazards, laboratory medicine provides many other medico-legal problems. In a recent survey of 160 requests for advice or assistance from members engaged in this branch of medicine the spectrum of problems was extremely wide. It ranged from blood transfusion mishaps to disputes over partnerships in private laboratories; and from errors in cytology diagnosis to lack of informed consent for marrow biopsy.

Haematology is perhaps the most 'clinical' of the pathology specialities, often having full diagnostic and therapeutic responsibility for patients, so it is not surprising that a wide range of possibilities exists for alleged negligence against haematologists.

Concentrating more on the laboratory aspects of the various disciplines, a number of features are common to all. Vicarious responsibility for technical staff is one such problem, especially in haematology and biochemistry, where many results are automated. Not only does a consultant have legal responsibility for his own professional decisions, but he may well have additional liability as the head of a department or division with management functions. Reports signed personally by pathologists are their own responsibility, but in these days of delegation and automated techniques, many reports go out either unsigned or over the signature of a laboratory scientific officer.

If an employee makes an error which leads to an action for damages, the employing authority carries responsibility under the 'master-servant' principle, but the employers may well seek to transfer all or part of this burden to the consultant in charge. If, however, the pathologist can prove that he employed a sufficiently trained and competent laboratory scientist and that he had established a safe system of work (which he had directly communicated to his staff, preferably in a written form), then he has discharged his legal liability. If the employee fails to follow such a set pattern of orders then, although he has a personal liability, it is usual for the employing authority to accept vicarious responsibility. If, however, the consultant has over-delegated a responsibility, that is, has placed an unreasonable burden upon a less-qualified or experienced member of his staff, then this improper delegation will prevent the consultant from transferring his responsibility. Of course, in a private laboratory the principle of 'master-servant' liability will rebound upon the pathologist and his partners and members are referred to Paragraph 5(c) of the Benefits of Membership set out on page 10.

Another current problem is the production of results which were not asked for by the clinician, usually by multi-test automated analysers. When an abnormal result appears, some laboratory consultants are of the opinion that it need not be communicated to the clinician: the onus of making this decision is naturally upon the laboratory doctor, but it must be pointed out that if a patient suffers harm through the clinician's ignorance of an abnormal parameter, such as a significantly-raised serum calcium, then the clinician might well look to his laboratory colleagues to bear the legal consequences of their decisions.

The majority of laboratory errors are not so much due to technical faults, but to failure of communication. Lost reports, errors in filing and typing and the oversight of results are far more common. Quite often, important results reach the ward, clinic or referring practitioner after the patient has left hospital and are merely inserted into the notes, without being acted upon, to lay unread until it is too late to avoid some damage to the patient.

The retention of reports, slides and specimens is also a source of problems because legal actions by patients may not be initiated for many years after the event. The definitive laboratory report for legal purposes is that which is placed in the patient's medical records, but it should be universal practice to retain a copy in the laboratory for an indefinite period, whether in flimsy, microfilm or computer form. In histopathology, tissue sections should be kept for at least thirty years, as storage of slides is not too difficult. Obviously, unstable specimens such as blood and other biological fluids cannot be retained for long, except for certain deep-frozen sera. A more difficult problem is surgical tissue and biopsy specimens. Although fixed material may be stored indefinitely, storage space usually limits the period for which it can be retained. It is recommended that gross specimens should be kept for at least one month after the report is issued, to allow time for the clinician to query any matters arising and to inform the laboratory of any potential legal issues which would require the material to be kept for a longer period — recommended by the Royal College of Pathologists as one year or more where the circumstances indicate.

In the autopsy room, repetitive problems include the incorrect identification of bodies, which though not leading to such serious repercussions as a mix-up in the operating theatre, can still cause much distress, acrimony and adverse publicity when the wrong corpse is either subjected to autopsy, buried or cremated. Permission for autopsy may also be deficient and cause distress to bereaved relatives, as well as complaints to the health authority. The provisions of any relevant statutory legislation must be strictly complied with, both for post-mortem examinations and any subsequent retention of tissues for research, teaching or therapeutic purposes.

Confidentiality of laboratory findings is as important as that of any other aspect of a patient's diagnosis and treatment. Care must be taken, when using data for research and publication, to preserve the anonymity of the subject. A recent case dealt with by the Society concerned data supplied to a tumour registry; a patient made strenuous complaints when identifiable facts appeared in a research paper. Another recent case, causing much publicity, arose because a private laboratory disposed of old reports on a public refuse-tip instead of by incineration or shredding. No report on either laboratory results or autopsy findings should be provided at the request of a lawyer, unless the latter assures the pathologist in writing that he either acts for the patient or has his express permission to obtain the information.

The increasing clinical content of many aspects of laboratory medicine, especially haematology, microbiology and cytology have brought the laboratory physician into closer contact with the patient. It is vital when invasive diagnostic procedures are to be undertaken — from a venepuncture to an organ biopsy — that true consent is obtained beforehand and that such consent be provable at a later date, either from a consent form, a definite entry in the clinical notes or adequate witnessing of oral consent.

Case reports

Monitoring and record keeping during anaesthesia: a £1-million claim

It is often claimed that, for anaesthetists, the quality of the contemporaneous anaesthetic record does not affect the quality of the anaesthetic or the safety of the patient. True as this may be, it is equally true that the quality of his record can frequently influence his reputation in court and the outcome of any claim for damages that may be made against him.

In a recent claim in Canada against an anaesthetist and two other medical practitioners, poor monitoring and an inadequate anaesthetic record were the major factors in an award of compensation and costs of well over £1,000,000 against an anaesthetist, a member of the Society. The case involved a 24-year-old Canadian Roman Catholic lady, married with three children. She entered hospital in Ottawa for a termination of pregnancy followed by laparoscopic sterilisation. The surgeon was a member of the Canadian Medical Protective Association (CMPA). Anaesthesia and surgery seemed uneventful until immediately after completion of the sterilisation when the anaesthetist noticed a cardiac irregularity on the pulse monitor. During the laparoscopy, at the request of the surgeons, the patient was totally covered with drapes except for a small area of abdomen and the left hand which was on an armboard. The theatre lights were turned off, leaving only sufficient light to allow the anaesthetist to see his instruments.

When the lights were eventually turned on, the patient was seen to be cyanosed and a cardiac arrest soon followed. Cardiac resuscitation restored a normal circulation within a minute or two but the patient, who remained comatose for three months, eventually regained consciousness and remained very severely brain-damaged.

Although the Society was aware that considerable damages and costs were at stake, it was decided to defend the member on the grounds that no gross fault in the management of the anaesthetic, which was likely to have caused the cardiac arrest, could be found and that there was a distinct possibility that a gas embolism could have caused the circulatory failure, for which the anaesthetist could not be held responsible.

The trial of the action was heard over 56 days from January to May 1985 and judgment was given in the Supreme Court of Ontario in December 1985. Despite thorough examination, cross-examination and re-examination of over 50 witnesses it was not possible to establish a definite cause for the mishap. The judgment, adverse to the anaesthetist, was greatly influenced by the judge's findings that the monitoring was inadequate and the records were poor. The judge considered that, irrespective of the cause of the hypoxaemia and cardiac arrest, if there had been more attention paid to the patient and a quicker response to the crisis by the anaesthetist the severity of the injuries to the patient would have been very substantially reduced.

The judge dismissed the claim against the other two defendants, including the surgeon, but awarded Canadian $2,044,871 damages against the anaesthetist. He also made an award of costs in favour of the plaintiff which amounted to $257,000. The damages were assessed under three main heads: an award of $431,533 was made to the Public Trustee to be managed on behalf of the patient; an award of $1,361,304 was made to the Ontario Health Insurance Plan for the cost of past and future care; and $252,034 were awarded under the Family Law Reform Act to several named members of the patient's family. The cost to the Society at applicable exchange rates amounted to over £1,000,000 and to this has to be added the defence costs.

Members' attention is drawn to the notice about practice in Canada on page 11 of this Report.

Fatal cardiac arrest under hypotensive anaesthesia — anaesthetist temporarily absent from operating table

Hypotensive anaesthesia using a beta-blocker and pentolinium was provided by a Society member to facilitate a minor ear operation.

About five minutes after induction of anaesthesia the member was summoned urgently to the telephone. He left the patient in charge of a senior nurse and went to answer the telephone situated in an adjoining room. He could see the monitor to which the patient was attached as the telephone receiver was held for him by a nurse and he was still in the theatre though away from the patient. His attention was drawn to shallow respirations and excessive bleeding. He immediately returned to the patient and, initially, thought the situation was normal but it soon became apparent that a cardiac arrest had occurred. The patient could not be resuscitated. At the inquest which followed the coroner returned a verdict of accidental death due to acute asthma under anaesthesia. Solicitors instructed by the deceased child's parents intimated a claim after receipt of expert advice to the effect that the anaesthetist's absence from the table "would be impossible to justify". The claim was settled by an *ex gratia* payment by the Society of £4,000 plus costs with no admission of liability.

The need for constant vigilance of the anaesthetised patient was stressed in an editorial in *Anaesthesia*, 1986, volume 41, pages 129, 130, written by Dr. R A Green FFARCS, a Member of Council of the Society.

Awareness whilst under general anaesthesia

It cannot be disputed that one of the prime reasons for inducing general anaesthesia is to produce in the patient a total unawareness of the operative procedure, yet the Society is receiving an increasing number of claims in which it is alleged that the patient was aware of both discomfort and severe pain during the course of the operation. Recent publicity concerning this problem has resulted in patients attempting to sue their anaesthetist for events which, on occasion, have occurred many years previously.

A review of cases which were dealt with by the Society revealed that, in the majority of cases, a defence of the anaesthetist was made difficult for the following reasons:

1 the anaesthetist had not adhered to generally accepted clinical practice in the choice of anaesthetic technique;

2 failure to notice and correct a fault in anaesthetic equipment (i.e. empty vaporiser or nitrous oxide cylinder). The standard of pre-anaesthetic apparatus checks was, on analysis, poor or non-existent;

3 a record of the anaesthetic procedure was minimal or absent.

It was also notable that, whilst many cases of alleged awareness occurred during anaesthesia for Caesarean section, many occurred during anaesthesia for routine, elective procedures (where analgesic drugs replaced inhalational agents). The latter are virtually impossible to defend and the former may be difficult unless the anaesthetic technique withstands objective review. In those claims which relate to events many years previously, there are constraints placed on the plaintiff in respect of the time lapse, but also there may be considerable problems for the defendant and the Society, especially when the anaesthetic record is poor.

The point is frequently made by anaesthetists that they warn the patients whom they are about to anaesthetise for Caesarean section of the slight risk of awareness; however, such a warning does not constitute a defence if the subsequent awareness has been caused by a deviation from accepted practice.

Members are urged to consider the problems discussed above and whenever possible ensure that they adhere to accepted techniques when anaesthetising for Caesarean section (ventilating the patient with 50% nitrous oxide and oxygen with no or minimal adjuvant is regarded by many as being no longer

acceptable). Furthermore, it is vital that full anaesthetic notes are made, including details of pre-operative assessment, gas flows, delivery volumes, physiological parameters, circuit used and the concentration of volatile agents selected, together with the timing of usage.

If these principles are applied, then, and only then, may it be possible to prove that any awareness was not due to negligence on the part of the anaesthetist.

If, post-operatively, a complaint of awareness is made, it should receive immediate and sympathetic consideration. Too often patients complain that they were not taken seriously, or, worse, were regarded as hysterical or as opportunist liars. It is recommended that an anaesthetist, ideally of consultant grade, should see the patient and offer an appropriate explanation. If the facts are carefully explained (viz. the difficult titration between maternal comfort and fetal safety) and the patient's complaint is taken seriously and handled compassionately, later complaints and claims may be reduced or avoided.

A lost airway

A 29-year-old woman underwent a dilatation and curettage at a district general hospital for evacuation of retained products of conception following a miscarriage. An uneventful anaesthetic was administered by a consultant anaesthetist who used a nasopharyngeal airway to avoid damage to the patient's capped teeth, which had been noted at a pre-operative visit. However, the anaesthetic records were completed by the senior house officer, not the consultant, and the latter had no recollection of the case.

Post-operatively the patient experienced difficulty in swallowing and stated that her nose was swollen and sore. However, she was discharged home one day after the operation.

Five days later the patient's general practitioner referred her to the casualty department from where she was referred to a consultant ear, nose and throat surgeon. He removed from the patient a plastic nasopharyngeal disposable airway. The patient made a claim for compensation. Following physical examination it was established that the patient had suffered no long-term damage to her nose and her claim was eventually settled for £1,244 inclusive of general and special damages and costs. The consultant anaesthetist, a member of the Society, believed that the flange on the end of the airway was too small to prevent it disappearing from sight during the operation. After this misfortune he changed his practice so that a safety-pin was inserted through the airway to act as an additional safety precaution.

Failure to diagnose intra-ocular foreign body

A 44-year-old male patient attended his general practitioner, a member of the Society, complaining that when using a hammer and chisel three days previously he felt something enter his left eye. The general practitioner examined the eye with an ophthalmoscope. A corneal abrasion was noted and Chloromycetin eye drops were prescribed. Visual acuity was not examined but the patient confirmed that he could see normally. He was due to go on holiday the following day and the general practitioner confirmed that he could drive but should stop frequently to put in the eye drops. No radiograph or ophthalmic referral was arranged.

Six days later, whilst on holiday, the patient attended a local hospital because of continuing irritation in his eye. Slit-lamp examination revealed a foreign body embedded in the outer layer of the cornea. A metal foreign body was removed at operation.

One month later the general practitioner received a letter from solicitors acting for the patient, alleging negligence and claiming damages. As the member failed to test visual acuity or arrange a radiograph or refer the patient to a specialist clinic there was no defence to the claim. Fortunately, no lasting damage was caused to the plaintiff's visual acuity and the claim was settled for £2,000 plus costs.

Burns from overheated instrument

A 24-year-old man suffered an injury at work when a fragment of a metal bearing flew into his left eye. A pre-operative examination showed a choroidal haemorrhage, a localised retinal detachment with a retinal tear and corresponding scleral wound. X-ray localisation of the foreign body suggested it was lodged at the posterior pole of the eye.

At operation the scleral wound was located 12 mm from the limbus. A giant magnet was used and approximately 1000 pulses over one hour were applied in an attempt to remove the foreign body. This was ultimately unsuccessful. The surgeon was aware that the magnet had become hot during the procedure. On removing the drapes the patient was noted to have full-thickness burns on the bridge of his nose, his left eyebrow, and right shoulder. These were caused by inadvertent contact with the hot casing of the magnet.

An enquiry following this incident showed:

1 the manufacturer's recommendations had not been adhered to.

2 the surgeon had not seen the manufacturer's recommendations which were not available in the main theatre.

Where a fairly specialised item of equipment is to be used, manufacturers' instructions must be available and must be read. Ironically, subsequent localisation showed the foreign body was extraocular. It cost £3,000 to settle the patient's claim for compensation which was, clearly, indefensible.

Complications following cosmetic operation

An English migrant patient was referred to a specialist ophthalmic surgeon, a Society member, for consideration of cosmetic surgery to remedy exophthalmos persisting after thyroid surgery in the United Kingdom. Bilateral blepharoplasties and canthoplasties were carried out with the object of obtaining a uniform appearance of both eyes.

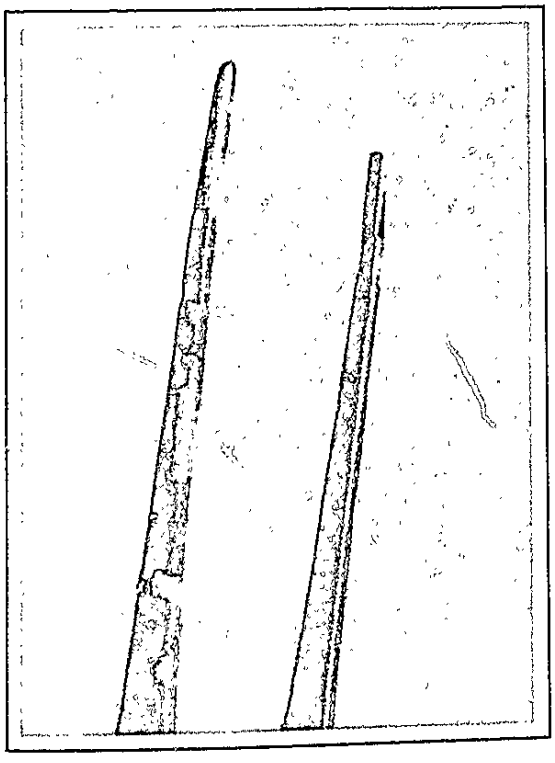
Shortly after the operation the patient noticed in-grown eyelashes despite an otherwise good cosmetic result. Attempts to remedy this by electrolysis failed, partly due to defective equipment. The patient then underwent manual depilation on an 'as needed' basis.

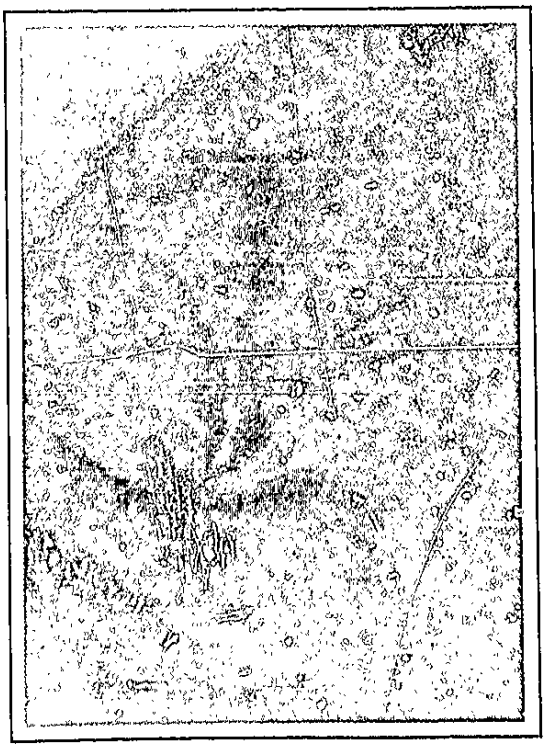
She sued the member and the hospital, alleging that the operation was incorrectly performed, that she was not warned of the risk that her eyelashes might turn in, and that the initial attempts to remedy the condition were improper. She sought A.$250,000 compensation.

