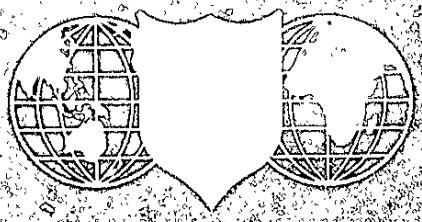
The Medical Protection Society

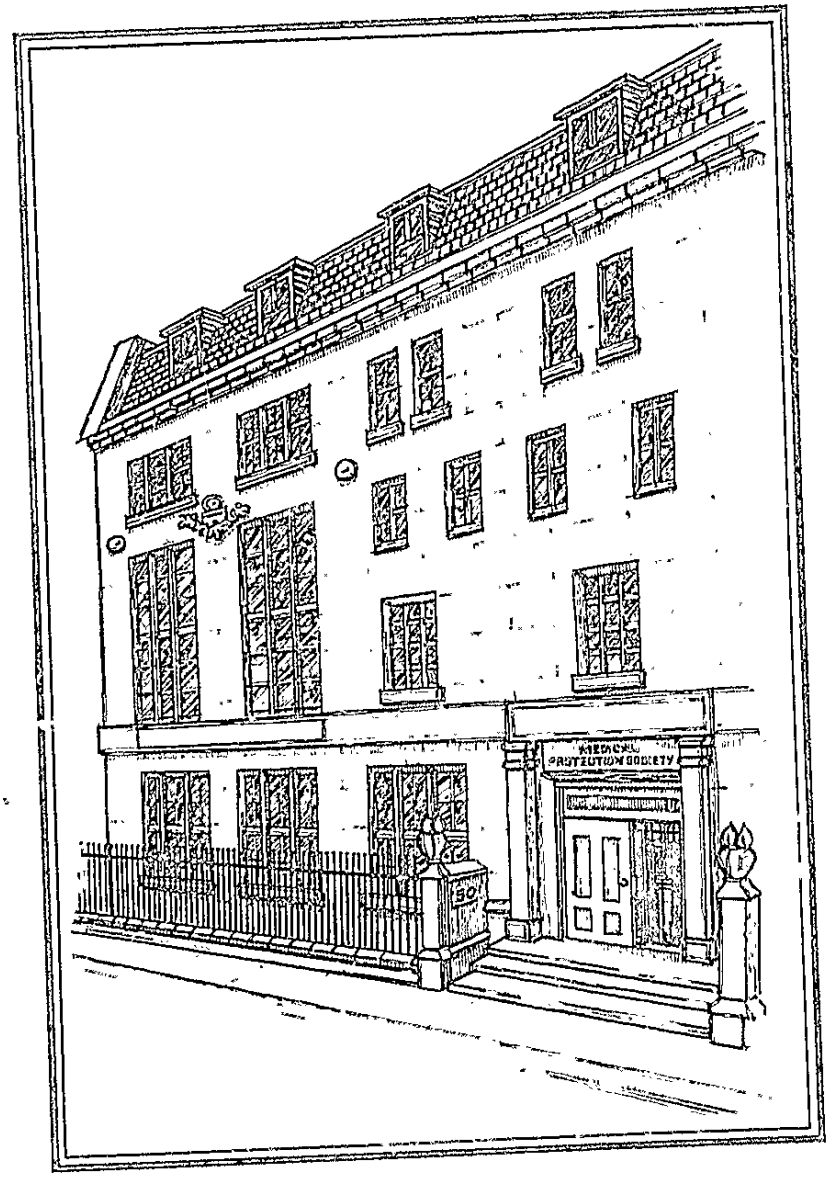


Annual Report and Accounts 1987

Number 95

Report of the Council

The Council have pleasure in presenting this Report to the Annual General Meeting of Members to be held on October 14, 1987 at the Society's house in London.



50 Hallam Street, London W1N 6DE

36142

The Medical Protection Society

A Company Limited by Guarantee

Registered in England number 36142

Annual Report of the Council and Accounts for the year ended 31 December 1986

Number 95

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

President	Sir John Ellis *MBE* MA MD FRCP
Treasurer	D G A Eadie MS FRCS
Chairman of Council	D W Sumner *TD* BSc MB ChB FRCP FRCPEd
Vice-Treasurer	R Myles Gibson *ERD* MSc MD FRCSEd FRCSEng
Vice-Chairman of Council	J J Bradley MB FRCP FRCPsych
Vice-Presidents	G J Myers BA MRCS LRCP
Australia	Professor A M Horsnell *AO* FDS FRACDS FICD MRCS LRCP R F J Wood MB BS FRACS DO P C Yates DOMS FRACS FRACO Hon R A Pargiter FRANZCP FRCPsych DPM I L McVey FRCS P E Mellows MB BS
New Zealand	Professor G L Brinkman MD FRCP FRACP Professor D S Cole MB ChB FRCS FRACS J W E Raine *OBE* FRCS FRACS W J Treadwell MB BCh FRCGP
South Africa	Professor F Daubenton JCD FRCOG
Members of Council	The President The Treasurer H Baderman BSc MB BS FRCP J J Bradley MB FRCP FRCPsych Professor Sir Paul Bramley MB ChB BDS FDS FRCS FRACDS A D G Brown MB ChB FRCOG Professor A G M Campbell MB ChB FRCPEd J O M C Craig FRCSI FRCS FRCR J L Dawson MS FRCS R Myles Gibson *ERD* MSc MD FRCSEd FRCSEng R A Green FFARCS M J Healy MB BS MRCGP DObstRCOG Professor M D Hickey MSc MD FRCPI DPH J V Jeffs MB BS FRCS M A Kettle FDS DOrth Professor D R Laurence MD FRCP Professor T K Marshall *CBE* MD FRCPath M A Pugh MB BS FRCS FRCOG A John Robertson MD FRCP MFOM Margaret Seward BDS MDS FDS Professor J Stevens MD FRCS D W Sumner *TD* BSc MB ChB FRCP FRCPEd Professor W J Tulley PhD BDS FDS DOrth R A Williams MA MB BChir FRCS DLO J Winstanley *MC TD* MB FRCS
Co-opted Members of Cases Committee	Diana Brinkley MA MB BS FRCR A Catterall MB MChir FRCS J Owen Drife MD BSc FRCSEd MRCOG R Goulding BSc MD FRCP FRCPath Professor B H Knight MD MRCP FRCPath DMJ Barrister J P Miller MA MSc DPhil FRCP K F Parsons MB ChB FRCSEd FRCSEng K V Sanderson MB BS FRCP T H Taylor MB BS FFARCS T Glyn Thomas MB BS FRCS
General Practice Advisory Board	Frances M Cranfield MB MRCS MRCGP DRCOG J B Evans MA BM BCh DObstRCOG M J Healy MB BS MRCGP DObstRCOG S A Moonsawmy MB ChB M John Oldroyd MB ChB FRCGP DA J D Sinson MB BS FRCGP