Expert opinions obtained in London and Australia led the Society to resist the claim since no negligence had occurred. The patient pursued her claim to court but, following a full trial, the judge dismissed the claim. In a 47-page judgment, the judge found that the risk of inversion of the eyelashes was too remote and that, even had the patient been warned of it, she would not have declined to have the operation.

Diathermy burn

Following a tonsillectomy operation burns were noted at the corner of the patient's mouth. Investigations revealed that they were due to defective insulation on the shafts of the diathermy forceps used during the operation. One photograph demonstrates the defective insulation and the other the burn. The subsequent claim for compensation was clearly indefensible and the cost of settlement was borne in equal shares between the Society on behalf of the surgeon and the health authority which provided the faulty instruments.





Retained forceps

A 53-year-old woman underwent a total abdominal hysterectomy performed by a registrar in obstetrics and gynaecology, a member of the Society. The procedure seemed to be uneventful but two years later the patient was re-admitted to hospital with acute abdominal pain. A radiograph then revealed the presence of artery forceps. A laparotomy was performed at which 45 cms. of gangrenous bowel were found wrapped round the forceps. The gangrenous bowel was excised and an end-to-end anastomosis was performed.

The subsequent claim for compensation could not be resisted and settlement was achieved for £9,000 to which sum had to be added a further £2,000 in plaintiff's solicitors' costs etc. The settlement figure was borne in equal shares by the Society on behalf of the registrar and by the health authority on behalf of the theatre nurse responsible for the swab and instrument count.

The attention of members is drawn to the publication of *'Theatre Safeguards'* (copies of which are available from the Society upon request), a booklet on common problems arising in the operating theatre and how to avoid them. The booklet has been produced by the three United Kingdom protection and defence organisations in conjunction with the Royal College of Nursing and the Association of Theatre Nurses.

Sterilisation without consent

A 25-year-old woman was admitted to a district hospital in Australia in early labour. It was her fourth pregnancy and all previous deliveries had required the use of forceps. After unsatisfactory progress, with the membranes ruptured for more than 48 hours, a decision was taken to proceed to Caesarean section. At that time the question of sterilisation was first raised, and the patient discussed this with the senior house officer on duty who, later in the day, explained to her colleague the patient's wish to have tubal ligation carried out at the same time as the Caesarean section.

Although it seems likely that the patient signed a consent form for the sterilisation, it was never thereafter found and it is possible that it may have been torn up by a member of the nursing staff when, later still, the patient changed her mind. However, this was not mentioned to the doctors although it was written down by the nurse in the nursing records.

The patient duly underwent the Caesarean section and the senior registrar performed bilateral tubal ligation. On the day after the operation the patient was told what had been done, and that a mistake had been made rapidly became apparent.

The inevitable claim resulted in a judgment against the hospital for A.$34,000 of which the Society paid one-eighth on behalf of the senior house officer. A similar contribution came from another medical defence organisation and the balance from the hospital.

Tuberculous meningitis

We reported last year (1985, No. 93, p.51) a settlement costing £275,000 for a case of tuberculous meningitis. We now report another case.

Following a positive Heaf test, a 12-year-old Asian boy was given BCG. His chest radiograph was normal. Two years later he started to complain of feeling dizzy with some nausea and abdominal pain. Three general practitioners saw him at home on 13 separate occasions over two months. The symptoms at first were of a cough but then he started to lose weight rapidly and had anorexia, vomiting and persistent abdominal pain. At the last attendance a domiciliary visit was arranged. The paediatrician admitted him immediately. He was suffering from tuberculous meningitis and died two months later.

The parents made a formal complaint to the Family Practitioner Committee. One of the partners was only involved at the outset and therefore was not implicated in the criticism. The other two doctors, one a member of the Society and the other of another defence organisation, were found to be not in breach by a Medical Service Committee.

A civil action was commenced and the parents also appealed to the Secretary of State against the finding of the Service Committee that there had been no breach of the Terms of Service for doctors. Expert opinions were taken on behalf of the practitioners. It was considered that two general practitioners had failed to give sufficient attention to the course of the boy's illness. It was thought to be in the best interests of the practitioners to settle out-of-court and this was achieved for £6,500 plus costs, shared between the two protection societies. The appeal to the Secretary of State was not pursued.

Slipped femoral epiphysis

A 14-year-old boy attended his general practitioner complaining of pain in his right knee and was given analgesics. Three days later, after a telephone call to the surgery, his mother was advised to take him to the local accident and emergency department. Due to an emergency situation there, and a long wait, he was not seen.

The following day, the general practitioner saw him again at home and arranged a radiograph of the knee. Over the next three days he was vomiting with the pain and his mother asked for a private consultant opinion. It was suggested however, that she should persuade her son to be more mobile as the radiograph was normal. Over the following week, during which his mother made daily contact with the general practitioner, the boy's condition became worse and he was eventually admitted to hospital by a locum. The diagnosis was a slipped upper femoral epiphysis.

The general practitioner, a member of the Society, was found in breach of his Terms of Service and a sum of £200 was directed to be withheld from his remuneration from the Family Practitioner Committee. There was no defence to the civil claim which followed, and this was settled for £506 including costs, being payment for 4 weeks' pain and suffering. Fortunately no lasting harm resulted from the delay in diagnosis and treatment; otherwise, the damages would have been much greater.

Not an oral contraceptive

A member was consulted by a young woman who asked for a change of her oral contraceptive pill. The member, a general practitioner, intended to prescribe Triphasil but unfortunately wrote 'Trisequens' on the prescription. This latter drug is a hormone supplement for post-menopausal women. His patient became pregnant and refused an abortion. Her subsequent claim against the member was clearly indefensible and the case was settled by the Society on behalf of the member. Members are reminded of the need for care over prescriptions.

Failure to recognise an arterial occlusion

A general practitioner in Australia was asked to see a 44-year-old man who complained of a sudden pain in his right leg which had come on whilst sitting. The general practitioner diagnosed sciatica and recommended bed rest together with ibuprofen tablets. On the following day the patient was seen at his home by the other member of the two-man partnership. The doctor recorded that the pain was still bad and extended from the right hip down into the leg. Pethidine was prescribed. On the next day the same practitioner again saw the patient and noted on this occasion not just that the pain was worse but that the right foot was cyanotic with no pulses palpable. The patient was immediately admitted to hospital where, the same night, he underwent an aorto-femoral angiogram and, the following day, a femoral artery thrombectomy and arterial graft. However, four days after the onset of his sudden pain the patient's right leg had to be amputated.

That the general practitioner's diagnosis had been wrong was not in doubt. Nor could it be denied that the degree of attention paid to the history and the thoroughness of the examination was somewhat inadequate. A successful defence to the claim brought against the two general practitioners was considered to be unattainable and so a settlement was negotiated.

Torsion of the testicle

Torsion of the testicle continues to be a diagnosis which general practitioners fail to consider or, if they do consider it, fail to take appropriate action. The conventional award for the loss of a testicle, where there are no additional complicating factors, is about £5,000. Here are two examples of indefensible claims:

1 A 4-year-old boy was taken by his parents to their general practitioner with the history of his having been sick the previous day, and with a left testicle which was slightly swollen and inflamed. Of the consultation the mother said that the general practitioner only looked at the boy's scrotum before diagnosing "an inflamed testicle", and prescribing penicillin. The general practitioner, however, stated that she did palpate the child's abdomen and inguinal orifices before "preferring" a diagnosis of epididymitis.

Two days later, with further enlargement of the testicle, another general practitioner was consulted and the boy was immediately referred to hospital where, at operation the same evening, a torsion of the left testicle was diagnosed and an infarcted testicle was removed.

The circumstances were the subject of a Service Committee hearing following which the doctor was found to be in breach of her Terms of Service, and warned to comply more closely in the future.

2 A 25-year-old man attended a general practice for the first time as a new patient. The doctor made comprehensive notes recording left testicular pain which had been present for some hours, and that the patient had vomited. After careful examination the cause was thought to be infective.

Two days later the patient reattended and was seen by another doctor who noted the condition to be worse. He referred the patient immediately to hospital where later the same day, at operation, torsion was diagnosed and an infarcted left testicle removed.

The two cases demonstrate the common failures which are:
(a) Failing to think of torsion as a diagnosis and/or
(b) Failing to recognise the need to exclude torsion by arranging prompt referral for specialist opinion.

Pain and swelling in the testicle in boys and young men should be regarded as caused by torsion of the testicle until the contrary is established. In the absence of significant urinary symptoms and of white cells in a centrifuged specimen of urine, some surgeons would say that a diagnosis of torsion cannot be excluded without an exploratory operation.

Pain in the ankle

A 23-year-old woman attended her general practitioner on 10 occasions over 5 months, complaining of pain and swelling in her right ankle. The problem was interpreted as being due to a form of arthritis and various remedies were prescribed. However, at the last attendance an X-ray was arranged which showed appearances suggestive of a Ewing's tumour. She was referred for an urgent orthopaedic appointment. After partial fibulectomy and chemotherapy she remained well for five years.

The patient made a complaint to the Family Practitioner Committee. At a Medical Service Committee, the general practitioner maintained that many of the consultations were to treat the lady's children but, because of very poor note-keeping, this could not be substantiated and the Committee accepted the patient's word. The general practitioner was found in breach of her Terms of Service, and, as well as a severe reprimand, a withholding of £300 was imposed.

When a civil claim was received, it was decided that it was not possible to defend the delay in referring this patient for specialist opinion. However, expert opinion was received that the delay would not influence the prognosis and the claim was settled for £1250, being an award for pain and suffering due to delay in referral.

Stick to the facts

A member of the Society practising as a general practitioner was incensed by his patient's refusal to meet his account. Unfortunately he allowed his anger to be reflected in the statements of account which he submitted to his patient on which he inscribed comments such as **"If you feel like refusing to pay me this amount also, go ahead and stick your money"** and **"If you don't feel like paying this account also you know what to do — exactly what I have suggested in the others"**.

The patient took exception to a medical practitioner acting in this way and made a formal complaint to the Medical Council which wrote to the member inviting his comments. The Society's solicitors assisted the member in his reply to the Medical Council which, fortunately, decided that no further action should be taken but reminded the practitioner that the matter was regarded as serious and that registered practitioners were expected to act in a highly professional manner at all times.

Gastrointestinal haemorrhage following use of steroids for head injury

In July 1977, a 30-year-old woman was admitted to hospital, unconscious, under the care of a consultant orthopaedic surgeon, a member of the Society, following a road traffic accident. Four days later she developed signs of raised intracranial pressure and was transferred back to a neurosurgical centre where a scan demonstrated cerebral contusion only. She was started on dexamethasone and a few days later was transferred back to the referring hospital under the member's care. At this time, she was taking dexamethasone 4 mg qds and no instructions were given by the neurosurgical centre regarding the future dose of this steroid. The patient continued to make good progress and, a week later, she was discharged for convalescent care.

At the convalescent home, she came under the care of two local general practitioners who were not members of the Society. Ten days later she complained of abdominal pain over the previous twelve hours which had not responded to antacids and paracetamol given by the nursing staff. On examination, she was tender just below the ribs and the visiting general practitioner prescribed further paracetamol, having discounted a gastric cause because of the failure of the antacids to relieve the pain.

There were no further problems until nearly a month later when she collapsed on getting out of the bath. The general practitioner attended and his clinical findings were a relatively low blood pressure, a few petechiae on the abdominal wall and slight swelling of the left ankle. He made a provisional diagnosis of pulmonary embolus and advised bed rest. Twenty four hours later she collapsed and died. At post-mortem examination the cause of death was massive gastro-intestinal haemorrhage from a duodenal ulcer. From the time of her admission to the neurosurgical centre, some seven weeks previously, she had remained on dexamethasone 4 mg qds.

Two years after the patient's death a statement of claim was issued, alleging negligence in that there was unsatisfactory use of dexamethasone, inadequate consultant supervision and inadequate medical care at the convalescent home. The Society accepted expert opinion that the patient's claim was indefensible. The main criticisms were of failures of adequate communication, first between neurosurgeon and orthopaedic surgeon on transfer back to the referring hospital and secondly between the hospital and the convalescent home medical and nursing staff. Additional criticisms were made of the continued treatment, under the supervision of the general practitioners, with dexamethasone and their failure to make due enquiry or seek advice. By agreement, 60% of the settlement figure was borne by the Society on behalf of the consultant orthopaedic surgeon under whose care the patient was initially admitted and the neurosurgeon who instigated the dexamethasone treatment with no instructions on its continuing use. The remaining 40% of the settlement was borne by another defence organisation on behalf of the two general practitioners who were responsible for the patient's care at the convalescent home.

By-pass on incorrect coronary vessels

Following investigation for coronary artery disease, a 61-year-old female patient was listed for a by-pass grafting procedure to the right coronary artery and lateral ventricular branch of the left coronary artery.

Before commencing the procedure the consultant surgeon viewed the angiogram in the cardiology department which was situated some distance from the theatre suite. The cine films of patients scheduled for surgery that week were kept on a particular shelf and the consultant selected a reel labelled with the correct surname but with a different forename from the patient about to undergo surgery, an expensive mistake which was not recognised. The consultant was joined by his senior registrar and they agreed that two by-pass procedures were required but came to the conclusion that they should be in respect of the left anterior descending coronary artery and the second lateral ventricular branch of the circumflex coronary artery.

The error was only realised at the conclusion of the procedure when the clinical notes were checked. The patient, who was still anaesthetised and intubated, was returned to theatre and the correct procedure performed from which she made satisfactory and unremarkable recovery.

The patient only learned of the mistake six weeks later. Whereas before surgery she had no history of any psychiatric problems she rapidly developed a severe depressive illness. Although liability was not disputed when an action for damages was commenced, the parties were unable to agree on quantum and so the case went to trial. The judge concluded his review of the psychiatric evidence with findings of fact that the patient had lost the empathy previously felt towards her husband, that her sex life seemed over and that the likelihood of permanent impairment to her enjoyment of life remained. She was awarded A$12,000 of which the hospital authorities contributed 40% and the Society 60% on behalf of the surgeon.

Misleading a patient?

In an Australian claim, a lady who had undergone a nephrectomy in 1969, for what she later said she understood to have been a malignancy, sued the general practitioner and the urologist, alleging she had been misled and allowed to remain in ignorance when the excised specimen had failed to reveal a malignancy. The statement of claim alleged that the doctors had acted negligently in that they had "... falsely and with knowledge of its falsity ... pretended that the removal of the kidney had been necessary because of a tumour."

In commenting upon the claim, which was brought in 1984 when the patient discovered from another doctor that her excised kidney had revealed no evidence of malignancy, the urologist was unable to recollect the exact conversations he had had with the patient but thought he had informed her that no tumour was present. The general practitioner said he had received no communication from the urologist in the postoperative period, nor had he been sent any report on the histology of the kidney, but in the notes was to be found an entry to the effect that the nephrectomy had been occasioned by a papillary carcinoma.

It was evident that there had been at least an embarrassing misunderstanding. A specialist psychiatrist who examined the patient concluded that the lady had suffered from psychological stress for 14 years, during which period she said she had believed she had been suffering from cancer.

It was the view of the Society's Cases Committee, supported by the general practitioner and the urologist, that a contested court hearing was not justifiable. A settlement was negotiated in the sum of A.$33,000.00.

Three missed colonic malignancies

The cases summarised below illustrate failure of communication in widely differing settings. Each ended fatally, which in one instance was probably inevitable. However, the diagnoses were unduly delayed and settlements have been negotiated to compensate for pain and suffering which might have been avoided or diminished. The cases also illustrate a need to check upon investigations which are requested and to refer to notes made at previous consultations.

1. A female patient was referred to hospital complaining of griping abdominal pain, flatulence and a suspected pelvic mass. The surgeon who saw her, a Society member, carried out a sigmoidoscopy, which was normal, and requested an urgent barium enema to rule out colonic cancer and arranged admission for gynaecological assessment and a possible EUA. Following admission the gynaecologists determined that there was no major abnormality present, having been told by junior staff that the barium enema was normal, hence the patient was discharged. In fact the radiologist had reported the presence of a narrowing of the sigmoid colon likely to be primary carcinoma. This report was not followed up. Two years later the patient was referred back when the diagnosis was rapidly established — the patient died after palliative resection and chemotherapy. Expert opinions deemed the matter to be indefensible and a settlement reflecting the role of the consultant, a Society member, and the junior staff, members of a sister organisation, was negotiated.

2. A female patient with a history of alcohol abuse was seen by a trainee in general practice, giving a history of altered bowel habit and explosive bowel movement. Rectal examination was refused. The doctor recorded a provisional diagnosis of diverticular disease or irritable bowel syndrome and the patient was asked to return with a stool specimen and to have a rectal examination and proctoscopy.

This provisional diagnosis and advice were recorded on a small medical records card. The patient returned much later than arranged and was seen by a partner in the practice, a Society member. Since the previous consultation an A4 system of recording had been introduced and the previous advice, filed at the back of the notes, was not noticed nor was it brought to the doctor's attention by the patient. It was later alleged that the stool specimen requested had been delivered, but no record of this could be traced. Over the next nine months the patient was treated for symptoms thought to be alcohol-related. It became apparent that her liver was grossly enlarged and a pelvic mass was present. She was referred to hospital where a moderately differentiated colorectal carcinoma with liver metastasis was diagnosed and symptomatic treatment only was provided up to the time of her death some 20 months after the patient's initial presentation. Expert opinion deemed the matter indefensible and a settlement was effected in the sum of £6,744.

3. A woman aged 50 years was referred to a consultant surgeon because of a three-to-four month history of the appearance of blood and slime in her motions and of abdominal pain. Physical examination and sigmoidoscopic examination revealed no cause for the symptoms. A barium enema radiological examination did not reveal any lesion in the large bowel.

The patient's symptoms continued. Barium meal examination with follow-through also revealed no cause. The surgeon concluded that malignancy was not the cause of the patient's symptoms, made an alternative diagnosis and recommended appropriate treatment to her general practitioner. Two weeks following her discharge the patient was referred to another consultant surgeon who reviewed the barium enema radiographs and noted on one of the films the presence of a stricture in the sigmoid colon, about 6 cm in length. The stricture proved to be malignant.

A claim was formulated and the Society was advised that the claim could not be defended. When the consultant surgeon and the consultant radiologist (both members of the Society) then reviewed the radiographs they both immediately noted the presence of the abnormality. Neither of them could understand how they came to overlook the appearance. The consultant surgeon comments "I can only assume that this film was not present with the other films when I examined them and had somehow gone missing". The consultant radiologist commented ". . . it is my normal practice to take 9 films on a barium enema examination . . . one clearly shows the presence of carcinoma of the sigmoid colon . . . I can only assume that I merely reported 7 or 8 of the films."