Dental Advisory Board	R J Andlaw LDSRCS MSc PhD Professor I C Benington BDS FDSRCS FFDRCSI Professor Sir Paul Bramley MB ChB BDS FRCS FRACDS J D Buxton MRCS LRCP FFARCS DA H P Cook MB BS FDS MDS J A Crease BDS LDSRCS E R Gordon MSc BDS DDS MGDSRCS R Haskell MB BS MRCP FDS T R Hill LDSRCS FDS Professor F E Hopper BDS MDS FDS M A Kettle FDS DOrth D J Lovelock MSc MDS FDSRCS T E McEwan MB BS FFARCS DA R G Mitchell LDS FDS MB ChB Professor W M Oliver *VRD* BDS FDS DRD MDS Margaret Seward BDS MDS FDS Professor W J Tulley PhD BDS FDS DOrth D K Whittaker BDS FDS PhD
Secretary	P G T Ford MB BS MRCGP DObstRCOG
Director of Development	W G Duncan Murray MD MFOM DIH
Deputy Secretary	R N Palmer LLB MB BS DObstRCOG Barrister
Regional Secretary	I M Quest MB ChB MRCGP DObstRCOG
Medical Secretariat	
Assistant Secretaries	J P Barker JP MB BS DMJ ACII B N MacKellar MB ChB DObstRCOG C J B Orr MAO FACS FRCOG D Nelson MRCS LRCP J D Hickey MB BS FFARCS Sheridan P Williams MB BS DCH Caroline A Steele MB ChB FRCS C A Owen BSc MPhil MB BS MRCGP Juliet M Davies MA MB BS MRCP FFARCS S D W Payne MB BS FRCS FRCSEd A T Day JP MB ChB MRCGP DObstRCOG Margaret A Evans MB ChB G D McEwan MB ChB MRCGP DObstRCOG G P Panting MB BS MRCGP DCH DRCOG DMJ
Dental Secretariat	
Deputy Secretary	D A Phillips BDS
Dental Secretaries	L Walters LDS RCS A M Milne MB ChB FDSRCSEd M L Butterworth BDS Miss M N K Boodhoo BDS FDS Mrs B Fox BDS DDPH F J M B Treweeke *MBE* LDS UBrist
Finance & Administration	
Registrar	A Gough FAAI
Administrative Officer	B A Brooking *MBE* JP BA MA MBIM
Financial Controller	P C C Hunter FCA
Professional Advisers	
Solicitors	Messrs Le Brasseur & Bury 71 Lincoln's Inn Fields, London WC2A 3JF
Auditors	Messrs Robson Rhodes, Chartered Accountants, 186 City Road, London EC1V 2NU
Bankers	Barclays Bank PLC (Cocks Biddulph branch) 16 Whitehall, London SW1A 2EA
Actuaries	Messrs Lane Clark & Peacock Regent House, 89 Kingsway, London WC2B 6RH
Investment Managers	Barclay de Zoete Wedd Investment Management Ltd., Seal House, 1 Swan Lane, London EC4R 3UD
Insurance Brokers	Harrison Horncastle Insurance Brokers Limited, The Harrcastle Building, The Minories, London E1 8AT

Contents

Report of the Chairman of the Council

To be presented at the Annual General Meeting, to be held on the 14th October, 1987 at 50 Hallam Street, London, W1.

The Overview

The Society's *raison d'être* has not changed since its foundation in 1892. This is to protect, support and safeguard the character and interests of medical and dental practitioners in the United Kingdom, Eire, and in other parts of the world.

The Society's Memorandum and Articles of Association, the Society's 'rule book', has not been revised for many years. The Council has been aware for some time that a major revision was needed to reflect better the changed circumstances in which the Society now operates and to ensure efficient and effective management. The proposed changes in no way alter the Society's aims or benefits of membership

A major benefit of membership is the provision of indemnity for damages and legal costs in negligence actions. This is the most significant factor in setting the rates of subscription, albeit that only approximately one quarter of requests for assistance are in respect of this benefit. The remaining three quarters, with the exception of the matters discussed below, although not expensive in money terms are expensive in staff time. It is the Society's firm belief that when a member writes for advice, and particularly if the member telephones for advice, that he or she will be able to discuss the problem with a fellow professional and not with an administrator. It is in part because of this policy that the Medical and Dental Secretariat is at its present size. The Society does not accept that, as a cost-cutting exercise, assistance to members should be given by lay people, as has been suggested.

Significant costs may be incurred in supporting members who are in conflict with their employers or paymasters. Costs incurred in defending a member against professional allegations brought by an employing Authority can exceed £100,000. When successfully rebutted these costs are seldom recovered, although in a recent case of allegations of overservicing in Australia, these costs amounted to circa. $500,000 which, on appeal, were reimbursed after the Crown case had been dismissed at the commital proceedings.

The costs of assisting members with such problems represent a significant demand on the professional and financial resources of the Society. No member in active practice can guarantee exemption from some form of accountability or safely assume that private resources would be sufficient to protect the professional reputation, on which a livelihood may depend.

That the provision of indemnity does not constitute insurance is well established so that the concept of a no-claims bonus is inappropriate to the mutuality basis of the Society. There is frequently a delay of over a year between the clinical incident and notification of the claim — an interval which may, on occasion, extend to two decades or more — and this is one reason why membership requires an annual subscription without variation according to the demands which an individual member may or may not make on the Society.

Risk Management

As important as the availability of funds to deal with claims against members is the responsibility to identify danger areas in clinical practice. This is done through analysis of data, appropriate research programmes and then to make the results available to the medical and dental professions directly and through responsible bodies. The Society's research Fellowship, established jointly with the Department of Psychology of University College, London, has established a prospective research programme with the aim of establishing relevant factors which result in avoidable mishaps in clinical practice.

The Society is co-operating with the Royal College of Obstetricians and Gynaecologists in an ongoing project to identify medico-legal problems in that discipline. It is hoped that this innovative approach may be extended to other clinical disciplines in due course. The Society has also been involved in the development of guidance notes to be promulgated by the Royal College of Radiologists on the important issue of consent in radiological practice and related matters.

The Society has an extensive data base. Whilst fully respecting the confidentiality of the incident reports provided by members, the Society recognises that it has a responsibility to analyse these data for the benefit of members and their patients. Many requests are received from individuals carrying out personal research and whilst in particular instances it may be possible to make a certain amount of data available, for obvious reasons of confidentiality the Society's overall policy is to maintain its own control over the release of such information.

Problems with the present legal system

It is beyond dispute that the present tort-based system, which requires a finding or admission of culpable fault, is open to criticism both in principle and in application. The legal process may result in very lengthy delays giving rise to understandable but unjustified criticism that the protection societies wilfully employ delaying tactics as a means of avoiding their financial responsibilities and liabilities. The latter criticism is erroneous. A number of constructive suggestions were made by the Society in response to the Lord Chancellor's consultation document dealing with personal injury litigation, prepared with the aim of expediting the legal process.

The concept of 'no-fault' compensation has been espoused by the British Medical Association. The Society, with its international membership, has no vested interest in fault-based arrangements. The Society, in its scheme of co-operation with the New Zealand Medical Association, has over a decade of experience in the working of a scheme of 'no-fault' compensation. We therefore have information which might well be relevant to a consideration of this concept as the professional, social and economic implications are considered in greater depth in the United Kingdom.

The pressure on individual practitioners to admit to a clinical mistake is increasing. This matter has attracted the attention of a Select Committee of the House of Commons and also the General Medical Council. The Society's advice is clear (see page 9). We neither support nor condone a 'cover-up' where a significant error is recognised, even though this may be tantamount to an admission of fault — the wrong operation is an obvious example. Such an admission would not prejudice the member's benefit of indemnity. However, the recognition of a 'mistake' may be difficult, requiring a long, cool and objective consideration of all the circumstances.

For this reason, the Society is opposed to a medical council requirement demanding immediate report to a patient or relatives of a 'mistake'. The Society is always ready to provide immediate advice on how best to proceed in circumstances where the possibility of a mistake is recognised by a member, or alleged by a patient.

Another development of concern is the freedom of solicitors to advertise their expertise in the prosecution of certain categories of alleged harm to patients. A number of advertisements have been referred to the Society but none has yet been shown to exceed the rules laid down by the Law Society. Our concern is not a defensive reaction to limit the Society's proper obligations but rather anxiety that ill-founded claims will be encouraged and in which it may be difficult to establish the veracity of the allegation e.g. awareness under anaesthesia.

Choice of solicitor

The benefits of membership are provided on the direction of the Council. Where legal assistance is required this is normally made available through the solicitors appointed by the Council. Whilst there may be some rare exceptions to this general rule, it is not open to a member to instruct a solicitor of his own choice, at the expense of the Society, without prior approval. Members may, however, be assured that their personal views on this matter will receive proper consideration.

The Council maintains a critical appraisal of the quality of legal support for which it is responsible on behalf of members and it is by reference to the quality of service provided, not the cost, that it has appointed solicitors in appropriate jurisdictions throughout the world.

Personae

The Society records with regret the deaths of Sir Harry Platt, Mr Keith Lyle and Mr Charles Drew whose obituaries follow. Dr Allan Brown joined the Council during the year, following the retirement of Dr G J Myers who was elected a Vice-President.

There have been changes in the medical Secretariat. Four new members have been appointed, Dr McEwan and Dr Panting to the London office and Dr Day and Dr Evans to the Leeds office. We are in the process of recruiting an additional dentist to join the Dental Secretariat. Dr Murray has been asked to assume the important role of reviewing and developing the Society's data base and information systems. Dr Palmer has been appointed the Deputy Secretary. Mr Hunter has been appointed Financial Controller.

On behalf of Council I am pleased to record its appreciation of the excellent work done on its behalf by the Secretariat and staff, its appointed solicitors and other professional advisers.

D W Sumner
Chairman of Council

Obituaries

Sir Harry Platt *Bart.* MS FRCS

Sir Harry was born in Lancashire on 7th October 1886 and died in December 1986. His childhood was dominated by a chronic osteomyelitis which he always felt was tuberculous. He was under the care of Robert Jones which may have focussed his interest on orthopaedics but did not avoid an ankylosed knee with considerable shortening.

He qualified in medicine from Manchester University in 1909 with the gold medal and proceeded MS in 1911 and FRCS in 1912. He then spent a year in Boston chiefly at the Massachusetts General Hospital where he was greatly impressed by the atmosphere of the University Hospital; he always strove to create one in Manchester although the innate conservativism of teaching hospitals prevented his obtaining a personal chair until 1939. He was appointed to the staff of Ancoats Hospital as a General Surgeon in 1914 — at the age of 28 — and organised the first segregated fracture clinic there in 1917. He moved to the Manchester Royal Infirmary in 1934 and, with Osmond Clarke, built up an internationally famous orthopaedic department.

When the British Orthopaedic Association was formed in 1918 he was the obvious choice as Hon. Secretary; he later became President of the BOA in 1934. He also served on the Council of the Royal College of Surgeons for many years and was the first orthopaedic surgeon to become President of the College, in 1934. From the outbreak of the second world war he became increasingly involved in vast schemes of hospital reorganisation which led to the basic structure of the NHS in 1948. While always admitting that he was a critic rather than a negotiator he developed a particular excellence in committee work which paid handsome dividends wherever he worked.