The patient's claim for compensation for the delay in diagnosis and treatment was settled out-of-court by payment of £7,345 inclusive of costs.

A negligent medical report for solicitors

Members are reminded that negligence may be alleged not only in their dealings with patients, but in the way they prepare medical reports.

A 50-year-old man attended the casualty department of a London teaching hospital. He had fallen and landed on the base of his spine. The casualty officer found abrasions and bruising of the lower spine and buttocks and interpreted an x-ray film as showing no bony injury. The patient was advised to rest at home and, subsequently, was seen on two occasions, complaining of persistent coccygeal pain. No specific action was taken.

The consultant in charge of the department was asked by the patient's solicitors to prepare a medical report. This he did, using the casualty officer's notes. The consultant did not ask to see the radiograph, nor did he ask for a radiologist's report. He restated the casualty officer's findings, that the patient had suffered superficial bruising only. On the basis of that medical report the solicitors acting for the patient settled his claim for a few hundred pounds.

The patient suffered persisting pain and subsequently it was shown that at the time of his initial fall he had sustained a fracture of his pelvis. It could not perhaps be described as a serious injury, but certainly it would have attracted more compensation had it been discovered before the claim had been settled. An action was commenced against the consultant, alleging negligence in the preparation of his report. Having regard to the fact that his report had been based solely upon the casualty officer's notes and interpretation of the radiograph, it was considered to be in the best interests of the consultant, a member of the Society, to negotiate a settlement of the claim against him.

High pressure oil injury

A farm worker was brought to the casualty department of a district hospital where the admitting nurse recorded: *"Finger over pressure hose, slit finger, oil in it".* The casualty officer noted a small, lacerated wound at the tip of the patient's left index finger and that the terminal segment was slightly swollen. He cleansed the wound and, leaving it open, applied a dressing. Tetanus toxoid and penicillin were given by injection. Three days later the patient returned and was seen by another casualty officer who, noting no signs of infection, referred him back to the care of his general practitioner.

Three days later and a week after the original injury the patient returned to the casualty department from where he was referred to the orthopaedic clinic. There he was seen by a consultant who himself took the history of an hydraulic fluid injection injury, noting that the treatment had been limited to an antibiotic, tetanus booster, analgesics and dressings. He recorded that the finger was now swollen, inflamed and stiff. Later the same day the surgeon explored the finger, decompressing the tissues, flushing the tendon sheath with saline and excising the necrotic entry site of the oil.

Although initial progress appeared good, contracture of the finger occurred which caused the patient functional disability as well as being cosmetically unattractive. These factors were taken into account in settling an indefensible claim for £2,821. The case was indefensible simply because the casualty officers had not asked the right questions, for if they had, they would have recognised the classical story of a high pressure oil injury with the potential for serious tissue damage. Prompt, appropriate treatment should have improved the prognosis.

Proteus enophthalmitis

A skilled manual worker attended an accident and emergency department complaining of watering from the left eye which had commenced the day before. Some eye drops had been administered at his place of work but his reason for attending hospital was because the eye had become swollen and a yellow discharge was present. The senior house officer, a member, noted the presence of a swelling in the left eye area and diagnosed conjunctivitis. He ordered a saline irrigation and the instillation of chloramphenicol eye drops for a period of five days and advised the patient to return for further treatment on an "SOS" basis. Two days later the patient attended his general practitioner who noted *"swollen eyelids++. Pus draining ? from the centre of the cornea. Zero visual acuity left eye".* The patient was immediately referred to hospital where he was admitted and a diagnosis of a corneal abscess with enophthalmitis was made. With intensive treatment the eye was saved but recovery was slow and treatment prolonged and there was little improvement in the visual acuity which was recorded as hand movements. The offending organism was identified as Proteus.

A claim was formulated. The Society was advised that it was likely that the senior house officer had not recognised the seriousness of the infection at the time of the patient's attendance at the accident and emergency department. Furthermore, the notes made at the time were silent on the question of the state of the cornea and the visual acuity in the eye which would almost certainly have been considerably depressed. The Society agreed to meet the claim for compensation. It was settled for £3,250.

Deep vein thrombosis

A 20-year-old female patient attended hospital with a history of waking up and falling downstairs. She had been found by her mother, lying on the floor. Her body was tense and her jaws were clenched. She had a previous history of asthma and had venous malformations of the skin. The previous day she had seen her general practitioner because of pain in the right leg. A diagnosis of thrombophlebitis was considered.

She was seen by the senior house officer in accident and emergency, a member of the Society, who noted the patient to be fully conscious. Her blood pressure was 110/90 and her pulse rate 100 beats per minute. He noted the venous malformations on the right leg but did not feel there was evidence of a deep venous thrombosis. An ECG was performed and interpreted by the senior house officer as normal. He felt the differential diagnosis was either a fit or a faint. Because the patient appeared well he discharged her home.

Whilst waiting in the casualty department the patient vomited. The senior house officer was telephoned by the night sister because she was not happy with the patient's condition. He informed the sister that it was not unusual for somebody to vomit after a fit, that she should be observed for 10 minutes, and could then go home if there were no further symptoms. He did not re-examine the patient. The patient was sent home but, 24 hours later, was found "collapsed". She was taken to another hospital but was dead on arrival. Subsequent post-mortem examination demonstrated that death was due to pulmonary embolism secondary to phlebothrombosis.

A claim was made on behalf of the estate. The Society was advised that the senior house officer should have taken more thought and care before sending home the patient, and that he should have reattended following the telephone call from the nursing sister. It was considered appropriate to settle the matter out-of-court and the parents accepted a sum in respect of funeral expenses and legal costs only.

A problem of delegation

A 34-year-old lady was seen in a joint clinic run by a consultant orthopaedic surgeon and a consultant rheumatologist. She had trigger finger and it was recorded that she was particularly anxious because her father had suffered from a similar condition which had not done well following an attempted surgical release. The patient was listed as a day case for incision of the flexor sheaths and the operation was carried out by a registrar. He performed a standard proximal teno-vaginotomy but when the tendons would not slide easily he made separate transverse incisions, opening the tendon sheaths between by tunnelling with scissors.

The patient did not do well. One month after surgery she had only about 40% finger movement. She decided to seek further advice. Later a consultant specialising in hand surgery commented that the surgeon who had performed the first operation had, by his procedure, divided ". . . the two main pulleys which prevent the flexor tendons from bowstringing".

That the registrar's operation could be criticised was never in doubt; what did exercise the Society was whether it had a responsibility on behalf of the consultant, who delegated it. It was established that the registrar had only previously performed four similar operations. The Society's Cases Committee accepted that it would have been more appropriate for a patient with a tenosynovitis of uncertain origin and a family history which, perhaps, should have rung 'warning bells', to have received the attention of someone more experienced. The Society agreed to contribute 30% towards the cost of the inevitable settlement. The balance was borne on behalf of the registrar by another defence society.

Consultant's responsibility

A 65-five-year-old lady had a manipulation of both shoulders by a consultant orthopaedic surgeon, a member of a sister defence society, and was subsequently seen by the senior house officer, a member of the Society, in outpatients on two occasions. Her main complaint at these visits was pain and stiffness and, on examination, there were no abnormal physical findings. At a further visit, when seen by the consultant again, the right shoulder was found to be dislocated and this recurred on two occasions following re-manipulation.

The patient brought a civil claim alleging negligence in respect of failure to notice the dislocation, which was assumed to have occurred soon after the first manipulation. However, the operation was carried out using an image intensifier and the shoulder was reported as being normal by the consultant. Therefore, with the absence of clinical signs, the senior house officer treated her symptomatically.

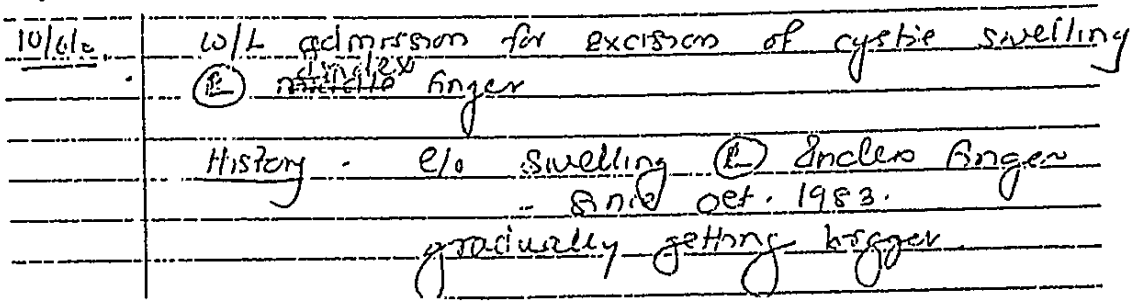
The Society rejected an invitation to contribute to the settlement of this claim. The member had written good notes of his findings and it was felt that he had done all that was expected of a doctor of his experience and qualifications. Full responsibility was accepted on behalf of the consultant.

Wrong finger

The patient was referred by her general practitioner to a consultant orthopaedic surgeon. An extract from the letter of referral stated: *"This patient has a ganglion on her left index finger which requires excision."*

The patient was examined by the consultant orthopaedic surgeon who then dictated: *"This patient has a cystic swelling arising from the flexor sheath of her middle finger of the left hand. This could be ganglionic".*

11 days later the patient was admitted for operation and the senior house officer made an entry in the hospital casenotes:



The operation was then carried out and an extract from the note of operation stated: *"Operation: Removal of ganglion Left middle finger. Attempted removal of ganglionic swelling through base of left middle finger."*

A claim was formulated in terms that the patient had been seeking an operation for a swelling on her index finger and in the event an operation had been performed for a swelling on the middle finger. The senior house officer was a member of the Society, but the consultant and the doctor who performed the operation were members of two sister organisations. Following discussions between the three defence societies it was agreed to settle the claim.

Delay in diagnosis of congenital dislocation of hip

A girl born in March 1980 was, in May of that year, thought to have a right inguinal hernia. In October she was admitted for treatment but no hernia was demonstrated, and in view of that it was not thought that an operation was justified. When the child was reviewed in January 1981 it was recorded that her parents had not noticed a lump and that the doctor could feel no swelling. Similarly in April 1981 there was no evidence of a hernia and the child was discharged from the clinic.

Whilst the matter of the hernia was under consideration at the hospital the child was, concurrently, seen at a developmental paediatric clinic by doctors and health visitors. Mention was made of problems with walking and, in June 1981, of the "left foot turning out . . .". In November 1981, the records show that a doctor had concluded that the "foot will right itself". A health visitor's entry in December 1982 reads "turns in foot. Limp persists". It was not until March 1983 that a radiograph was taken which revealed a congenitally dislocated hip (CDH) and the child was referred for orthopaedic treatment.

It so happened that all the doctors who had seen the child about the suspected inguinal hernia were members of the Society, whereas those who had examined the child at the clinic were members of another defence organisation. In an expert opinion written on behalf of the clinic doctors, a consultant in orthopaedic surgery concluded that the claim was wholly indefensible but suggested that the surgeons consulted about the inguinal hernia were in part responsible for the delay in diagnosis of the CDH. They were, he wrote "admittedly concerned with a lump in the child's right groin . . . (but) . . . their attention should have been drawn to possible hip abnormalities. They should have carried out specific clinical tests on the hips and should also have taken X-rays". This opinion was not shared by the specialist general surgeons on the Society's Cases Committee, which declined a request that the Society should contribute towards the cost of a settlement of the claim brought on behalf of the girl. It was subsequently learned that the other defence organisation accepted they were exclusively liable.

Dosage of intrathecal drugs

Members are reminded that the greatest care is required in the calculation and administration of drugs given by the intrathecal route. In general, intrathecal doses are much lower than intravenous or intramuscular doses. The four case reports which follow, of avoidable errors, are illustrative.

1. Death following intrathecal Vindesine

A 4½-year-old boy who suffered from acute lymphoblastic leukaemia received chemotherapy. The senior house officer on the firm caring for the child had administered methotrexate and Cytosine intrathecally but had never been asked to give the drug Vindesine. The registrar had correctly written up the route for administration of the Vindesine as intravenous, but by mistake the senior house officer gave this drug, as he had the others, intrathecally.

The child suffered no adverse reaction at the time but, after 48 hours, weakness and a loss of sensation resulted in his being admitted to hospital where he deteriorated and died the day after, from a cardiorespiratory arrest.

The death was the subject of an inquest and the coroner recorded the cause as having been due to Vindesine toxicity. The pathologist giving evidence described Vindesine crystallisation within nerve cells and stated that although evidence of leukaemia was present that disease had not caused the child's death.

A claim brought by the parents followed the inquest and clearly the mistake could not be defended. A settlement was agreed in the sum of £5,210 damages and costs.

2. Death following an overdose of intrathecal methotrexate

A 4-year-old boy underwent a course of chemotherapy for the treatment of a medulloblastoma of the fourth ventricle. The treatment protocols provided for both intravenous and intrathecal injections of a number of drugs including methotrexate. The tenth course of treatment was written up on a protocol which was fixed inside the front cover of the case notes. Other instructions were written into the daily case notes, in chronological order.

Because the regular paediatric senior house officer on the oncology firm was unable to give the midnight dose of intrathecal methotrexate, the paediatric registrar spoke to another senior house officer, on another firm, and asked her to give the midnight dose. Through a series of misunderstandings the senior house officer, reading from the main body of the notes and not from the treatment protocol, drew up and administered intrathecally what was intended to be the intravenous dose of methotrexate. Instead of 3.3 mg. in a fluid volume of 1.33 ml., she administered 660 mg. methotrexate in a fluid volume of 26 ml. into the ventricular system through an indwelling reservoir, allegedly ignoring warnings from the boy's mother that he had never previously had so large an injection.

The boy had immediate convulsions, witnessed by his mother. Despite intensive intervention and treatment, the boy died two days later and his death became the subject of an inquest and, subsequently, both criminal and civil litigation. The senior house officer who administered the injection, a member of the Society, was committed for trial by jury, charged with the manslaughter of the boy. The Society prepared the member's defence and instructed leading and junior counsel. After a trial lasting several days the member was acquitted.

There followed a civil action for damages for negligence. The Society authorised the exploration of a settlement out-of-court but the negotiations were protracted, largely because of the boy's mother's claim for damages for nervous shock and the length of time before her mental condition and prognosis could be assessed as stable enough to conclude a settlement. The civil claim was finally settled by payment of damages of £65,000 of which a large element represented payment for nervous shock, an increasingly important and costly head of damages in modern personal injury litigation.

3. Intrathecal penicillin overdose followed by deafness

In November 1975 a boy aged 2½ years was treated in Scotland by his general medical practitioner for a respiratory tract infection. The initial surgery attendance was followed by 3 home visits over a period of a week. A partner then visited and referred the boy to hospital where, on admission, he was seen by a senior house officer in paediatrics who found the boy ill, pale and irritable with fever and neck stiffness. A lumbar puncture was performed and the boy was treated with intravenous benzyl penicillin and sulphadiazine.

One day after admission to hospital the boy remained unconscious. Examination of the cerebrospinal fluid confirmed a diagnosis of pneumococcal meningitis. The consultant paediatrician decided that an

intrathecal injection of soluble penicillin should be given and he asked the senior house officer to administer this, intending a dose of 10,000 units. The senior house officer erroneously injected 300,000 units, immediately realised the error and informed the consultant. The boy had a fit within a few minutes and was treated with Valium and hydrocortisone. Attempts were made to remove penicillin from the cerebrospinal fluid. Within a few hours there were signs of gastrointestinal bleeding and there was twitching of the left side of the face. The boy was treated with phenobarbitone and dexamethasone. Every possible enquiry was made and treatment given to try to limit the effects of the penicillin overdose.

Within a few days the boy made a good recovery from the meningitis but he was left with profound, bilateral, sensorineural deafness. He suffered a hearing loss between 500 and 4,000 Hertz at 100 to 110 decibels. He was also left with serious speech defects, an abnormal gait and an altered personality. He attended a special school.

The boy's parents commenced a claim for compensation against the health board which managed the hospital, alleging that but for the intrathecal penicillin overdose the boy's chances of recovery from the pneumococcal meningitis without any lasting deficit such as deafness would have been materially greater. The fact that an erroneous overdose was administered was admitted at an early stage but the claim was contested on the grounds that it was the meningitis and not the penicillin overdose which had caused the deafness. Apart from the damage to his hearing the boy made a rapid and sustained recovery from the meningitis, establishing that the treatment was effective.

The Society on behalf of the senior house officer, another defence society on behalf of the consultant and the health board obtained expert opinions from several paediatricians, paediatric neurologists, microbiologists, otolaryngologist and others and sought legal advice from senior advocates of the Scottish Bar. The matter proceeded to trial in 1984 with the boy's father acting as litigant in person. At trial the critical issue for the judge was whether there was evidence which would entitle him to hold, on the balance of probabilities, that the admitted overdose had caused or materially contributed to the boy's deafness. The weight of evidence from the paediatric neurologists and microbiologists was that there was no causal connection between the overdose and the deafness. For the plaintiff one expert, a consultant neurosurgeon, proclaimed that there was a causal connection.

The consultant neurosurgeon gave his opinion that penicillin would accumulate in the cerebello-pontine angle and was capable of inflicting direct toxic damage on the auditory nerve as part of widespread damage to the nervous system caused wholly or at least partly by direct toxic action by the overdose. Unfortunately, some of the factual assumptions of the consultant neurosurgeon were erroneous and he also gave his evidence on the mistaken assertion that sensorineural deafness is a common toxic effect of antibiotic overdosage incuding penicillin. The expert evidence called by the defence was that there was no scientific evidence that penicillin could play any part whatever in the emergence of sensorineural deafness in a patient suffering from acute pneumococcal meningitis.

The judge rejected much of the case presented on behalf of the boy and of the consultant neurosurgeon's evidence but nonetheless decided, on a theory of his own creation unsupported by expert testimony, that the boy's deafness was caused by pneumococcal meningitis by a "direct infection mechanism." The judge's theory was that in the acute phase of the disease meningeal inflammation occurs. Purulent material concentrates in various sites including the arachnoid in the region of the internal auditory canal where it may produce an inflammation of the auditory nerve. The pneumococcal bacteria produce virulent toxins. Normally the body's defence mechanisms would counter the toxins. The penicillin overdose led to fits associated with the firing of neurones in the cerebral cortex. This firing of neurones created an additional demand on oxygenated blood which weakened and distracted the response of the boy's defence mechanisms to the toxins. His responses to the toxins were thereby weaker than they would have been had there been no overdose. This tipped the balance so as to give advantage to the toxins. The judge found in favour of the plaintiff and awarded damages of £102,000 and costs.