He became a Vice-President of the Medical Protection Society in 1959 and was a most regular attender of the Council and Cases Committee where his wise counsel was greatly appreciated. He seemed to have personal knowledge of many of the defendants as indeed he had of many orthopaedic surgeons around the world.

He had a profound influence on the basic structure and function of the NHS and marked innumerable orthopaedic surgeons, worldwide, with his unique combination of high integrity, technical excellence and (despite his somewhat bluff exterior) a kindly caring for all his patients. The Medical Protection Society was indeed very fortunate to have had his active cooperation for so long.

R C F C

Charles Edwin Drew *LVO VRD* FRCS

Charles Drew, who died on 31st May 1987 at the age of 70, was educated at Westminster City School, King's College, London, and at the Westminster Hospital Medical School. He qualified in 1941, and soon joined the Royal Navy: he was always keen on sport, and ability at water polo no doubt helped his survival after his ship was sunk in the Mediterranean.

He obtained the FRCS in 1946, and after junior posts at the Brompton and the Westminster Hospitals, was appointed assistant surgeon with Clement (later Sir Clement) Price Thomas. They operated on King George VI at Buckingham Palace in 1951 and both were subsequently awarded honours in the Royal Victorian Order, the personal gift of the Sovereign. He became honorary consultant thoracic surgeon to both the Royal Navy and the Army, as well as the King Edward VII Hospital, Midhurst, where he was chairman of the Medical Advisory Committee and later a member of their Council.

Co-opted onto the Cases Committee in 1976, he was elected to the Council of the Society in 1978 and served on several of its committees. His apparent reserve hid a great sense of fun, and a firm resolve to do and say only what he knew to be honest: his contributions to committees were always succinct and totally clear. The day seemed all the better for having been in his company, whether discussing the Times' crossword, fishing, gardening, or his family. The Society will miss his wisdom, and all who worked with him at Hallam Street will remember with affection his outstanding personality.

A J R

T Keith Lyle *CBE* MA MD MChir FRCS FRCP

The Council of the Society was saddened to learn of the death, earlier this year, of Thomas Keith Lyle. The son of an ophthalmic surgeon, he was himself consultant ophthalmic surgeon at Moorfields Eye Hospital, King's College Hospital and the National Hospital for Nervous Diseases.

He served as Dean of the Institute of Ophthalmology and served with the Royal Air Force Voluntary Reserve from 1939-1946. He later became civilian consultant in ophthalmology to the Royal Air Force. Keith Lyle was actively involved with the Order of St John of Jerusalem, of which he was Hospitaller, so that he spent much time in serving the Ophthalmic Hospital in Jerusalem. He was appointed a knight grand cross of the Order of St John.

He was elected to the Council of the Society in 1965 on which he served for 11 years. He also served on the Cases Committee of the Society, giving opinions and advice on the wide diversity of cases which fell to be considered. His quiet demeanour, kindly manner and wise counsel was ever at the disposal of the Society and its members.

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. The Society does not encourage members to withhold objective, factual information or expressions of sympathy.

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.**
- **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.**

Communications with the Society

Members should not incur legal expense without the Society's approval

The Society cannot accept responsibility for legal costs incurred by members without prior authority. Sympathetic consideration will invariably be given to any such request that arises out of a *bona fide* medico-legal emergency, e.g. the service of a writ, but members are urged to contact the Society before incurring any legal expense.

Members requiring advice or assistance are asked to contact the Society in the first instance as set out below.

United Kingdom

Registered Office

Address: 50 Hallam Street, London W1N 6DE, England
Telephone: 01-637 0541 (International + 44 1 637 0541)
(Including 24-hour telephone advice service for emergencies)
Facsimile: 01-636 0690 (International + 44 1 636 0690)
Telex: 8952848 (MEDPRO G)
Telegrams: Medicavero, London W1N 6DE

Northern Regional Office

Address: 30 Park Square, Leeds LS1 2PF, England
Telephone: 0532 442115 (International + 44 532 442115)
Facsimile: 0532 453615 (International + 44 532 453615)

Ireland

Members should contact the Society in London in the first instance. In cases of **real urgency**, immediate advice may be sought from the Society's solicitors in Belfast or Dublin.

Messrs. Carson & McDowell
Murray House, Murray Street,
Belfast BT1 6HS.
Telephone: Belfast (0232) 244951
Telex: 74550
Facsimile: (0232) 245768

Messrs. Hayes & Sons,
15 St. Stephen's Green North,
Dublin 2.
Telephone: Dublin 688399
Telex: 90369 HSS
Facsimile: Dublin 612163

Overseas

(a) By letter, telephone, telex or facsimile to the Registered Office in London, or

(b) Through the appropriate Scheme of Co-operation (see list on p.79) or

(c) Solicitors for the Society in Australian Capital Territory and New South Wales

Messrs. Abbott Tout Creer & Wilkinson,
Law Society Building, 11 London Circuit
CANBERRA CITY, ACT 2601.
Telephone (062) 49 7788
Facsimile (062) 49 1196

Messrs. Minter Ellison,
ANZ Bank Building, 68 Pitt Street,
SYDNEY, NSW 2000
Telephone (02) 232 8644
Facsimile (02) 235 2185

24-hour telephone advice service for emergencies

Crises in professional practice do not always occur during normal office hours (9 a.m. to 5.15 p.m.). To provide a service for members who have a professional problem which demands immediate attention outside these hours, the Society has arranged for incoming telephone calls to the Society's London telephone number to be intercepted by a telephone answering service. Members are asked to give their name and telephone number to the answering service, which will then contact a member of the professional secretariat at home. The member's call will be returned as soon as possible. For all other matters, members are asked to communicate with the Society as recommended above.

Advice from Council

Criminal Injuries Compensation Board

It is fortunate that members of the Society do not often become the victims of crimes of violence committed by their patients but this does sometimes happen and in such circumstances members are encouraged to seek the Society's assistance. This is because it may prove possible to make an application under the Criminal Injuries Compensation Scheme on behalf of the member: the basic condition of such an application is that the Applicant must have sustained injuries either as a result of a crime of violence or when trying to apprehend a criminal or when helping the police to do so. If that basic condition is satisfied, the Criminal Injuries Compensation Board may make an award of compensation if the injury is sufficiently serious, but this is subject to the incident being reported to the police without delay.

Recently, a general practitioner member contacted the Society having sustained a fracture of the left ulna at the hands of the psychiatrically-disturbed son of one of his patients when attempting to arrange his hospital admission in company with a consultant psychiatrist. The member remained in plaster for fifteen weeks, during which time he was unable to drive and his partners had to cover his night duties. The Society's solicitors made an application to the Criminal Injuries Compensation Board on the member's behalf and he accepted the Board's offer of £6,660 in respect of the claim.

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", 1987 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 used, in certain circumstances, to be protected by Crown Immunity from legal actions. For the immunity to apply, the doctor or dentist must have been acting within the scope of his official military duties and the patients must have been service personnel who are either on duty or on military premises when treated.

The Statutory provision which conferred this immunity (Section 10 of the Crown Proceedings Act 1947) has been repealed with effect from 15 May 1987. Consequently a doctor or dentist serving in the armed forces may now be liable in law for the negligent treatment of a member of the armed forces who is on duty or on military premises when treated, where the negligence occurs on or after 15 May 1987.

As before, 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".

The benefits of membership of the Society are therefore of even greater importance to doctors or dentists in the armed forces than previously.

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. The Royal College of Physicians of London has published "Guidelines on the Practice of Research Ethics Committee" and also a report, "Research on Healthy Volunteers", to both of which members are referred when contemplating and planning research and trials.

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' (April 1987):

> *"45. 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."*

Low-calorie diets

Low-calorie and micro-calorie diets are much advertised in the press and news media. Persons who respond to the advertisements are sometimes asked to approach their medical practitioners to obtain a signature on a form to the effect that the medical practitioner can see no contra-indication to the diet and agrees to supervise the patient. Council strongly advises members not to signify their agreement by signing such statements on behalf of patients unless they are satisfied about the full implications of the diet and are prepared to accept clinical and legal responsibility for the implications of the document which they are asked to sign. Members are reminded of the advice of the General Medical Council ('Professional Conduct and Discipline: Fitness to Practice', April 1987, paragraph 36):

> *"The public are entitled to expect that a registered medical practitioner will afford and maintain a good standard of medical care. This includes:*
>
> *(a) conscientious assessment of the history, symptoms and signs of a patient's condition;*
>
> *(b) sufficiently thorough professional attention, examination and, where necessary, diagnostic investigation;*
>
> *(c) competent and considerate professional management;*
>
> *(d) appropriate and prompt action upon evidence suggesting the existence of a condition requiring urgent medical intervention; and*
>
> *(e) readiness, where the circumstances so warrant, to consult appropriate professional colleagues."*

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), page 77).

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.

Product Liability

In last year's Annual Report (number 94, page 18) attention was drawn to the adoption of an EEC Directive on product liability and the obligation of member states of the European Community to adapt their domestic laws to give effect to the Directive by the end of July 1988. In short, "product liability" is the term indicating the liability of a manufacturer or supplier of goods to someone who is caused injury by a defect in the goods in question, without proof by the injured party of any negligence or breach of contract on the part of the manufacturer or supplier.

The main provisions of the EEC Directive were summarised in last year's Annual Report. The Consumer Protection Act 1987 which, amongst other provisions, gives effect to the Directive in the United Kingdon. was enacted on 15 May 1987.

In last year's Report, attention was focused on the potential responsibilities of medical practitioners and pharmacists in relation to drugs. The effect of the proposed legislation on medical and surgical practice is not, however, limited to drugs. For example, the expression "product" is defined in the Act as meaning any goods or electricity and as including a product which is comprised in another product whether by virtue of being a component part or raw material or otherwise. That definition would seem to extend to prostheses and other items such as pacemakers provided in the course of treatment. The import of the legislation is, of course, that, if the safety of such an item is not such as someone generally is entitled to expect, the product in question is defective and (subject to the statutory defences) anyone who suffers damage from the defect will have a claim for compensation under the legislation without having to prove negligence or breach of contract. That claim will lie primarily against the "producer" of the product as that expression is defined in the legislation, but as was envisaged in paragraph two of the item in last year's Annual Report, a supplier — and again the expression "supply" is specifically defined in the legislation — shall also be liable for the damage, unless on request 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.

The insertion of a prosthesis or other artefact (eg. pacemaker wires, nails, plates or screws) in the course of treatment is likely to constitute a "supply" for this purpose. With regard to practice in the National Health Service, it is anticipated that normally the DHSS and/or the relevant Health Authority will be the supplier but the definition of "supply" might be wide enough to include an individual clinician in certain cases.

Medical staff committees and clinical divisions in specialties which include the provision of prostheses and other items such as pacemakers, wires, nails, plates or screws are advised to obtain confirmation from the Health Authorities in question that adequate arrangements are being made by management in the Districts and Regions concerned, to enable any obligations arising under the legislation in this regard to be properly met. Such arrangements might well have to include the specific delegation to a designated member or members of the Authority's staff of the duty of recording the prostheses or other artefacts so provided for treatment purposes, and also specific provision for identifying the supplier/manufacturers of the prostheses or other artefacts so provided for each individual patient.

The potential obligations of a clinician in relation to prostheses and other items provided in the course of private practice may be greater still, particularly where the clinician may also have some management or administrative responsibility for a private nursing home or hospital.

Modifications of standard equipment

If a piece of standard equipment is modified by a doctor, the doctor may become the "producer" of the modified equipment for the purposes of product liability.

Re-use of 'once only' disposable products

There are special risks attaching to the re-use of 'once only' equipment. If such equipment is used more than once, in contravention of the manufacturer's recommendations, the manufacturer is likely to be able to avoid responsibility on a product liability basis. Legal liability which might arise from the re-use of such equipment is likely to fall on the clinician or the Health Authority concerned. The re-use of 'once only' equipment may well be the result of financial stringencies within the National Health Service and if clinicians are asked to accept a practice of such equipment being re-used, they are advised to ensure that the Health Authority accepts any resultant liability which may occur.