After careful consideration the health board, with the full support of the Society, lodged an appeal against the judgment which appeared to be against the weight of both the evidence and scientific reason. The appeal was allowed, judgments being delivered in December 1985, more than a decade after the incident. The main ground of appeal was that the judge's thesis for awarding compensation was a creation of the judge himself and, moreover, a thesis which was not put to the medical experts in the case for their consideration and comment. There was no evidence to support it and it formed no part of the plaintiff's case at trial. In overturning the judgment the senior judge in the appeal stated that the trial judge had **"gone far outwith his judicial role. It is one thing for a judge to lend his assistance to a party litigant to present his case in evidence. That is entirely proper. It is quite another thing and wholly improper for a judge to neglect the principle of doing justice between the parties and of fairness to both parties by going further and giving a decision in favour of one party upon a ground of his own devising which has not**

been the subject of consideration and exploration at the proof, and of which the opposing party has had no notice whatever. The result . . . is that the judgment . . . is quite indefensible . . . the simple truth in this tragic case is that . . . the only possible conclusion is that the deafness was attributable to pneumococcal meningitis alone."

The appeal court was also critical of the views expressed by the consultant neurosurgeon, who had based his opinions on false factual assumptions, commenting that "in these circumstances it can hardly be said that (his) opinion about (the boy's) prospects was soundly based." The appeal court, allowing the appeal, substituted a sum of £3,000 plus interest as an appropriate award for the sequelae which were attributable to the intrathecal penicillin overdose. This award was less than the sum tendered by the defendants in an attempt to settle the matter out of court, thus protecting the position on costs.

4. Epidural penicillin overdose with neurological sequelae

A 21-year-old housewife with one child was admitted to hospital in Australia, in labour at term in her second pregnancy. An epidural was set up. A Caesarean section was performed for failure to progress and a healthy male infant delivered. One hour pre-operatively the patient's temperature was 38.5°C but no cause for this was found. Postoperatively the obstetrician, a member of the Society, discussed with the anaesthetist, a member of a sister society, whether penicillin should be administered into the epidural space before the epidural catheter was removed. It was decided to administer penicillin by this route but 500,000 units were injected. A few hours later the patient suffered *grand mal* convulsions. She was transferred to an intensive care unit and treated for penicillin neuropathy.

Eighteen months later the patient still suffered a significant intellectual disability with poor memory and impaired hearing and vision. Her claim for compensation for the negligent overdose was settled out-of-court for A.$150,000 shared equally between the Society on behalf of the obstetrician and the anaesthetist's defence society.

Neonatal infusions and extravasation

One sort of claim which angers doctors is that which follows heroic efforts to save life but, during resuscitative procedures, some unavoidable damage is done. An example of this is the extremely small, premature infant, intensively treated in the neo-natal unit with intravenous infusions, who survives neurologically intact but with superficial scarring caused by the tissuing of a drip.

Such tiny babies' drips have frequently to be re-sited and, however carefully this is done and however 'eagle-eyed' are the nurses and doctors, extravasation of fluid can sometimes occur. Tissue damage in such circumstances is unavoidable and necrosis around the site (frequently scalp or foot) sometimes follows. When a claim follows alleging negligence, the anger felt by the members of the dedicated team who have striven so hard to save what only a few years ago would have been the unsalvable is readily appreciated, at least by those who have the knowledge and the capacity to understand.

There are some cases in medical litigation where an expediency settlement is not an acceptable option.

Dermatological complications resulting from the omission of zinc from parenteral nutrition

A 30-year-old woman was admitted to a hospital in Australia for the investigation of Crohn's disease. She had previously undergone caecostomy from which recovery had been complicated by an abscess and a small bowel fistula. After further surgery it was decided that she required parenteral nutrition which was delivered through a right subclavian catheter. After a week the patient had developed an acneiform rash and a month later was diagnosed as suffering from clinical manifestations of acrodermatitis-enteropathica. The cause was attributed to zinc deficiency.

The parenteral nutrition was given under the direction of a specialist physician, a member of the Society. He had, apparently, given no consideration to the question of zinc supplements. The claim, in which the doctor and the hospital were both named defendants, alleged residual and persisting skin, hair and nail changes caused by the zinc deficiency.

The Society was advised by experts in England that the condition had been known of for many years prior to the events giving rise to this claim, and that a specialist in the field ought to have anticipated this recognised complication and taken action to prevent it.

Delay in diagnosis of a spinal meningioma

In 1975, a 25-year-old housewife was referred to a consultant physician at a hospital in the Republic of Ireland. She had spasticity in both legs with bilateral ankle clonus and extensor plantar responses. A clinical diagnosis of multiple sclerosis was made. ACTH gel was prescribed but after three months there had been no improvement.

The patient was referred for a second opinion to a consultant neurologist and admitted to hospital under his care. The history obtained on admission included reference to transient numbness in the right arm two years previously, and numbness in the hands and right leg "... on and off for 3/52". However, the signs recorded were exclusively in the legs with decreased power and co-ordination, increased reflexes and bilateral extensor plantar responses and decreased vibration and pain sense. Although it is clear that a spinal cord lesion was more than seriously considered, the patient was discharged after a 5-day admission with the diagnosis of multiple sclerosis. A myelogram was not amongst the investigations ordered.

The patient was supposed to return to the care of the general physician for follow up but did not do so and it was only three years later, in 1978, that, following increasing spasticity and spasms, a consultant orthopaedic surgeon referred her once more to the neurologist. Following further in-patient assessment by the neurologist, she underwent myelography which initially was inconclusive. However, following a repeat screening it was agreed that exploration of the cord was indicated. At operation a meningioma was removed but the patient was left with a permanent and serious neurological disability.

In 1980 she initiated a claim for damages alleging that, had the proper tests been carried out in 1975, a diagnosis could have been made at that time and a recovery anticipated. The facts of the case were analysed by the Cases Committee of the Society on behalf of the neurologist and by the equivalent committee of the defence organisation representing the consultant physician. It was agreed that whilst a defence to the allegation of failing to carry out a myelogram might well be possible, it would have been difficult to deny that her loss to follow-up was other than a negligent oversight. For this reason, primarily, it was considered that the case could not be won and a settlement was negotiated in the sum of £200,000 to which both defence societies contributed equally.

Ownership of radiographs

A consultant physician was consulted privately by a young woman who had a six-month history of sciatic pain. He advised that she should be admitted to hospital for investigation, including a lumbar myelogram. This took place and the radiologist reported the presence of a disc protrusion. The report and the X-ray films were sent to the consultant physician. He subsequently referred the patient to a surgical colleague who decided that she should undergo a laminectomy. This was carried out and a good result was achieved.

The patient subsequently wrote to the physician asking him to forward the radiographs to her. The physician replied that he was unwilling to do this, though he offered to forward them to the patient's general practitioner or any other doctor she had consulted who might reasonably require them for the purposes of diagnosis or treatment. The patient refused this offer and subsequently issued proceedings against the physician for recovery of the radiographs.

The physician referred the matter to the Society whose solicitors entered a defence to the claim on the grounds that, since the physician asked the radiologist to take the films for diagnostic purposes, they became the physician's property when the radiologist forwarded them to him and the physician was under no obligation to give them to the patient. Shortly before the date fixed for the hearing of the action, the plaintiff discontinued her claim.

Members are advised that the question of ownership of radiographs depends on the original agreement between patient and doctor; as a result, a member in a similar position who considers that his patient may wish to obtain possession of the radiographs taken by himself or a colleague (for example, because the patient comes from overseas), should ensure that the patient is made aware at the outset, preferably in writing, whether he is prepared to agree to this.

Wrong patient — operation list altered

A 43-year-old woman was admitted to hospital as a day case for elective carpal tunnel release of the right wrist. The registrar in orthopaedics, a member of the Society, conducted a pre-operative ward round and examined the patient. The patient had been placed second on the operating list, the first case being the transfer of an index finger extensor to the thumb for a ruptured thumb extensor tendon. Between the time of the pre-operative examination and the commencement of the list, the order of the list was changed so that the patient for the carpal tunnel release was placed first on the list. The registrar was unaware of this change and failed to check the notes and patient before he began the operation.

When the patient was brought into theatre the registrar mistook her for the patient who was originally first on the list and made a small transverse skin incision over the dorsal aspect of the metacarpal phalangeal joint. The anaesthetist and the assistant medical staff then pointed out to the

registrar that the patient was to have a carpal tunnel release. Three skin sutures were required to close the incision, the hand was turned over and the carpal tunnel release performed.

Prior to discharge on the same day, the registrar saw the patient and explained what had happened. She had an uncomplicated post-operative recovery and an excellent result was achieved from the carpal tunnel release. She subsequently instructed solicitors to pursue a claim for damages.

There were features of the treatment of this patient which contravened normal standards of practice, in that the standard pre-operative checks about the identity of the patient and site of operation were not undertaken by the surgeon. The claim was indefensible and settlement was achieved on behalf of the Society's member for the sum of £300 plus £45 costs.

A problem with a podiatrist

A specialist orthopaedic surgeon was asked by a podiatrist with whom he worked to sign a fee-claiming certificate approving her treatment of a 45-year-old woman patient suffering from a bunion. Trusting the podiatrist and thinking she was to give conservative chiropody treatment, the consultant signed the certificate without further enquiry and without entering any details on the form. Later the podiatrist performed a corrective osteotomy with the insertion of a silastic spacer.

Some months afterwards the orthopaedic surgeon saw the patient for the first time. She was referred to him by her general practitioner although he also received a letter from the podiatrist. The information he received was that although the podiatrist's operation appeared initially to be successful, the wound became infected and thereafter the patient complained of stiffness in the toe and the foot. The surgeon admitted the patient to hospital, excised an area of necrotic skin and a sloughing extensor tendon, replaced the silastic implant with one of a different size and performed a tendon transplant. The patient's post-operative progress seemed satisfactory.

Three months after his operation, the surgeon received a letter from solicitors acting for the patient, threatening a claim against him. The surgeon ignored the letter and sent his patient a follow-up appointment. The patient's solicitors seemed irritated by this and wrote to the surgeon again, reminding him of the claim and asking him not to try to contact his patient/their client again.

A writ was served, naming the podiatrist as first defendant and the orthopaedic surgeon as second defendant. It was alleged that the patient had been left with a virtual ankylosis of the left great toe, uncomfortable drooping of the left little toe, unsightly scarring and permanent sensory impairment. It was alleged against the podiatrist that she had failed to advise appropriate treatment and failed to carry out what treatment was given by her with sufficient skill. The statement of claim contained criticisms of the orthopaedic surgeon in respect of the second operation performed by him but also made allegations concerning the supervision of the first operation, details of which the surgeon had, at the time, known nothing.

Expert advice was received by the Society to the effect that the delegation of treatment to, and supervision of, the podiatrist was inappropriate. It could not have been argued in court that the surgeon knew nothing of what the podiatrist did whilst at the same time admitting that he had issued a 'blank cheque', by signing the patient's benefit certificate to enable her to reclaim the podiatrist's fees. The Society considered that it was in the member's best interests for a settlement to be negotiated and this was the view also taken by the podiatrist's insurers. Discussions between the two defendants' representatives resulted in £21,000 being paid into court which the plaintiff accepted. The Society contributed 35%.

Cross-Infection: A Constant Challenge in Dental Practice

by M V Martin PhD BDS
Senior Lecturer and Honorary Consultant, University of Liverpool School of Dental Surgery

Introduction

Recently a number of dental surgeons and their assistants have contracted hepatitis B as a result of their work. This infection has produced debilitating illness and sadly, in a minority of cases, death. Conversely, a dentist who was an asymptomatic carrier of hepatitis B infected a number of his patients as a result of poor aseptic techniques. Cross-infection is a constant problem in dental practice.

Although there is a long list of micro-organisms capable of being transferred during dental practice, including viruses, bacteria, yeasts, protozoa and parasites, real estimates of the incidence of cross-infection, are unavailable. The reason for this lack of documentary evidence on dental cross-infection, with the exception of cases involving hepatitis B, lies in the outpatient nature of dentistry and the variation in the incubation periods of illnesses. Many patients who are infected fail to link subsequent illness with recent dental surgery. This situation is, however, likely to change in an increasingly litigation-conscious population.

The legal obligation

Many practising dentists do not realise that they have a legal obligation, both at common law and under the provisions of the Health and Safety at Work Act, 1974, to prevent cross-infection. The dentist, as an employer, must provide a place of work which is safe and "without risk to health". Thus all staff must be trained and supervised in methods of infection control by their employer, the dentist. Further, as far as practicable, persons not in the employ of the dental practitioner who visit the place of work should not be exposed to health risks. The implication is clear: the dental practitioner is responsible for cross-infection control.

The standard required

Treatment of a known hepatitis B carrier is relatively straightforward using the procedures recommended by the Expert Group on Hepatitis B in Dentistry. However, since the majority of carriers are asymptomatic and undiagnosed they are likely to present as patients in general dental practice. It follows that the prevention of the spread of hepatitis B by asymptomatic carriers is a realistic standard for cross-infection control in dental practice. High standards need to be set in history-taking, personal protection, sterilisation and disinfection.

Personal protection

In the practice of dentistry it is common for a minimum of protective garments to be worn. Body areas most at risk are hands and eyes and, to a lesser extent, nose and mouth.

Hands are probably the major vectors of cross-infection in dental practice. Without proper surgical handwashing the potential for the transfer of micro-organisms to and from the patient is high, yet many dentists regularly practise with unprotected cuts and abrasions on their hands. Saliva contains micro-organisms which could cause opportunistic infections if they gain entry through breaks in the skin. A good example of such infection is the herpetic whitlow which can be painful and costly in lost practice time. Protective gloves are perhaps the only sure way of preventing cross-infection by hands and these are now routinely used in some dental hospitals and students are taught to use them from the start of clinical practice. It is ironic that many dental surgeons object to the wearing of gloves, claiming loss of tactile sensitivity and yet in other surgical disciplines they are used for operations many times more delicate than those in dentistry. Gloves are strongly recommended for routine use by both dentists and assistants in dental practice.

It is surprising how many dental surgeons expose their eyes to potential infection. A salutary lesson in the necessity for the wearing of protective spectacles is to examine a pair of corrective spectacles, worn by a colleague. At the end of treatment the glass will be covered in detritus. Protective spectacles are not aesthetic, but they are an essential pre-requisite to protect the eyes from infection.

The value of masks in safe dental practice is more controversial. Masks do offer a physical barrier to airborne particles but they rapidly become wet and porous to micro-organisms. Theatre-type masks

are much better than the simple paper type in preventing the transmission of micro-organisms between the patient and the operator. Masks are strongly to be recommended when treating high-risk patients or where large amounts of aerosols are created, for example in ultrasonic scaling.

The medical history

The cornerstone of good professional practice is the taking of an adequate medical history. This should be taken in a logical manner with sufficient time allowed. Many practices employ standard proformas containing a series of simple questions. These provide a useful guide to elicit information on any medical problems the patient may have but they are seldom exhaustive and it is therefore a dangerous practice for such proformas to be interpreted by dental surgery assistants. The clear responsibility for the taking of a good medical history rests with the dental practitioner.

It is important to be aware of the dynamic quality of a patient's medical history. Weeks may elapse between visits for some types of dental treatment and therefore any change of medical status should be checked on every occasion. Often the simple question "Have you been well since I last saw you?" will elicit surprising answers, which may be essential to safe practice.

Sterilisation and disinfection

A considerable amount of confusion exists in the minds of some dental practitioners concerning sterilisation and disinfection. Sterilisation is the achievement of the absence of all micro-organisms from dental equipment and is ideal for all surgical instruments. Disinfection is the removal of some micro-organisms and is best reserved for those instruments not used in surgery, for example impression trays and pulp testers. Sadly, many practitioners still believe that surgical cleanliness implying sterilisation is not necessary, only requiring 'kitchen cleanliness'. Kitchen utensils, although they may enter the mouth do not usually penetrate the oral tissues or release blood. In contrast most dental instruments, including burs and handpieces, are always blood-contaminated after use and should be sterilised. Blood and saliva can be potent vectors of cross-infection and should be removed from instruments prior to sterilisation.

Sterilisation of instruments is best achieved by use of the hot-air oven or the autoclave. The hot-air oven is operationally slow (180°C for 30 minutes or 160°C for one hour are recommended times) and can cause tempering of some steel instruments, for example reamers. Many ovens do not have a time lock and unfortunately can be interrupted in mid-cycle thus rendering them ineffective. The autoclave is the quickest way of achieving sterilisation of dental instruments (a temperature of 134°C for four minutes or 121°C for 15 minutes is recommended). Unlike hot-air ovens, autoclaves usually have a time lock to prevent interruption of the cycle.

Many practices still use 'boilers', which are not recommended. A recent survey has shown that they neither sterilise nor disinfect. The Department of Health and Social Security has issued the recommendation that all NHS practitioners should discontinue the use of boilers, now revealed as a potential cross-infection hazard. Advertisements in the dental press have recently featured 'cold sterilising agents'. It is important to realise that these are not substitutes for autoclaves or hot-air ovens. In practice, dental instruments require to soak in such agents for between four and eight hours to achieve sterilisation comparable to that achieved by the autoclave or hot air oven. In addition these agents often contain glutaraldehyde, an irritant to the skin, thus requiring instruments to be washed in sterile water before use, an inconvenient extra step in processing.

Disinfectants containing glutaraldehyde are recommended for use on surfaces of non-surgical instruments used in treating hepatitis B carriers. Because they are an irritant to the skin if used routinely, a simple disinfectant such as one containing chlorhexidine gluconate is preferable in routine practice.

Some instruments are impossible to sterilise in dental practice. A good example is that of local anaesthetic hypodermic needles. These are invariably blood-contaminated after use yet in a recent survey 30% of practices visited were found to re-use them. This 'economy' cannot be condemned strongly enough. They should be used once and disposed of correctly, in a 'sharps box' suitable for incineration.