Nerve and Flexor Tendon Injury

by J V Jeffs MB BS FRCS
Consultant Plastic Surgeon, Charing Cross Hospital, London and
Member of Council and Cases Committee, The Medical Protection Society

Although there is still argument about materials and technique, it is generally agreed that tendon and nerve injuries are best treated, where the wounds are suitable, by early primary repair to produce the best results. This assumes that the repair is done by a surgeon experienced in such repairs and with access to suitable instruments and surroundings and, at least equally important, who can provide proper post-operative supervision and physiotherapy.

It is obvious that such injuries should be diagnosed early — not only to obtain the best functional results for the patient but also to avoid a claim alleging negligence in failing to make the diagnosis. It is taught that proper diagnosis depends on accurate anatomical localisation of the injury. Conversely, a knowledge of the anatomy of the hand and forearm should raise the 'suspicion index' when confronted with an injury of these regions.

Flexor tendons

It should be assumed that any laceration of the palmar surface of the wrist, hand or fingers has damaged a flexor tendon until this is disproved. Any laceration extending for half the circumference of the finger is almost certainly proof of a tendon or nerve injury. Each finger has two flexor tendons acting on different interphalangeal joints. The instruction to 'bend the fingers' is therefore not likely to produce detailed information about joint movements.

The normal resting position of the relaxed hand palmar surface up with the hand on a supporting table is of partial flexion of the fingers at all joints progressively from index to little finger. If the tendon of a finger is cut the finger will be extended by the unopposed pull of the extensor tendon and will thus be out of line with adjacent fingers.

Each joint then must be moved actively by the patient to demonstrate flexor function. Even in the presence of a painful wound some movement of intact tendons can usually be obtained with gentle persuasion.

If there is movement in all joints, thought can be given to the repair of the wound. Here is a difficulty. If a flexor wound is not explored to its depth, there will be uncertainty as to whether or not a tendon has been partially divided. Such a tendon, when stressed after the healing of the skin wound, will perhaps snap — or will heal with a 'notch' or swelling which may cause jamming or a 'trigger' effect. Such wounds should then be explored until an intact sheath is seen. If the sheath is damaged there is a very high chance that the tendon is also damaged. Remember that if you delegate the suturing of a wound then you are responsible for ensuring that whoever does it is competent to undertake it.

Nerve Injuries

As with tendons a high index of suspicion will help and a knowledge of the course and function of the nerves in the hand and forearm is necessary. At the wrist the median and ulnar nerves subserve both motor and sensor function. The radial nerve at this level is sensory only.

First listen to the patient; repeatedly cases are reported to the Society in which the patient says that he said his finger was numb at the time of the first examination. Examine, then, the hand distal to the injury, first for motor function and then for sensory function. There is in the hand some overlap between the median and ulnar distributions both in motor and sensory function. The median nerve, however, always supplies the opponens muscle of the thumb and the ulnar nerve always supplies the abductor of the little finger. Test movements of these muscles against resistance, place the digits in the required position and ask the patient to maintain that position against resistance.

Test each area of the hand for sensitivity to light touch. Do not approach an apprehensive child with a large sharp pin. I use for skin testing a leatherworker's tool, consisting of a metal wheel whose circumference is filed into teeth like a small gearwheel. The wheel is placed over the area of normal sensation and run lightly on to the part to be tested. Any change is readily felt by the patient.

There is now an important development in the diagnosis of nerve injuries. For a long time there have been anecdotal reports on good authority of nerves, later shown to be divided, producing no upset in sensation or motor activity until Wallerian degeneration ensues. There is now laboratory evidence that 'jump' potentials can cross the gap in a divided axon until the distal axon degenerates. The obvious conclusion is, that in an injury with a high

suspicion of nerve damage because of its history and siting, the nerve must be explored or the patient seen at short intervals (of days) until the matter is beyond doubt. It will be still difficult to defend the sending away without a return appointment of such a patient. This is one reason why I am against the use of 'absorbable' sutures in the skin when patients are not seen again for removal of the sutures and wound inspection. The opportunity for further checks on tendon and nerve function are then lost.

Assuming now that with careful examination a tendon or nerve injury has been diagnosed, or suspected strongly, what should then be done?

For those working in a centre with an orthopaedic/plastic/hand surgical team available, there is no difficulty. The patient is referred straightaway and not to the next clinic. If such expertise is not available on site, then I think such is the importance of these injuries that telephone advice must be sought and the patient sent to the nearest centre the same day if this is thought advisable.

If such a centre is really remote and there is a strong suspicion of injury to nerve or tendon, then it may be justifiable to explore gently the wound under local anaesthetic (no adrenaline in fingers) without enlarging it if possible in order to confirm or deny the suspicion of injury to tendon or nerve.

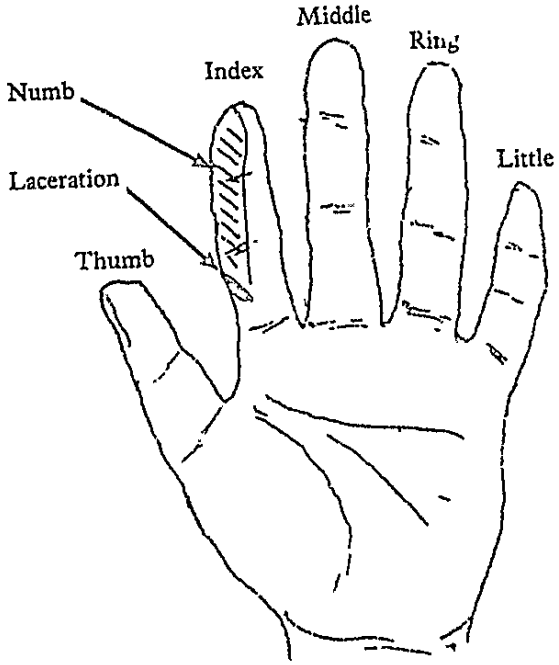
In summary, the diagnosis of nerve or tendon injury in the hand or forearm is a matter for schematic careful examination. Of prime importance, having done all this careful examination, is the noting of the findings which are easily and quickly tabulated thus.