The future challenge

The prevention of cross-infection is a real challenge in dental practice. Hepatitis B, the prevention of which has been suggested as a standard for cross-infection control measures, is rising steadily in incidence in the UK. Most practitioners will now undoubtedly treat several hepatitis B carriers every year. The problems associated with AIDS and the HTLV3/LAV virus have been discussed in the article by Dr D J Jeffries on page 19 of this report, to which the reader is referred. If serious illness is not to result then the challenge of preventing cross-infection in dental practice requires constant vigilance, planning and some financial investment. Practitioners ignore the danger at their peril.

Medico-Legal Consequences of Extracting Lower Third Molar Teeth

by R Haskell MB BS BDS MRCP FDSRCS
Consultant Oral Surgeon, The United Medical and Dental Schools of Guy's and St. Thomas's, London
Member of the Dental Advisory Board, The Medical Protection Society

In connection with the extraction of teeth, claims for negligence are associated with the lower wisdom teeth much more than any other, if the extraction of wrong teeth is discounted.

Most claims revolve around three clinical complications, ie
(a) Damage to the inferior dental nerve

(b) Damage to the lingual nerve

(c) Fracture of the mandible.

These remain as complications and not claims only if the patient accepts that he has been treated with the care which he could reasonably expect from a competent practitioner. If he feels that this is not the case he may seek legal redress.

If a claim for negligence is made, the Society will, on behalf of a member, scrutinise the management of the whole episode. The duty of care which is owed to the patient can be deficient in 1 diagnosis or 2 technique of extraction and management of complications.

1 Diagnosis
First and foremost it must be possible to justify the need for extraction. There is a common belief that an impacted tooth offends by its presence. It does not. There should be a clear indication for the removal of the tooth, either to relieve symptoms or, if the extraction is proposed on prophylactic grounds, the patient must be fully informed. A patient who exchanges a completely asymptomatic unerupted tooth for a permanently hypersensitive and painful numb lip must feel that 'something has gone wrong'. Secondly, apart from clinical assessment, it is obligatory with any partly unerupted impacted tooth that a proper radiograph should be taken. Such a radiograph must show the entire tooth and its depth and relationship to the lower second molar and indicate the relationship to distal bone, the inferior dental neurovascular bundle and ideally the lower border of the mandible. A periapical film will do all but the last and is adequate but an extra-oral film is advisable. Of such films an orthopantomograph is the most desirable. The one drawback of extra-oral films is that they do not have the detail which allows one to assess the relationship of the tooth with the inferior dental neurovascular bundle so, if the orthopantomograph shows a possible close relationship, a periapical film is essential to assess the probable risk to the nerve during extraction.

The radiographic signs which presage an intimate relationship between the inferior dental neurovascular bundle and the tooth are:

(i) loss of the 'tramlines' surrounding the bundle;

(ii) narrowing of the radiolucency of the canal;

(iii) diminution of the apparent radio-opacity of the canal.

If these signs are present, the patient should be warned of the possibility of a numb, painful lip and such warning recorded. Fortunately the number of cases in which numbness results from extraction is only a fraction of those in which radiographs suggest the possibility of damage.

At the end of the assessment a clear picture of the probable course of extraction should be present in the operator's mind; if not, the patient should be referred to a better qualified colleague. All assessments of the difficulty of extraction can only be partial as the quality of bone, which is very variable, is unpredictable and the bucco-lingual disposition of the tooth, which is highly significant, can only be discerned when the bulk of the crown is visible. Regardless of the skill which is used, removal of impacted wisdom teeth usually causes much post-operative pain, swelling and trismus and it is imperative to warn of this otherwise the patient will assume that something has gone amiss.

Surgical removal justifies the prophylactic use of antibiotics which certainly diminish post-operative complications and discomfort. If the extraction is to involve bone removal on the lingual side of the mandible (the lingual-split technique with a chisel) the patient must be warned of the probability of lingual nerve anaesthesia. It is not uncommon for transient partial loss of sensation in the lingual nerve distribution to occur and last for up to one month with this technique.

2 Technique of extraction and management of complications

(a) **Lingual nerve** — Important considerations are the protection of the lingual nerve, which is effected by passing a Howarth periosteal elevator down the lingual side subperiosteally in all cases in which bone is to be removed. Furthermore, use of a bur must be carried out with the bur being drawn from the lingual to the buccal. Removal of the lingual plate with a chisel exposes the lingual nerve to a greater theoretical than practical risk of permanent damage although temporary hypoaesthesia due to stretching is common.

The lingual nerve may be crushed between the tongue retractor and the lingual plate or retractor. The position adopted by this retractor is that almost designed to crush the nerve, so great care must be taken to ensure that it does not do so. The relative risk to the lingual nerve from the bur, the chisel and simple elevation without bone removal is very hard to assess. In practice the Society has more cases of lingual nerve damage associated with the bur than the chisel but that probably reflects the greater use of the bur overall. Post-operatively if numbness of the tongue is complained of it is managed by masterly inactivity, there being no evidence that active intervention is of value, but persistent observation is essential until it is clear that any residual numbness is permanent.

Theoretically it should be possible to remove any wisdom tooth without damage to the lingual nerve; in practice this is not the case. We need to know a lot more about nerve damage and how it is brought about.

(b) **Inferior dental nerve** — Damage to the inferior dental nerve may be unavoidable but the probability of damage is predictable and in those cases the patient must be warned of the risk of numbness of the lip and that such a warning has been given should be recorded in the notes.

Techniques to avoid damage to the nerve where an intimate relationship exists are spelt out in textbooks. My own view is that such patients are better treated by a consultant in hospital under general anaesthesia and removal of the lingual plate with a chisel is advisable. Again, once the nerve has been damaged there seems to be no active treatment which is beneficial but review is essential till a steady state is reached (one year).

Permanent damage to the lingual nerve is more commonly associated with claims by patients than is damage to the inferior dental nerve. This may be because it is more common but more likely because it produces a more severe disability which the patient has great difficulty in accepting as a complication of the surgery. Of the single nerve damage claims 40% were for the inferior dental and 60% for the lingual. In isolated cases both nerves were damaged.

(c) **Fracture of the mandible** — This is exceptionally rare with the extraction of any teeth except impacted wisdom teeth. It is obviously more common when extensive bone removal has taken place. The strength of the mandible lies in the buccal plate and the curved upper and lower borders. Once buccal bone is removed below the external oblique ridge the resistance of the mandible is grossly compromised and surprisingly little force in elevation of the tooth will fracture the mandible; indeed it is possible for the operator not to realise that a fracture has occurred. It is also possible for the mandible to fracture within the first week after operation under the influence of normal occlusal forces.

It is very hard to justify the use of forceps to extract an impacted tooth after bone removal since too great a force can be misdirected. If a fracture occurs the patient should be sent to the local oral surgery department for management. The patient should be told what has happened.

Failure to observe the points noted above may lead to a complication becoming the basis of a claim for negligence. The files of the Society reveal 42 involvements of the nerves (lingual or inferior dental) and 8 fractures of the mandible occurring between 1982 and 1985. Other bases for claims which may occur with any tooth extraction include handpiece burns (1) failure to complete the extraction (5) and infection (2). Careful assessment, meticulous technique and management of all complications until they resolve — or are accepted by the patients — will keep the patient happy and will help to avoid trouble.

The Dental Report

T R Hill FDS RCS(Eng)
Consultant, Department of Conservative Dentistry, Eastman Dental Hospital, London
Member of the Dental Advisory Board, The Medical Protection Society

The dental surgeon in the 80's caring for an increasingly litigation-conscious public may be forgiven for misquoting Bulwer-Lytton and thinking, "the pen is mightier than the bur". The growing volume of legal work within the profession leads to a greater chance that a practitioner will be requested to supply a dental report for the legal profession. Most dental surgeons are more 'at home' in the surgery than they are at the office desk and thus, when faced with the semantic correctness of the legal profession, feel overawed by the prospect of committing to paper their thoughts and observations. The purpose of this article is to allay some of those fears and suggest a way of preparing such reports by a method similar to normal history taking. Concurrent with the article is a model report based on a case where the legal profession has been involved.

When a report on a patient's dental condition has been requested, the dental surgeon involved is probably being asked for two distinct and separate entities. He is being asked to provide a factual report of the patient's dental condition at that time. He will probably also be asked to provide his opinion regarding the treatment rendered to that patient. These are two clearly defined tasks which should not be confused in the report. Many practitioners are concerned when a solicitor requests an 'expert' opinion about a patient, but every dental surgeon is an 'expert' at dentistry when compared with members of the legal profession; thus a practitioner's professional opinion is as valid as a legal opinion given by a solicitor. It would be up to the solicitor to select an expert in the field required. If the opinion differs from that expected or hoped for that is the solicitor's problem and no concern of the practitioner, but this only holds true when fact and opinion have been clearly separated within the report.

The compilation of a report is rendered less daunting if distinct sections, under separate headings, are used in a similar manner to a new patient history. The first section, therefore, would be the 'history of present condition or:

> ***Dental report on Mr. X of (address):*** ***Date of birth***
>
> ***I. Statement by patient on (date of examination)***
> *Mr. X stated that he had had some crowns constructed (privately) for a number of his back teeth some seven to eight years ago. More recently Mr. X had consulted Mr. A on the National Health Scheme complaining of food packing between two lower right teeth. Mr. A observed the crowns in Mr X's mouth and referred him to a dental hospital for a second opinion. They opined that the original crowns that had been fitted by the previous practitioner should be replaced. Mr. X also stated that he is claiming back the fee he paid his original private dentist for the unsatisfactory crowns.*
>
> *Mr. X returned to Mr. A who has arranged to remake the crowns.*

This section is the first of the factual sections and is basically a report of the patient's problems, actions and opinions which are factual inasmuch as they are reported in good faith. Note that it is not necessary to agree with the patient or necessarily believe the accuracy of these comments. The main use of this section is to establish a chronological order of events from the patient's viewpoint. The chronology may well be questioned later but should be reported as the patient states it. An example of patient confusion in this respect is when a post crown is constructed on a previously root-filled tooth, the root filling having taken place many years before. The patient may consider the preparation for the post as a deliberate devitalisation of the tooth, the instrumentation and technique being similar in the patient's estimation.

The threat of execution, it is said, concentrates the mind to a remarkable degree. A similar process seems to take place with patients who are litigation minded. Symptoms can be exaggerated, and the effect of pain on the life-style is often remarkable. It must be remembered that these patients are exceedingly anxious about both their dental condition and the possible financial considerations and thus will try to put their best case forward. Their comments and opinions are best contained in the statement by patient section, and not incorporated in other sections of observed facts or opinions.

> ***II. Present complaints***
> *Currently Mr. X complains of food packing on the lower right hand side, causing pain and bleeding of the gum.*

It is generally wise to include this heading in the report even though some of the complaints may well have been mentioned in the previous section. The list of complaints, in certain cases, could be

extensive but can be listed under subheadings. The benefit of this section to the reader is that a concise statement of the patient's problems is readily available. The advantage to the report writer is that when considering the opinion section, reference back to the complaints will give an aide memoire to avoid omitting some points. On some occasions this section is very useful to imply to the reader that the patient is making exaggerated and irrational claims about his condition.

III. Medical history

There is nothing in Mr. X's previous medical history relevant to his dental condition or future dental treatment.

This section is added mainly for completeness; but were there to be a particular medical complication relating to the dental treatment then mention of this would avoid awkward comments at a later date.

IV. Examination

A. Clinical

1. *All teeth were present with the exception of the four wisdom teeth, i.e.*
   7654321 | 1234567
   7654321 | 1234567
2. *Porcelain bonded to gold crowns were present on 765| and $\overline{76}$|.*
3. *The remainder of the teeth had either no restorations or satisfactory fillings.*
4. *The 7| and 6| crowns were inexplicably splinted together.*
5. *The crowns present exhibited considerable positive margins and severe over-contouring in the cervical areas; no marginal decay, however, was observed with any of these restorations.*
6. *An open contact was observed between $\overline{7}$| and $\overline{6}$|.*
7. *In general the periodontal condition was very good but did exhibit varying degrees of inflammation in proximity to the bonded crowns.*
8. *Wear facets were observed on the occlusal surfaces and incisal edges of the bonded crowns and the teeth; indicative of parafunctional activity.*
9. *The retruded axis position was difficult to obtain, but the occlusion seemed reasonably stable.*

B. Radiographic

(i) The interdental bony height was normal for a patient of Mr. X's age.

(ii) The crowned teeth exhibited bulbous and overhanging gingival margins, but recurrent decay was not a feature.

(iii) Some suspected root caries was noted on the 76.|

(iv) No other dental or bony abnormalities were observed.

This section is of course the report of the dental findings and should be as factual as is practicable. It is prudent to remember that a non-dental lawyer will have to understand clearly the facts that are raised. For example, "12 short RF needs endodontics and PC" is difficult for a dentist to understand and impossible for a lawyer. Better would be "the upper left central incisor has a deficient root filling and needs further endodontic treatment and a post crown". It is clear and unequivocal but as written combines both fact and opinion. It would be preferable, therefore, to split this point into two sections, i.e. in the examination section *"the upper left central incisor has a short root filling but no apical pathology was noted on radiograph"* and in the opinion section *"the upper left central incisor needs further endodontic treatment and a post crown to render dental health"*.

There are occasions when observed facts are in fact professional judgments. For example, in number 5 of the clinical examination above it is the writer's opinion that over-contouring occurred, as no measurable yardstick can be applied to this fact. Other examples become apparent when judging an existing root filling in relation to its position within the root canal or whether an apical seal has been effected, gross anomalies are readily described but the nearer to satisfactory the appearance, the more judgmental the writer has to be. The same factors would apply to crown margins and their detectability by either probe or radiograph. The question of aesthetics in relation to anterior crown work is yet a further area of factual difficulty. It would be the writer's opinion only if he stated that the crowns were aesthetically pleasing or conversely were unacceptable; the patient's opinion is the one that really matters and should have been covered in a previous section. This does not mean to say that the writer should not report on the positioning, contour and colour of restorations which may or may not have a bearing on the aesthetics but could well affect the occlusion and gingival

condition. A word of warning should be given here in regard to apical areas of radiolucency on root-filled teeth. The writer can point out the radiographic finding but state that he or she is unable to infer from one examination whether this is an area which is increasing or decreasing in size.

V Opinion

From my clinical and radiographic examination I have formed the opinion that:—

1. *Mr. X is fortunately a "periodontally immune" patient and as such enjoys a remarkably healthy periodontium that is denied many.*
2. *The crowns originally supplied to Mr. X some years ago are undoubtedly suspect from a periodontal viewpoint. The fact that Mr. X has not suffered gross periodontal breakdown is entirely due to his innate resistance.*
3. *The crowns as supplied have lasted, on this particular occasion, for a number of years; hence they could not be termed overt failures.*
4. *The lack of recurrent decay around these crowns shows that their marginal fit must be adequate but were fitted with over-contoured gingival margins.*
5. *Whilst the crowns were in place Mr. X had essentially a symptom-free period, with his only complaint being food packing.*
6. *The occlusal anomalies and parafunction noted were minimal, requiring minor occlusal adjustment.*
7. *The root caries seen in 76| would be eliminated with new crowns.*
8. *Replacement of these crowns is necessary for the long-term health of Mr. X's mouth.*

Signature:
Name and qualifications: *Date:*
Address and telephone number:

The Opinion section should be the only place in the dental report where the writer gives his opinion upon the previously stated facts. Once again a little care is needed to differentiate fact and opinion as it is easy to fall into the trap of presenting an opinion as a fact. An example may clarify this point: It is perfectly correct to say that "in my opinion it is a nice day", but it would be unwise to say "it is a nice day" unless it has clearly been inferred that this is what you think. In other words "it is a nice day" can be challenged for authenticity and definition of, say, "nice". On the other hand it is a fact if you say "the patient said it was a nice day"; the writer of the report can only be challenged on memory. Better still would be to say "I noted down on the day sheet that the patient said 'it was a nice day'," and then produce the day sheet. Obviously this last reference is a fact and would appear in an earlier section of the report.

Although perfectly entitled to an opinion, the writer of the report is frequently referring to the work of a colleague. Criticism of professional standards is easy, especially with the benefit of hindsight, but before condemning another practitioner's work it might be wise to consider one's own patients. Would they all bear critical examination by another practitioner? We must all treat at some time the fidget, the retcher or the hand puller whose final treatment standard is the best that one could obtain under those conditions; consider demonstrating one of these patients as an example of your professional standard. The author suggests, as a yardstick, whether if the work observed was in your cousin's mouth with no symptoms, would you let it remain or would you replace that work; obviously for no fee for your cousin! In other words, could I do better in the circumstances? If I could, is it justified for me to proceed?

When requesting a dental report, lawyers frequently ask whether the work in question constitutes negligence on the part of the previous practitioner. The author is very reluctant to use the word 'negligence' in a dental report; far better to state that in the writer's opinion the work observed fell below an acceptable professional standard and should be replaced. The word negligence has many legal connotations and could well lead the writer of a dental report into difficulties. The instructing lawyer may question the cost of replacement of the work that was unsatisfactory. The dental report should be confined to the dental facts and to the writer's opinion upon those facts and is not a forum for quantum. The information is better reported to the lawyers in a separate confidential letter. In this way one may avoid the need for explaining fee structures were the case to go to Court.

In conclusion it must be stated that litigation in the dental field is increasing and thus more and more dental surgeons are being asked to comment on colleagues' work. The furbishment of a dental report need not be an awesome undertaking but some care should be taken to protect both the writer

and the profession in general. For this reason the compilation of a report, as another aspect of dentistry, should command a reasonable fee. The quick short letter to a lawyer frequently evokes a reply requesting further details. It is thus easy to fall into a prolonged correspondence with the lawyer, which, if for nuisance value only, is more time consuming than a considered dental report in the first instance.

Employment Law: recent cases and trends

Following the article in last year's Annual Report (No. 93, page 61) dealing with practice management and employment law, an update of the Society's involvement in employment law cases and of recent trends and case law in the Industrial Tribunals of relevance to practitioners is set out below.

Three recent cases where the Society has assisted dental members

1. A dental nurse/receptionist was dismissed after warning for constant poor time-keeping. She claimed unfair dismissal but the Society's solicitors successfully argued in correspondence that the Tribunal did not have jurisdiction to consider the application for various reasons. The nurse had just less than the required period of two years' continuous employment with the dentist. Although she had in fact worked for him over two years previously at his former practice, there had nevertheless been a gap between the employments, and hence a break in the continuity of her employment. The Tribunal indicated to the nurse that she could pursue additional allegations she had made that the dentist had unlawfully discriminated against her on the ground of her sex by dismissing her because of pregnancy. The two year continuous employment provisions do not apply to application for unfair dismissal on the grounds of pregnancy. It was successfully argued on behalf of the dentist that to claim sexual discrimination the nurse, as she had been employed by a business with fewer than five employees, would have to show victimisation by her employer effectively amounting to positive steps taken to prevent her from being treated equally under the provisions of the Equal Pay Act or Sex Discrimination Act and to treat her less favourably than he would have treated another employee in the circumstances. The nurse withdrew her application.

2. A dental nurse who had been employed for 9 years brought an application for unfair dismissal following a final verbal warning from her employer when she refused to collect NHS charges from a patient and to ensure that the patient signed the estimate form. She had received a number of prior warnings for unco-operative and insubordinate conduct. On behalf of the dentist it was claimed that the nurse had resigned her post, or if not, that she had been fairly dismissed as a result of her misconduct and/or incompetence. Although it was felt the dentist had strong grounds to resist the application he was advised that the case would take two days to fight which would involve him in absences from his surgery and it was very unlikely that, if successful, an order for costs would be made. The claim was settled for a modest 'nuisance-value' amount.

3. The Society provided assistance to a dentist whose former receptionist brought an application for unfair dismissal. The dentist had received complaints about her over-bearing attitude to patients and fellow staff. One member of staff had left as a result of the receptionist's rudeness and antagonism. The practitioner spoke to her about the complaints, then followed this up with a letter of dismissal. It was, however, unclear, and certainly arguable, as to whether the receptionist resigned of her own accord before receiving this letter. Nevertheless the practitioner was advised that he had acted rather precipitately and that a proper warnings procedure should have been followed for misconduct of this nature. Also the receptionist had not been allowed a proper opportunity to respond to some of the criticisms. The practitioner 'scored an own goal' by providing the receptionist with a good reference. He was advised that there was a real risk of findings of unfair dismissal by a Tribunal. In the event the claim was settled for one-third of its full potential value on the basis of two-thirds contributory fault by the receptionist.

Recent trends and case law

ACAS published a draft code of practice in November 1985 dealing largely with disciplinary rules and procedures. These are relevant, particularly to dental practitioner employers. They emphasise the need to set out in an employee's contract instances of conduct justifying dismissal and summary (i.e. on the spot) dismissal such as theft, persistent absences without explanation, abusive and insubordinate behaviour. The guidelines also stress the need for the employer to follow a proper warning procedure, to take prompt action to investigate an employee's misconduct and then allow the employee to put his/her side of the case. Practitioner-employers are encouraged to obtain a copy of the ACAS guidelines as soon as they are implemented.

The courts have re-affirmed that where an employee is dismissed for the suspected commission of a criminal offence, the test to be applied in deciding whether or not the dismissal was unfair is whether

the employer reasonably believed the employee to be guilty at the time of dismissal. Therefore a later acquittal by a criminal court does not necessarily cause a dismissal to be unfair. In addition an employer can bring disciplinary proceedings after the employee has been acquitted of the criminal charge. Criminal courts apply a totally different standard of proof, namely that guilt has to be proved "beyond reasonable doubt". A tribunal has even held that evidence obtained after an internal appeal against dismissal which might have corroborated the applicant's defence to dismissal for dishonesty was irrelevant, **Greenall Whitley PLC** v **Carr** (1985) IRLR 289 EAT.

In the case of **Wadi v Cornwall and Isles of Scilly FPC** (1985) ICR 492 EAT, the Tribunal held that the refusal by a Family Practitioner Committee of an Indian doctor's application for selection to a vacant position in a general medical practice was not racial discrimination. As there was no contractual relationship between a doctor and either the Family Practitioner Committee or the Medical Practices Committee under the statutory scheme for the selection of doctors, therefore the Race Relations Act was not applicable

In the case of **Irani v Southampton and Southwest Hants Health Authority** (1985) TRLR 203 ChD a court granted a part-time ophthalmologist an interlocutory injunction to restrain the Health Authority from dismissing him in breach of a contractually-binding disputes-procedure which applied to him. This form of relief in employment disputes is granted very rarely.

In the case of **Bliss v South East Thames Regional Health Authority** (1985) Times 25/4/1985 the plaintiff, a consultant surgeon, was found by the Court of Appeal to have been wrongfully dismissed following a breach of contract by his employer, who required him to undergo a psychiatric examination after he had disagreed substantially with a colleague. This requirement, which he refused, was held objectively unjustifiable on the facts. It was also held he had not affirmed the contract merely by continuing to accept his salary as it was considered that he needed time to decide whether or not to return to work.

Developments in dental law

General Dental Council: Professional Conduct and Health Committees

1985 saw significant changes and developments in dental law, the most important concerning the committees of the General Dental Council and their powers. The Professional Conduct Committee replaced the Disciplinary Committee on 1st October 1984. The words "infamous or disgraceful conduct in a professional respect" were replaced by the term "serious professional misconduct". On 1st January 1985 the General Dental Council Health Committee Procedure Rules came into force, with a Health Committee operating with jurisdiction over dentists whose fitness to practise was seriously impaired by reason of physical or mental condition. During 1985 practitioners have appeared before the Health Committee, who judged their fitness to practise to be seriously impaired and directed the Registrar to suspend their registration. The Health Committee has recommended that certain practitioners should remain under medical supervision and agree to undergo treatment. The Health Committee has the power to direct that the registration of a dentist should be conditional on compliance, during a period not exceeding three years, with such requirements as the Committee may think fit to impose for the protection of members of the public or in the practitioner's own interests. Examples of this might be that a practitioner is directed not to practise single-handed or to carry out particular kinds of treatment.

General Dental Council: advertising

A second highly significant development in 1985 took place at the public meeting of the General Dental Council on 12th November, when amendments to the Notice for the Guidance of Dentists in relation to the section on advertising and canvassing were approved. Although dentists should avoid personal publicity in the media which would have the effect of promoting their own reputation, or which would be detrimental to the interests of the profession as a whole, the Council accepted that advertising should have the object of facilitating an informed choice by patients seeking treatment. Accordingly, factual information to that end could be published in the press or, indeed, on radio and television. Similarly, advertisements for staff vacancies in the press could include the telephone number of the practice, as well as the name and address of the dentist, but should be restricted to a statement of the essential facts about the post. The Council, however, reiterated the view that it is contrary to the public interest and discreditable to the profession if a dentist canvasses for the purpose of obtaining patients or promoting his own professional advantage, so that any dentist who does so is liable to proceedings for misconduct.

The 'Schanschieff Report'

The Report of the Committee of Enquiry into Unnecessary Dental Treatment (the 'Schanschieff Report'), set up in 1984 after allegations that some dentists might be defrauding both patient and

taxpayer, was published in the spring of 1986. It recommends that any dentist found guilty of deliberate unnecessary treatment, or any dentist who over-treats because his knowledge is out of date, so that there is evidence of "serious incompetence", should be referred to the General Dental Council. The report was at pains to point out that the majority of dentists were honest and provided a good service upon which the public could rely but there were cases of persistent flagrant abuse, with a small but significant and unacceptable amount of deliberate and unnecessary treatment. The report commented that the nation's dental health was improving rapidly and that there was a risk of increasing numbers of dentists being tempted into carrying out unnecessary treatment to maintain their incomes. It advised the Department of Health and Social Security to reconsider whether the present system of paying dentists was appropriate in furthering preventative dentistry.

A question of seniority

A 53-year-old member in general practice for over twenty years also worked two sessions per week in the dental department of a local hospital for most of that time. In 1984 he was made redundant at the hospital and given a small pension and a lump sum. He was not advised that there would be any disadvantages to this.

When he was nearly 55 he approached his Family Practitioner Committee to claim seniority payments, only to be informed that he was ineligible as he was in receipt of a National Health Service pension. The member made persistent efforts to have this ruling reconsidered but was unable to make any progress.

He finally approached the Society who took up his case with the Department of Health and Social Security, pointing out the iniquity whereby the member, by receiving his small pension in all innocence, was barred from seniority payments which were worth more than twice the value of the pension. The Department made further investigations and ruled that as the pension was not in respect of general dental service work, the claim for seniority payments would be allowed.

Members are advised to make full enquiries about any possible future complications before accepting NHS pensions.

An expensive free advertisement

A member placed an advertisement, in a free-advertising magazine circulated to all general dental practitioners, for a full-time associate with a view to purchase of the practice. Some weeks later a young associate, also a member of the Society, was interviewed and accepted the position. The principal was amazed some time later to receive a bill from an agency requesting payment for services in finding a suitable associate for the practice. The member consulted the Society and investigation revealed that the free magazine and the agency were owned by the same company. The managing director insisted that the dentist had asked the agency to supply suitable candidates and eventually sued the member for the agency fees.

Although this matter was not clearly within the scope of the benefits of membership of the Society, the Dental Advisory Board felt that, as a matter of principle and in the interests of the membership at large, the member should be helped. The claim was strongly resisted.

The case was heard before a county court registrar and the member was represented by counsel. There was a conflict of evidence in that the company maintained that they had not only agreed to place an advertisement for the member but also he had asked that the matter be dealt with through the employment agency side of the business. The company produced a telephone fact sheet which had allegedly been filled in during the telephone conversation placing the advertisement. The registrar accepted the evidence of the Society's member and found in his favour. He also made an order against the company to pay witness fees.

Although this case had a happy ending for the member, much distress and a lot of time was lost from the surgery in preparing the case. It illustrates that any agreement made between a dental practitioner and a newspaper or agency should be made in writing so that the facts cannot then be in dispute if a disagreement arises.

A patient's dilemma

Over-prescription by dentists is currently a matter of public interest and the Government, recognising this, set-up the Committee of Enquiry into Unnecessary Dental Treatment. The resulting 'Schanschieff report' confirms that there is evidence to suggest that a significant amount of unnecessary dental treatment is currently being provided for patients in the general dental service.

It is therefore not surprising that the Society has an increasing number of requests for assistance from members who find themselves the subject of a complaint by a patient that they have provided

unnecessary treatment. Patients clearly find themselves in a dilemma. They have happily been receiving dental care for many years from a practitioner who knows them well and can decide from experience how long cavities take to develop and whether the patient is likely to respond to preventative advice. However, the day may arise when the dentist goes on holiday and the patient requires some further treatment, perhaps because a filling has broken or toothache arises.

A dentist provided care for a patient who attended regularly for some years but she was on holiday when the patient requested some emergency treatment. The patient had broken a filling and consulted another practitioner, a member of the Society. He provided the necessary emergency treatment and took two bitewing radiographs to see if any further treatment was required. After looking at these radiographs he advised that she needed six further fillings which he then provided.

The member was surprised to receive a copy of a complaint made by the patient to the Family Practitioner Committee alleging that either he had provided unnecessary treatment for her or alternatively that the first dentist who had completed a course of treatment some weeks before the filling had broken, had not carried out treatment which was necessary for dental fitness.

The Society assisted the member in giving a detailed explanation of the reasons why he had decided that the fillings were necessary and his explanation satisfied the patient and nothing further was heard of the matter. However, the patient's dilemma is not difficult to imagine for it would seem obvious to the patient that either the first or the second dentist must be at fault. As patients must rely on the expert advice of their dentist, it is important that dentists carefully consider whether they are intervening prematurely. Members are advised that careful consideration should be given as to whether restorations could last longer or whether early carious lesions could regress if preventative measures were followed by the patient. While there may be legitimate differences of opinion between dentists, inappropriate treatment is not in the best interest of the patient or the profession.

Blacklisted

Members will be aware that the pursuit of bad debts *per se* is not within the scope of the Society. Unfortunately, bad debts are a fact of life in general dental practice and it would appear that the services of debt collection agencies are increasingly being used.

A dental practitioner sought the Society's advice having received a letter from the solicitors of one of his patients whom he had pursued in respect of unpaid fees through a debt collection agency. The fee in question was finally paid, but the patient nevertheless received a County Court summons issued by the agency. There had clearly been a mistake and the practitioner immediately instructed the agency to take the necessary steps to have the action struck out. Unfortunately, the agency did not act as instructed and, in his absence, judgment was entered against the patient. The next the patient knew was that the Bailiff was at his door with instructions to distrain for the monies involved. The patient was, however, able to persuade the Bailiff not to take any further action for the time being as the debt had been settled.

Quite understandably the patient felt highly aggrieved and claimed from the practitioner, through solicitors, an unqualified apology plus compensation for running the risk of possibly having his name placed on a blacklist of debtors through no fault of his own but due to the administrative incompetence of others. The practitioner sent a copy of the letter from the patient's solicitors to the agency who admitted in writing that they had received notification that the account had been paid. The agency further admitted they did not act upon the information passed on by the practitioner, and offered an unqualified apology for any distress their own failure had caused the patient, together with an offer to pay him reasonable compensation.

It is fortunate that the agency upon learning of their error acted so promptly, thereby resolving a very worrying matter as far as the practitioner was concerned. It is prudent to retain copies of all instructions to debt collection agencies and keep them under regular review.

Psychiatric dentistry

A consultant in oral and maxillo-facial surgery saw a 20-year-old patient whose chief complaint was of a subjective sensation that his jaw had moved in a downward direction causing his facial skin to loosen. The surgeon noted a mild mandibular prognathism with an anterior open bite of minimal proportion. He felt that it warranted correction on its own merits although the jaw problem was subjectively assuming unrealistic proportions in the patient's mind.

After suitable psychiatric counselling the corrective surgery took place. The patient was bitterly disappointed with the resulting appearance stating that previously he had a long lean face matching his stature but now he had a short, fat face.

He therefore wished to have the surgery reversed. The practitioner felt that further psychiatric counselling was more advisable than any further surgery. Following this advice a number of incidents occurred in which the patient threw bricks through the car window and surgery window of the clinician. Police arrested the patient and malicious damage charges were laid against him. The practitioner also had himself to engage a security firm to provide 24-hour protection since serious threats were made by the patient to kill the member. The Society paid the legal fees incurred in dealing with this difficult problem.

Acid burn on the face

Technical advances have brought into common use a wide range of dental materials, some of which require careful handling.

A 15-year-old girl presented at the member's surgery and said that she had not received any treatment for two years. Her front teeth were in a poor state and she was anxious to improve her appearance. The member considered that the most appropriate treatment for a patient of this age was to restore the teeth with acid etch composite restorations. One tooth was completed and the patient was pleased with the result but took a year before returning to complete her treatment. Another incisor tooth was then restored using the acid etch technique and the patient left the surgery apparently very satisfied.

However, she returned a few minutes later complaining that there was a red mark on her chin which was now quite noticeable. The member, realising that a drop of etching fluid might have dropped on the patient's chin, followed the instructions on the information leaflet with the filling material and washed the area of skin with water. The patient was instructed to repeat the process at home.

Two weeks later the patient returned with a red mark measuring 1cm × 0.5cm clearly visible on her chin. Her parents complained that she was upset that this had shown up on family wedding photographs taken a few days after her dental treatment. The etching fluid was analysed and found to contain the usual concentration of 50% by weight free phosphoric acid. Some weeks later the member received a letter from solicitors acting for the patient, alleging negligence in the treatment which had resulted in an unsightly acid burn on the patient's chin.

The patient was examined a year later. The opinion was expressed that the raised red scar would continue to subside but that the patient would be left with a flat scar, perhaps slightly whiter and more depressed than the surrounding skin. The Society took the view that the claim could not be successfully defended and a settlement was made of £9,000 plus £2,400 legal costs.

New techniques bring new hazards into the dental surgery and members need to remain vigilant. Careful protection of patients' eyes, oral mucosa and skin are important considerations when using powerful chemical agents.

Periodontal ligament injection of local anaesthetic

Prior to preparing 6| for a full crown, a member of the Society in general dental practice administered local anaesthetic into the periodontal ligament with a syringe specifically designed for the purpose. A pre-treatment periapical radiograph did not show any contra-indication to intraligamentary analgesia. The crown preparation was completed, impressions taken and a temporary aluminium cap fitted without incident. A month later, when the patient returned to have the crown fitted, the practitioner found the gingival tissues surrounding 6| to be somewhat inflamed and that she had been placed on antibiotics by another dentist. The practitioner decided to defer fitting the crown to allow the gingival condition to settle. A further appointment was made but the patient did not attend and never returned to the practice. The practitioner submitted a small account to cover the cost of the treatment he had provided, but received a reply to the effect that his account would not be paid and that he would be hearing from the patient's solicitors.

One year later he received a letter from the patient's solicitors detailing the clinical state of the gingival margin around 6|as reported by another dental practitioner approximately five weeks after the crown preparation. The patient's solicitors alleged that their client had suffered from acute localised osteomyelitis in the region which was caused by the injudicious use of an intra-ligamentary syringe and that the practitioner would be held responsible for the pain, discomfort and subsequent expenditure incurred by the patient as a result.

The practitioner disputed the allegations. He had used intra-ligamentary local analgesia for at least six months prior to the treatment in question and had administered over 1,000 injections with little complaint other than occasional transient post injection soreness. The patient's solicitors sought £5,000 compensation. Expert opinion was received that the member's treatment was not open to criticism and the Society resolved to defend the claim.

Fifteen months later the practitioner, experts and lawyers attended for trial at the county court, only to be informed that because the judge had other matters put onto his list, he only had a day and a half to hear the case which he considered to be inadequate time. The trial was therefore postponed, to the considerable inconvenience of both parties. A further date for trial was set six months later, but after a three day hearing, it was still not completed. The following month the hearing was reconvened for a further three days but still without completion. Finally, a month later, after listening to all the evidence the judge said the defendant had given competent treatment. He considered the chain of causation was not established and the evidence of the defendant's experts was preferred. Judgment was therefore given for the defendant practitioner with costs.

This case shows how the costs of an action even in the county court can, on occasion, far outweigh the damages being sought. The Society's dental advisors were adamant however, that it was in the practitioner's and profession's interest that the case be defended resolutely.

A serious allegation

A general dental practitioner member of the Society surgically removed both lower and upper left third molar teeth for a 22-year-old male patient under intravenous valium and local anaesthetic. Good pre-extraction radiographs enabled him accurately to assess the degree of difficulty he would encounter. Although one of the extractions proved fairly difficult, the teeth were completely removed and the sockets sutured.