MCP	=	Metacarpophalangeal
PIP	=	Proximal Interphalangeal
DIP	=	Distal Interphalangeal
F/E	=	Flexion/Extension either in degrees estimated or ✓ to show movement equal to digit on other hand.

Mrs A. N. Other 25.12.86

Movements
MCP F/E ✓✓
PIP F/E ✓✓
DIP F/E ✓✓

Drs Name:
Date:



△ = Division digital nerve radial aspect index finger.

Most Accident and Emergency Departments have a rubber stamp of a hand outline whereon areas of loss of sensation can be recorded or ticked as being normal.

If a patient has to be referred for repair such a record is impressive to the receiver. If the findings show no abnormality then there is a written record showing this for future reference. The importance of keeping careful, accurate notes cannot be overstressed.

Iatrogenic Vascular Injury

by J V Jeffs MB BS FRCS
Consultant Plastic Surgeon, Charing Cross Hospital, London and
Member of Council and Cases Committee, The Medical Protection Society

Some leaking of blood from a puncture wound in a vein or an artery is inevitable but is usually minimal if pressure is applied to the site on withdrawing the needle or cannula. Such leakage can be of serious consequence if the venous pressure is raised, either by proximal pressure from clothing, dressing or dependency, or if the artery continues to bleed due to too short a period of compression. If the patient has abnormal clotting functions due to disease or therapy, bleeding from a punctured vein or artery can also continue dangerously. Tissue pressure usually limits venous bleeding, but arterial bleeding under intact skin can produce compartment pressure elevation sufficient to imperil muscle and nerve function. The breakdown of the extravasated blood leads to free radicals which are tissue toxic, and in association with the increased pressure can readily produce skin death, especially in the elderly, as is frequently seen in the pre-tibial haematoma following closed injuries in old people.

A similar chain of events is seen when intravenous transfusions leak or "tissue" as seems now to be the accepted active verb for this happening. Here, in addition to the pressure changes produced, there is the added hazard of infiltration of the soft tissues with fluid which may be hyperosmolar or tissue toxic, such as bicarbonate solution, hypermolar sugars or cytotoxic drugs.

The siting of venepunctures and intravenous cannulae cannot always be ideal, but if it is not, then extra precautions must be taken to avoid extravasation due to displacement of the needle or cannula. No long-term unattended, intravenous medication should be given through a sharp needle which may easily penetrate the vein wall with slight movements of the limb. Having said this, a narrow gauge 'butterfly' may be the only possible instrument in a neonate. It is just these mobile limbs with indwelling sharp needles that need most care in fixation and protection from the other limb and movements.

Constant or regular close inspection is necessary. In less than half an hour enough fluid can leak into a baby's foot to imperil the skin and the raising of a drip reservoir to clear a drip cannula should never be done unless it is certain that the needle or cannula is patent and properly sited in the vein.

In the event that fluid has leaked into the tissues, attempts must be made to reduce the tissue pressure. This is best done by elevating the part and by cooling it with cold packs frequently renewed, and by splinting the part. Infiltration of the tissues with Hyalase distributes the fluid, but should obviously not be done if the leakage contains cytotoxic drugs. Infiltration with steroids or their general use has not shown to be of benefit. Nor have non-steroidal anti-inflammatory agents. If, despite these measures skin death is inevitable, then the area should be excised and replaced by a graft. This should be done urgently if there is a large haematoma, since the initial area of skin death is likely to increase if such a large haematoma is present. However, in neonates, it is often best to await separation of the slough and healing by secondary intent, even with cicatrisation which can be corrected later. Splinting should be used to ensure correct limb posture. The ante-cubital fossa breakdown following cytotoxic leakage is notorious for causing elbow flexion contracture, difficult or impossible to correct at later operation. Since in these cases nothing can be done to prevent tissue death once the leakage has occurred, there is a school of thought which favours early excision of dead tissue in all dimensions to relieve pain and reduce the chance of infection, although this is not usually practicable in these marrow-depressed patients.

To sum up, extravasation of blood or therapeutic fluid by the displacement or leakage from an intravenous cannula or needle can have very severe effects on local tissue. It can lead to skin loss and if such is over tendon or bone, more than simple split skin grafts to salvage the function of the limb may be necessary. Every effort should therefore be made to site such cannulae in the best available place, to anchor them firmly and to inspect them regularly and often. Drips should not be made to run the better by raising the pressure without ensuring that the cannulae is patent and properly in place. If there is extravasation of blood or fluid, the limb should be splinted and elevated without encircling retaining straps, and the affected part cooled. Watch must be kept for compromise of the distal circulation to muscle as evidenced by pain on passive movement of the fingers, or to nerves as evidenced by paraesethesia. If necessary, decompression must be done promptly. If tissue death is inevitable, advice on its replacement should be sought early rather than late.

Arteries are now cannulated for diagnostic purposes with increasing frequency. Intra-arterial lines are now standard in monitoring blood pressure during many operations and the small incidence of complications is attributed to the ability of the cannulators and the skill of the manufacturers of the cannulae. Nevertheless, to insert a needle into an artery is a physical insult to the vessel and considerable intimal damage can be seen on scanning electron microscopy. Where cannulae or

catheters are large enough to need an arteriotomy, damage done is obviously greater and here the pressure of distension and tearing of the intima can lead to later thrombosis. Even in "routine" arterial puncture of the radial artery, one survey showed significant morbidity in the hands of one in a thousand patients.

Of much greater seriousness is inadvertant injection into an artery. This can happen when the artery is selected in mistake for a vein and previous Reports have offered advice concerning the selection of sites for intravenous injections. Mistakes also occur when an injection is made into an open arterial line in mistake for a venous line. Clear labelling of the lines must therefore be done. In conscious patients there is immediate pain spreading to the area supplied by the artery. This is followed by rapid arterial spasm of intense degree and the part distally becomes white. The end result of these mistakes depends on the volume of substance injected and its type. The exact mechanism of the damage produced is still unknown. It may be that there is micro-embolisation by the crystalline part of the substance or by small thrombotic emboli. The release of thromboxane has recently been implicated in the ultimate death of the tissue. Whatever the actual mechanism, the cause of the tissue death is interruption of its arterial input, except where the substance injected is cytotoxic. This tissue death may be permanent from the time of injection or produced later by progressive thrombosis of the vessel from intimal damage.