Two days later, the patient returned having had some post-extraction bleeding and complaining of pain. On examination, the bleeding had ceased and a prescription was issued for an antibiotic and painkillers. Nine days after extraction, the sutures were removed and healing appeared normal.

Much to the practitioner's surprise three and a half months later, the patient's mother returned to the surgery to inform the practitioner that her son had been admitted to hospital five weeks post-extraction with viral encephalitis for which he was still receiving treatment as an in-patient. Furthermore, she alleged that her son's illness could be linked to his dental extractions. Although the dentist offered an explanation and reassurance, she was clearly unconvinced when she left the surgery. Prudently, on the same day the practitioner sent a report to the Society in case the matter was pursued. He was advised that there was no further action to take for the time being other than to keep the written records and pre-extraction radiographs safely.

Nothing further happened for nearly two years. Then the practitioner received a letter from the patient's solicitors notifying him they had been consulted by his patient in connection with a possible claim for professional negligence against him following the removal of three wisdom teeth two years previously. The practitioner immediately passed this letter to the Society together with the relevant records and radiographs. The patient's solicitors were invited to set out their allegations in detail. Four months later the patient's solicitors wrote, rehearsing the history as they understood it and although they still made no specific allegations of negligence against the practitioner, they nominated an expert who was prepared to advise and requested that the records be released to him. The records were released to the patient's nominated expert. As nearly three years had passed since the time of the alleged negligence, the patient's solicitors issued a writ to protect their client's interests. Approximately one year later the writ was served but, a few weeks later, the patient's solicitors informed the Society that having taken counsel's opinion, they were unable to serve a statement of claim. The Society's solicitors requested the patient's solicitors to file a notice of discontinuance which they did soon thereafter.

Even though this particular case was discontinued a great deal of time and legal expense was necessary to rebut successfully an allegation of negligence against a member. The Society's efforts on the practitioner's behalf were made easier by his co-operation in keeping the Society informed as the case progressed in the early stages together with keeping adequate written and radiographic records.

In brief

An expensive gesture

The member treated a patient who had greatly helped a handicapped relation of the dentist. The work was carried out as a gesture of thanks and no fee was charged other than 50% of the laboratory expenses. In the event a five-unit bridge, six root canal treatments and sixteen crowns proved defective. The Society settled the resulting claim for £16,000 plus costs.

Root canal therapy

Three cases from the Society's files where Endomethasone was used to root-fill lower posterior teeth resulted in payments of damages of £875, £3,700 and £4,295.75 respectively. In all three cases paste

had been extruded into the inferior dental canal and anaesthesia of the inferior dental nerve distribution had resulted.

Reamer trouble

Breaking a reamer in a root canal is not necessarily negligent but leaving the broken portion in place without completing preparation of the canal and without informing the patient can be. One such case was settled by the Society for £700. A typical case where a patient inhaled a reamer was settled for £322.50.

Lip cut with air rotor

A patient received a cut to the lip from an airturbine burr. A residual scar on the angle of the mouth resulted in a claim against a member which was settled for £1,166.75.

Extraction of the wrong tooth

The left upper second molar was extracted for a patient instead of the right upper second molar. The resulting claim was settled for IR£1,028.64.

In another case the right upper second molar was incorrectly extracted instead of the right upper third molar. Settlement was effected for £1,560.

Treasurer's report

The substantial increases in the medical subscription rates may understandably cause concern — even consternation — to some members. Yet the cost of providing indemnity has risen considerably throughout the world and for some professional groups has more than doubled. The reasons for this are not hard to find and include increased public-awareness of the possibilities of litigation, advances in medical science which, like constant nursing and supervision, are extremely costly and the anxieties of the underwriting markets concerning future trends. This factor is reflected in the premium paid by the Society for the stop-loss insurance which has increased threefold and which protects the Society against unexpectedly high settlements and judgments. Also, development in legal attitudes must be allowed for. Damages awarded following a failed sterilisation procedure, for example, may now include provision for the upkeep of the child so that the contingent liability for all such cases reported to the Society has to be increased.

The million-pound judgment in a personal injury case is just round the corner in the United Kingdom and has already arrived in Canada (see page 32). The incident giving rise to a claim may have occurred many years before the level of damages is determined. Damages will be assessed according to current conditions yet the subscription paid during the year of the incident may well have been substantially less than that charged during the year of settlement. Also, due attention must be paid to the possibility that some aspects of clinical management will give rise to successful litigation yet may not be recognised or reported until years after the incident. These latent claims, incurred but not reported, require particularly careful estimation and provide one reason why a 'no-claim bonus' concept cannot be introduced. The Society's policy is to set rates of subscription that will provide sufficient funds to cover all awards no matter how far in the future they may be made, in respect of incidents that occur during the current year.

The problems referred to above have only limited application to claims arising out of dental practice so that it has been possible to limit an increase in the dental subscription to 10%.

Every effort is being made through forward financial planning and budgetary control to contain the inevitable increase in administrative expenses. It is, however, the Society's firm policy that the substantial number of problems, other than claims, for which members of the Society look to the Society for help require the maintenance of a fully staffed professional Secretariat, both medical and dental, and wherever necessary ready access to legal advice — and these are not cheap commodities. In these days of increasing complaints and enquiries into members' professional competence and conduct, a service of the highest quality is essential.

For all the reasons that I have outlined I hope it will be apparent that the modest surplus of income over expenditure of the order set out in the Accounts at page 64 will be quite insufficient for next year; hence the need for the substantial increase that I have recommended.

The particular financial problems of junior colleagues are appreciated and concessionary rates will be available for six years following qualification.

G J Myers
Treasurer

The Medical Protection Society Limited
(A Company Limited by Guarantee)

Income and Expenditure Account
Year ended 31st December 1985

	Note	1985 £000	*1984 £000*
Income			
Members' subscriptions and donations	2	16,438	*14,442*
Dividends and interest	3	1,626	*1,125*
Rents		30	*17*
		18,094	*15,584*
Expenses			
Costs and damages	1(f)	7,687	*6,597*
Legal expenses		2,396	*2,382*
Administration expenses	4	3,242	*2,519*
Exchange adjustments	1(d)	1,058	*(106)*
		14,383	*11,392*
Surplus on Ordinary Activities Before Taxation		3,711	*4,192*
Taxation	5	(644)	*(494)*
Surplus After Taxation		3,067	*3,698*
Extraordinary Items			
Surplus on Revaluation of Investments		1,022	*996*
Profit on Sale of Investments (less corporation tax of £22,856, 1984 – £32,243)		57	*24*
		4,146	*4,718*
Transfer to provision for indemnity	12	(4,100)	*(4,700)*
Surplus for the Year Transferred to accumulated funds	13	46	*18*

The notes on pages 67 to 71 form part of these accounts.

Balance Sheet
As at 31st December 1985

	Notes	1985 £000	*1984 £000*
Fixed Assets			
Tangible assets	8	536	*422*
Investments	9	16,601	*12,199*
		17,137	*12,621*
Current Assets			
Debtors	10	354	*977*
Bank deposit accounts		5,457	*5,017*
Cash at bank and in hand		1,135	*1,088*
		6,946	*7,082*
Creditors: Amounts falling due within one year	11	3,891	*3,657*
Net Current Assets		3,055	*3,425*
Total Assets Less Current Liabilities		20,192	*16,046*
Provision for Liabilities and Charges	12	(19,200)	*(15,100)*
		992	*946*
Accumulated Funds	12, 13	992	*946*

D W Sumner — *Chairman of Council*
G J Myers — *Treasurer*

18th June 1986

The notes on pages 67 to 71 form part of these accounts.

Report of the Auditors to the Members of The Medical Protection Society Limited

We have audited the accounts set out on pages 64 to 71 in accordance with approved auditing standards.

Note 12 details the estimated contingent liability for costs and damages in connection with claims undertaken up to 31st December 1985, and the extent to which provision has been made. No recognition is taken for incidents which have occurred but for which no notification has been received.

Subject to the effect this may have on the accounts, in our opinion the accounts give a true and fair view of the state of the affairs of the Society at 31st December 1985, and of the excess of income over expenditure and the source and application of funds for the year ended on that date and comply with the Companies Act 1985.

ROBSON RHODES

Chartered Accountants

186 City Road
London EC1V 2NU
18th June 1986

Statement of Source and Application of Funds

Year ended 31st December 1985

	1985 £000	*1984 £000*
Source of Funds		
Surplus on ordinary activities before taxation	3,711	*4,192*
Items not involving movement of funds		
– Depreciation	105	*70*
– (Profit)/loss on sale of fixed assets	(3)	*4*
	102	*74*
Funds Generated by Operations	3,813	*4,266*
Funds from Other Sources		
Proceeds from sale of investments	3,980	*629*
Proceeds from sale of fixed assets	16	*18*
Loan repayments	5	*10*
Total Funds Generated	7,814	*4,923*
Application of Funds		
Loans advanced	141	—
Purchase of investments	7,281	*3,057*
Purchase of fixed assets	233	*175*
Taxation paid	564	*440*
	8,219	*3,672*
	(405)	*1,251*
Movements in Working Capital		
(Increase)/decrease in debtors	762	*(653)*
Increase in creditors	1,172	*695*
Increase/(decrease) in subscriptions paid in advance	(1,098)	*1,436*
	836	*1,478*
Movement in Net Liquid Funds		
Increase/(decrease) in cash and bank balances	431	*2,729*

The notes on pages 67 to 71 form part of these accounts.

Notes to the Accounts

Year ended 31st December 1985

1. Accounting Policies

(a) Convention

The accounts have been prepared in accordance with the historical cost convention, as modified by the inclusion of investments at market value.

The principal accounting policies adopted by the Society within that convention are set out below.

(b) Subscriptions

Subscriptions received by the Society and its agents during the year ended 31st December 1985 and due before that date are included as income of the year without apportionment.

(c) Depreciation

Depreciation is not provided in respect of freehold land. On other assets it is provided in equal annual instalments over their anticipated useful lives. The rates of depreciation are as follows:

Freehold property	—2% per annum
Leasehold properties	—over life of leases
Furniture, fittings and fire alarm	—5% per annum
Heating	—10% per annum
Office equipment	—15% per annum
Motor vehicles	—25% per annum
Computer	—20% per annum

(d) Translation of foreign currency transactions

Debts paid and subscriptions received in foreign currencies are translated to their sterling equivalent at the date of payment or receipt. Current assets and liabilities appearing in the balance sheet are translated at the rate of exchange ruling at 31st December.

(e) Dividends and interest

Only dividends and interest received to 31st December each year are included. Income is not accrued other than on short-term loans and bank deposit accounts.

(f) Costs and damages

Provision is made in the accounts and included in creditors for all agreed liabilities on cases notified before 31st December 1985. Further provision is made for undetermined liabilities as provision for indemnity (note 12).

(g) Taxation

Provision is made in the accounts for taxation on investment income received in the year, and on capital gains on investments disposed of during the year.

2. Subscriptions

Subscription analysed by geographical area:	1985 £000	*1984* *£000*
United Kingdom and Eire	11,481	*9,817*
Australia and New Zealand	3,790	*3,326*
South Africa	606	*709*
Far East	561	*590*
	16,438	*14,442*

Notes to the Accounts (Continued)
Year ended 31st December 1985

3. Dividends and Interest

	1985 £000	*1984 £000*
Listed investments — franked	269	*188*
— unfranked	650	*508*
Loan and bank interest	707	*429*
	1,626	*1,125*

4. Administration Expenses

	1985 £000	*1984 £000*
Charged under this classification are:		
Audit fee	7	*6*
Donations	—	*1*
Emoluments and expenses of members of Council (Note 6)	96	*92*
Depreciation on fixed assets	105	*70*

5. Taxation

	1985 £000	*1984 £000*
Corporation tax at 41.25% (1984–46.25%) on income from investments for year to 31st December 1985	563	*438*
Income tax on franked investment income	81	*56*
	644	*494*

6. Emoluments of Members of Council

	1985	*1984*
Chairman and highest paid member of Council	£9,530	*£9,530*

The emoluments of other members of Council fell in the following ranges:

	1985	*1984*
£ 0 — £ 5,000	25	*24*
£5,001 — £10,000	1	*1*

Notes to the Accounts (Continued)
Year ended 31st December 1985

7. Employees' Remuneration

The average number of people employed by the Society during the year was 72 *(1984 — 63).*

Costs in respect of these employees:

	1985 £000	*1984 £000*
Wages and salaries	1,116	*851*
Social Security costs	66	*48*
Pension costs	171	157
	1,353	*1,056*

Executive employees received remuneration in the following ranges:

	1985	*1984*
£30,001 — £35,000	4	*7*
£35,001 — £40,000	4	*1*
£40,001 — £45,000	1	—

At 31st December 1985. there were loans outstanding to 7 employees *(1984 — 2)* amounting to £144,495 *(1984 — £5,894),* £5,535 of which is included in investments (being mortgage loans).

8. Tangible Assets

	Freehold property £000	*Leasehold property* £000	*Computer and other office equipment and furniture* £000	*Motor cars* £000	*Total* £000
Cost					
As at 1st January 1985	81	144	268	111	604
Additions	—	—	179	54	233
Disposals	—	—	—	(36)	(36)
As at 31st December 1985	81	144	447	129	801
Depreciation					
As at 1st January 1985	9	30	96	47	182
Provided in year	1	3	67	34	105
Released on disposals	—	—	—	(22)	(22)
As at 31st December 1985	10	33	163	59	265
Net Book Values					
As at 31st December 1984	72	114	172	64	422
As at 31st December 1985	71	111	284	70	536

Leasehold property includes property on short lease with net book value of £1,450 *(1984 — £1,934).* The Council consider, based on professional advice, that the market value of the freehold and long leasehold properties is £1,450,000.

Capital Commitments
Capital expenditure approved but not contracted for amounted to £Nil *(1984 — £Nil).*
Capital expenditure approved and contracted for amounted to £Nil *(1984 — £Nil).*

Notes to the Accounts (Continued)
Year ended 31st December 1985

9. Investments

	1985 £000	*1984 £000*
Valuation at 1st January	12,199	*8,730*
Additions	7,281	*3,056*
Disposals	(3,899)	*(573)*
Loans repaid	(2)	*(10)*
Surplus on revaluation of listed investments	1,022	*996*
Valuation at 31st December	16,601	*12,199*
Investments at 31st December comprise:		
General fund—listed		
—on UK stock exchange	13,997	*10,830*
—on foreign stock exchanges	2,595	*1,360*
Loans to employees (secured)	6	*6*
Portraits	3	*3*
	16,601	*12,199*

Loans to employees and portraits are stated at cost.

Listed investments are revalued at the year end middle market value.

The comparable amount for listed investments, if stated under historical cost rules would be £13,018,229 *(1984 — £9,215,354).*

Profit/loss on investments sold represents the surplus/deficit of amounts realised by comparison with the book value of those investments.

The company does not maintain a separate revaluation reserve for surpluses on revaluation of listed investments as required by the Companies Act 1985. The surplus on revaluation of listed investments is credited to the income and expenditure account and used to maintain the provision for indemnity (see note 12). The Council of Management consider that a more true and fair view is given by this treatment.

10. Debtors

	1985 £000	*1984 £000*
Overseas subscriptions owing	23	*782*
Employee loans	139	—
Other debtors	154	*179*
Prepayments	38	*16*
	354	*977*

Notes to the Accounts (Continued)
Year ended 31st December 1985

11. Creditors: Amounts falling due within one year

	1985	*1984*
	£000	*£000*
Bank overdraft	56	—
Subscriptions paid in advance	453	*1,551*
Corporation tax	419	*316*
Other taxes and social security	37	*33*
Other creditors and accruals	2,926	*1,757*
	3,891	*3,657*

12. Provision for Liabilities and Charges
Provision for Indemnity

The Society has undertaken the defence of certain notified claims and given indemnity against undetermined costs and damages which may be incurred. A provision of £19,200,000 *(1984 — £15,100,000)* has been made in respect of this contingent liability. This is net of any recovery to be made by the Society under its own reinsurance arrangements.

The Society has estimated that its total possible contingent liability for costs and damages in connection with claims undertaken up to 31st December 1985 could be in the region of £34,000,000 *(1984 — £25,000,000)* based on current settlement levels. However, the Society considers that the total contingent liability should not exceed £24,000,000 *(1984 — £19,000,000)* against which £19,200,000 has been provided.

The Society is empowered to grant indemnity to members, past members or their personal representatives subject only to statutory limitations on the time allowed between the cause of any action and the commencement of such action. No provision is made for incidents which have occurred but for which no notification of a claim has been received.

The Society has the right to call for funds from its members up to an amount equal to the annual subscription in the event that the Society's funds proved inadequate to meet the cost of claims.

13. Accumulated Funds

	1985	*1984*
	£000	*£000*
At 1st January	946	*928*
Surplus of income over expenditure	46	*18*
At 31st December	992	*946*

14. Other Contingent Liabilities
Taxation

No provision has been made for the capital gains tax liability of approximately £1,030,000 *(1984—£825,000)* which would arise should the Society's investments be sold at their year-end value.

15. The Society is limited by guarantee of up to £1 per member.

Education and publications

In furtherance of the philosophy that prevention is better than cure, The Society continues to expand educational activities in both the undergraduate and postgraduate fields. The Society is also engaged in research into legal aspects of medical and dental practice. The Society continually revises its publications and every effort is made to produce material which is of practical relevance and easily assimilated.

Society publications and audio-visual aids

The following Society publications and audio-visual aids are available to Members upon request:

Medical Publications

- Pitfalls of Practice *(Revised 1986).*
- Consent, Confidentiality, Disclosure of Medical Records.
- Statutory Notifications — A Card for U.K. Practitioners *(Revised 1986).*
- General Practice Complaints Procedure.
- The Mental Health Act, 1983. *(Revised 1986).*
- Damage to Teeth during Administration of General Anaesthesia.
- The Abortion Act — comments and advice.
- Medico-Legal Reports and Appearing in Court.

Dental Publications

- Self-Protection in Dentistry.
- Consent to Dental Treatment.
- Hepatitis and Dental Treatment
- And Now to Practice — Summary of Dental Seminar for final-year students.
- And Now to Practice — Checklist of points for students about to qualify.
- MPS Dental News

Films: 16 mm colour and Video cassettes

Medical

- The Communicators.
- The Letter.
- For Your Ears Only.

Dental

- Medical Emergencies in Dentistry.
- Radiation Dangers in Dentistry.
- The Break.

Tape/Slide programmes (also available on Video cassettes)

- Pitfalls in Hand Injuries.
- Pitfalls in Attempted Suicide.

Protection Matters (A journal for clinical students and junior hospital doctors published each academic term).

Principal Articles	Issue No.
History-Taking	1
Orthopaedic Injuries	2
Paediatric Prescribing	3
Psychiatric Emergencies	4
Drips	5
Diabetes	6
Forensic Matters	7
Pitfalls in Head Injury Management	8
Pitfalls in Sterilisation	9
Pitfalls in Suturing	9

The Companies Act, 1948

Company Limited by Guarantee

Memorandum of Association of the Medical Protection Society Limited

(Formerly The London and Counties Medical Protection Society Limited)

Being a Company limited by Guarantee, and not having a capital divided into shares.

1st. The name of the Company is the Medical Protection Society Limited.

2nd The Registered Office of the Company will be situate in England.

3rd. The objects for which the Company (in this clause called 'the Society') is established are:—

(A) To protect, support and safeguard the character and interests of medical and dental practitioners who, in some part of the United Kingdom or in Eire, or in any other part of the world, in exercise of some proper qualification or entitlement approved by the Council are for the time being practising their profession or are teaching medicine, surgery or dentistry in any of their branches; or any other persons, approved by the Council, who are engaged in any science or art allied or auxiliary thereto or calculated or intended to be of use in connection therewith.

(B) To give advice and assistance to members of the Society with regard to any question or matter in anywise affecting their professional character or interests, whether directly or indirectly.

(C) To indemnify, wholly or in part, and on such terms and conditions, if any, as may from time to time seem expedient, the members of the Society or any of them with regard to actions, proceedings, claims and demands by or against them and in anywise affecting their professional character or interests, whether directly or indirectly, and also with regard to all incidental or consequent losses, damages, costs, charges and expenses.

(CC) To grant to the personal representatives of deceased members and to ex-members and their personal representatives, for such period after membership and on such terms (if any) as may be thought fit, all or any of the privileges to which the deceased or former member would have been entitled if still a member of the Society.

(D) To effect and obtain all such insurances, re-insurances, counter insurances and guarantees and adopt all such measures for mitigating the risks or liabilities of the Society or its members as may seem expedient.

(E) To take or assist in taking all proper proceedings to repress malpractice and to expose and punish persons who may commit offences under any of the Acts relating to medical and dental practitioners and also persons who may be concerned in making or supporting fraudulent or unjustifiable claims or charges against members of the Society.

(F) To conduct or assist in conducting arbitrations and other proceedings for settling disputes and difficulties between members of the Society "*inter se*" or between such members and persons who are not members to appoint an Arbitrator or Arbitrators and other persons for the purposes of any such arbitration or proceeding and to pay or receive remuneration in respect of any such arbitration or proceedings.

(G) To consider, originate and support improvements and decisions in the law by proceedings or otherwise which may seem directly or indirectly conducive to any of the Society's objects, and to resist and oppose alterations therein which may seem directly or indirectly adverse to the interests of the Society, or its members or any section thereof or of any persons or class of persons qualified for membership of the Society.

(H) To hold, hire, lease, purchase, sublet, mortgage and sell land and property of any kind necessary or convenient for the purposes of the Society, and to invest moneys not required for immediate use in such manner as may be determined by the Council.

(I) The income of the Society whencesoever derived shall be applied to the promotion of the objects set forth in this Memorandum, provided that nothing contained in it shall prevent the payment in good faith of remuneration to any officers, members or servants of the Society for any services actually rendered to or at the request of the Society, or any costs incurred by them in transacting the business or promoting the interests of the Society.

(J) To support with its funds any charitable or public body or any institution, society or organisation which may be for the benefit of the Society or its members or for the benefit of any of the sciences or arts of surgery, medicine, dentistry, prophylaxis, diagnostics or therapeutics or any branch thereof or any such other science or art as is mentioned in sub-clause (A) hereof.

(JJ) To establish, promote or assist in establishing or promoting and to subscribe to and support and to become a member of any other company, association or body having objects similar or in part similar to the objects of the Society or the establishment or maintenance whereof is calculated to be of advantage to the Society or its members or any section thereof respectively.

(K) To do all such things as are incidental or conducive to the attainment of the above objects or any of them.

4th. Every member of the Company undertakes to contribute to the assets of the Company, in the event of the same being wound up during the time that he is a member, or within one year afterwards, for payments of the debts and liabilities of the Company contracted before the time at which he ceases to be a member, and the costs, charges, and expenses of winding up the same, and for the adjustment of the rights of the contributories amongst themselves, such amount as may be required, not exceeding £1.

The Companies Act, 1948

Articles of Association of the Medical Protection Society Limited

Being a Company limited by Guarantee, and not having a capital divided into shares.

As amended by Special Resolution of the 7th December, 1983, and embodying all material Special Resolutions to that date.

1. The Society for the purposes of registration is declared to consist of 95,000 members; the Council hereafter mentioned may when they think fit register an increase of members.

2. Any person qualified for admission to membership in accordance with sub-clause (A) of Clause 3 of the Memorandum of Association may, if accepted by the Council, become a member of the Society

3. Each candidate for membership shall sign and deliver to the Secretary an application in such form as may be approved by the Council. On the passing by the Council of a resolution, accepting such applicant as a member, his name shall be entered on the register of members and his membership shall be deemed to have commenced from the day immediately following the date upon which his application for membership was received by the Society.

4. Any member may withdraw from the Society, on giving two months' notice in writing to the Secretary, and on paying all subscriptions and calls accrued due from him to the Society.

5. The Council may, by giving 14 days' notice to any member whose conduct or membership is in the opinion of the Council detrimental to the Society, determine his membership, and thereupon he shall cease to be a member, but shall nevertheless pay all subscriptions and calls in arrear.

6. Each member shall as from the day of his election and every anniversary of that day pay the Society an annual subscription of such sum as the Council may prescribe and every subscription shall be payable in advance in such manner as the Council may agree. The Council shall have power from time to time to impose an entrance fee and thereafter to abolish the same.

6A. Additional benefits or special indemnity may be offered to members on such terms and in return for such extra payment or subscription as the Council may from time to time prescribe.

6B. (a) The Council shall have power to elect associate members of the Society upon such terms and subject to such conditions and to the payment of such annual subscription as the Council may from time to time prescribe.

(b) An associate member shall be entitled to all the rights and privileges to which a member under Article 3 is entitled save that he shall not be entitled to receive notice of or to attend or vote at any Meeting of the Society.

7. The Council may, from time to time, call on the members to contribute funds for the purposes of the Society, or any of them, and each member shall pay every call so made to the Treasurer at the times and place appointed by the Council, but a member shall not be called upon to pay, in any financial year, more than an amount equal to the Annual Subscription in force at that date applicable to his class of membership. This call will be in addition to the Annual Subscription. A call shall be deemed to have been made at the time when the resolution of the Council making the same was passed. Twenty-one days' notice shall be given of each call, and a call shall not be made unless under circumstances considered by the Council to be urgent or exceptional.

8. A member whose subscription, entrance fee or call is more than one calendar month in arrear shall not unless the Council shall for special reasons decide otherwise be granted under Article 16 any indemnity in respect of any action, proceeding, claim, or demand threatened, commenced or made prior to such subscription, entrance fee or call being paid. If the default shall continue for six calendar months the Council may, by notice, determine the membership of such member, but such determination shall be without prejudice to any claim the Society may have upon him.

9. The Annual General Meeting of the Society shall be held on such day, and at such time and place as the Council may determine. The Council shall have power at any time to call Special General Meetings, and a Special General Meeting shall be called by the Council on receipt by them of the requisition to that effect signed by not less than one hundred members. Not less than twenty-one days' notice shall be given of all General Meetings of the Society.

10. The President shall preside at every General Meeting but if there be no President or if at any Meeting he shall not be present within fifteen minutes after the time appointed for holding the same, or shall be unwilling to preside, the Chairman of the Council shall preside or if he is absent or unwilling to preside, the members present shall choose some member of the Council or if no such member be present or if all the members of the Council present shall decline to take the Chair they shall choose some member of the Society who shall be present to preside. Ten members shall be a quorum at General Meetings and every member shall have one vote.

10A. Upon a poll votes may be given by proxy. The instrument appointing a proxy shall be in writing under the hand of the appointor. No person shall be appointed a proxy who is not a member, and qualified to vote. The instrument appointing a proxy shall be deposited at the registered office of the Society, not less than 48 hours before the time fixed for taking the poll at which such proxy is to be used.

Every instrument of proxy shall, as nearly as circumstances will admit, be in the form or to the effect following:—

I,
of
being a member of the Medical Protection Society, Limited, hereby appoint
of
or failing him
of
as my proxy to vote for me and on my behalf at the Special $\frac{\text{Adjourned}}{\text{General}}$
Meeting of the Society to be held on the day of
, and at any adjournment thereof.
As WITNESS my hand this day of

11. At a General Meeting, unless a poll is demanded by at least five members, a declaration by the Chairman that a resolution has been carried or lost shall be sufficient evidence of the fact. If a poll is demanded as above mentioned, it shall be taken in such manner as the Chairman directs, and either at once, or after adjournment, and the result of the poll shall be deemed the resolution of the Meeting.

12. The management of the Society shall be vested in a Council, who may exercise all the powers of the Company, and may form Committees to assist them in dealing with matters which may arise, and the Council shall have power to make rules and bye-laws for the guidance of such Committees, and for their own guidance, and any such Committees may consist of members of the Council and/or members of the Society who are not members of the Council and/or any other persons as the Council shall from time to time determine and the appointment of any member of the Society or any person who is not such a member to any such Committee shall not be deemed to constitute an appointment of such member to membership of the Council.

13. The Council shall consist of a President, a Treasurer and twenty-four elected members. The quorum for a Council Meeting shall be six.

13A. At each Annual General Meeting the President, the Treasurer and one-third of the Elected Members who have been continuously longest in office since their last appointment shall retire. As between two or more of such elected members who have been continuously in office an equal length of time the member or members to retire shall, in default of agreement, be determined by lot. The places of all the officers and members of the Council retiring under this article and any other vacancies for the time being shall be filled by election at the same Annual Meeting, and retiring officers and members shall be eligible for re-election. No person who has held the appointment of President or Treasurer continuously during the immediately preceding five years shall be eligible for re-election to that Office.

13B. If at any Annual General Meeting the places of the retiring officers and members of the Council are not filled up, the retiring officers and members of the Council or such of them as have not had their place filled up shall, if willing, continue in office until the next Annual General Meeting, unless it shall be expressly determined at such Annual General Meeting that such places shall not be filled up.

14. The Council may from time to time elect any person to be a Vice-President of the Society for such period as the Council shall think fit. A Vice-President shall not *ipso facto* be deemed to be a member of the Council but shall be entitled to attend and speak, but may not vote, at all meetings of the Council.

14A. The Council may from time to time appoint any person to fill a casual vacancy in the office of President, Treasurer or Elected Member of the Council. Any person so appointed shall retain office only until the next Annual General Meeting at which he shall retire but he shall be eligible for re-election but shall not, if an Elected Member, be taken into account in determining the Elected Members who are to retire by rotation at such Meeting.

14B. No person who has attained the age of seventy-two years shall be eligible for election or re-election as President, Vice-President, Treasurer or as a member of the Council. A person who attains the age of seventy-two whilst serving as an elected member of the Council shall vacate office at the first Annual General Meeting held after his or her attainment of that age.

15. No member of the Council or other officer of the Company shall be disqualified by his office from being appointed or requested by the Council or otherwise to act as Arbitrator or Umpire or to give his professional services or to perform any special services or to make any special exertions of whatsoever nature for any of the purposes of the Company or its members or from taking any fees or other remuneration in respect of any arbitration or award or in respect of any such professional services or special services or exertions as aforesaid.

16. Subject as aforesaid the Society may upon the request of any person who is or has been a member or of the personal representatives of such person grant an indemnity wholly or in part to such member, former member or personal representatives with regard to any action, proceeding, claim or demand by or against such member, or against such former member or his personal representatives and affecting either directly or indirectly the professional character or interests of the member or former member, and also with regard to all incidental or consequential losses, damages, costs, charges and expenses but subject to the following provisos, viz:—

(A) Before making any such grant the Council must be reasonably satisfied that the incident or event which is the cause of such action, proceeding, claim or demand took place or occurred at a time when the member or former member was a member of the Society.

(B) From and after any such request for indemnity the member, former member or his personal representatives shall throughout all the proceedings whether of a strictly legal nature or otherwise abide absolutely by every decision of the Council, and shall not without the consent of the Council take any step with reference to such proceedings or to the determination thereof.

(C) The indemnity which may be granted by the Society shall be unlimited or such sum as the Council may from time to time determine.

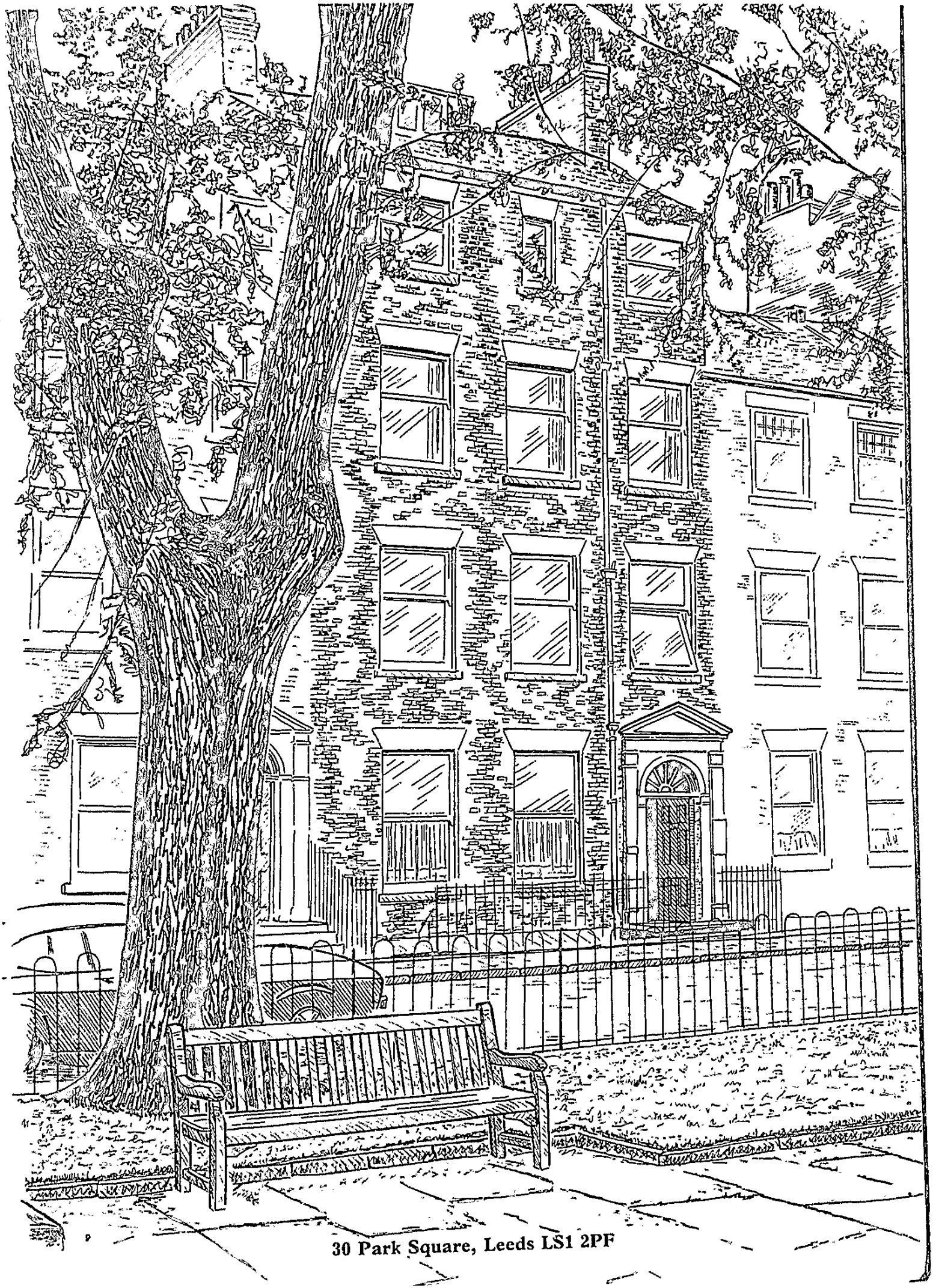
(D) The Society may at any time by notice in writing without assigning any reason determine any indemnity granted under this article except in respect of any moneys which shall have become immediately payable under such indemnity prior to the date of such notice.

17. The indemnity mentioned in the last preceding article may be granted in any case either by a resolution of the Council or by an agreement in writing or otherwise as may be deemed expedient, and such grant may in every case be made after such investigation and upon such terms and conditions as the Council think proper (but subject to the provisions of the last preceding article) and so that it shall be in the absolute discretion of the Council in every case to limit or restrict such indemnity or altogether to decline to grant the same.

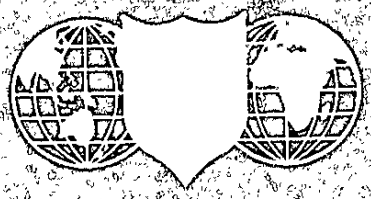
18. The Council shall have power to cause proper books and accounts to be kept and audited, and payments necessary for the conduct of the business to be made, and to do all other acts which they may consider necessary or expedient for the purposes of the Society.

19. Any notice required by these Articles or otherwise may be served upon any member either personally or by sending it through the post in a prepaid letter addressed to him at his registered address and proof of posting shall be deemed to be proof of service as on the day on which such posting was made. If a member has no registered address in the United Kingdom he shall not be entitled to receive any notices from the Company.

20. The Society shall be wound up voluntarily, if, and when, an extraordinary resolution, as defined by the Companies Act, 1948, requiring the same to be wound up voluntarily is passed by a General Meeting.



30 Park Square, Leeds LS1 2PF



The Medical Protection Society

Registered Office

50 Hallam Street, London W1N 6DE

Telephone: 01-637 0541 (International +44 1 637 0541)
Facsimile: 01-636 0690 (International +44 1 636 0690)
Telex: 8952848 (MEDPRO G)

Northern Regional Office

30 Park Square, Leeds LS1 2PF

Telephone: 0532-442115 (International +44 532 442115)
Facsimile: 0532-453615 (International +44 532 453615)