The treatment of such an accident is far from organised and is often anecdotal. No firm protocol is available. It is probable that the needle will be withdrawn rapidly when it is realised that an injection has been made into an artery. This may not be the best thing to do as some authorities advise that injection into the needle or cannula of a volume of diluting isotonic fluid followed by papaveratum to release the spasm. Sympathetic blockade is advocated with local anaesthetic followed by surgical sympathectomy if the former proves temporarily effective. Hydrocortisone infiltrated locally or given generally, has not shown to be of use in two small series. In a recent article the use of thromboxane inhibitor generally was shown to be of definite benefit in reducing expected tissue loss in the laboratory animal and the topical application of extracts of aloes with the inhibitor showed greater effect than the use of either alone. We do not know whether these results can be reproduced in humans.

General supportive measures such as pain relief, cooling the part and elevating it and ensuring normal circulatory volume in the patient should be entrained. The use of a low molecular weight dextran generally or intra-arterially to the affected limb does not appear to be of use. Arterial reconstruction has also been reported but is obviously more successful where the damage is mechanical and limited to a short area of an artery, and is unlikely to be of help where a toxic substance has been injected and the damage is due to the local and distal effects on the arterial intima and to the diffusion of the substance into the tissues.

The mid-phase after attempts to reduce the initial insult will be one of awaiting demarcation of tissue death. During this time the part should be kept cool and dry and splinted in the best position to avoid contractures. Muscle swelling may lead to fibrosis and the presence of pain on passive movement of fingers indicates the need for decompression of the muscle compartment. As soon as dead tissue is demarcated it should be excised and the defect made good by grafts or flaps where tendons, nerves, joints or bones are exposed In these arterially damaged patients, long term reconstruction will be limited by the circulatory compromise in the part.

In summary, the treatment of extravasation of blood or drugs from the vein or inadvertent cannulation of arteries cannot be laid down, except for agreed general measures. The local treatment will depend on so many factors, such as volume injected, substance injected, the site of injection and the state of the arteries themselves, that no simple regime to follow can be offered.

Case reports

Injection at the wrong site — manufacturer's advice ignored

A member practising overseas injected an anti-flammatory drug into the muscles of the upper arm contrary to the manufacturer's printed recommendation that the drug should only be injected into the upper outer thigh or buttock. Radial neuropraxis and tendon damage requiring remedial surgery resulted. As the member contended that he often disregarded manufacturer's advice the case was deemed indefensible and was settled for an amount equivalent to £1,000 plus costs.

Sciatic nerve damage following intramuscular injection

For many years the Society has advised that the lateral aspect of the thigh is the least unsafe site for deep intramuscular injections. It remains our experience that intramuscular injections into the buttock and into the upper arm are prone to cause neurological damage.

A 52-year-old taxi driver in Hong Kong attended his general practitioner with a complaint of pain in the right elbow. The practitioner, a member of the Society, diagnosed tennis elbow and the treatment included an intramuscular injection of 2 ml Tomanol into the left buttock. The injection was personally administered by the member into the buttock using a 1½" long disposable needle.

Immediately after the injection, the patient complained of numbness of the left leg. On re-examination four days later, decreased sensation of the L4/L5 and S1 segments was detected but motor function and tendon reflexes were stated to be normal. A course of steroids was prescribed.

The patient subsequently attended a university hospital complaining of numbness of the left sole and medial side of the left leg and difficulty in walking. On examination there was mild muscle wasting of the calf and weakness of plantar-flexion and inversion of the left foot. An EMG showed evidence of widespread denervation in muscles innervated by the left sciatic nerve with evidence of delayed conduction of the sciatic nerve proximally.

A claim for compensation was made and the Society was advised that this claim was indefensible, it being difficult to deny that the injection and the plaintiff's disability were causally related. Tomanol contains isopyrin 480 mg. with phebuzine sodium 260 mg. and the member stated that his reason for not choosing the lateral aspect of the thigh for the injection was pure convenience because it was considered to be rather awkward to ask patients to take off their trousers each time an injection was needed.

The patient's claim was settled for HK$46,000 inclusive of both general and special damages.

Kenalog Injection — atrophy and depigmentation

A 22-year-old female patient attended her general practitioner requesting an injection of Kenalog, 80 mgs. for hayfever and eczema. The practitioner, a member of the Society, administered an injection into the upper thigh. It was on a Saturday morning and no nursing staff were present.

Six months later the patient attended the member complaining of muscle atrophy and depigmentation corresponding with the site of the injection. She subsequently made a claim for compensation alleging negligence in the choice of the site for the injection and in failing to heed the known risks and side effects published in the manufacturer's data sheet. This included the statement that "the injection should be deep into the upper outer quadrant of the gluteal muscle . . . *N.B. to avoid the danger of subcutaneous fat atrophy it is important to ensure that deep intramuscular injection is given into the gluteal site. The deltoid should not be used.*"

The patient alleged that the indentation and whitening of the skin made her selfconscious about the appearance of her thigh. She claimed now to be unable to take part in modelling competitions and to have been deprived of the opportunity of earning money as a model.

Her claim was settled for £1,180.

Watch the diluent — intravenous potassium chloride

An 8-year-old boy was admitted to a district general hospital with a diagnosis of osteomyelitis of the humerus. He was treated with intravenous Fucidin and ampicillin. The senior house officer, a member of the Society, attended on the ward to administer intravenous ampicillin. An intravenous tray had been set up by the nurse. Fortuitously, as it transpired, the cardiac arrest team were already present on the ward to attend another emergency.

The senior house officer checked the ampicillin and took from the tray an ampoule of diluent from the box which he presumed contained normal saline. It was in fact an ampoule of potassium chloride. He administered by slow intravenous injection 500 mg ampicillin in 10 ml potassium chloride and after the administration of 2½ ml, the child became pale, pulseless and vomited. The cardiac arrest team, already present on the ward, were asked to assist in the resuscitation and the child was fully resuscitated and, fortunately, suffered no lasting sequelae.

The claim for compensation brought on behalf of the child was settled for £725 plus costs to which the Society contributed 75% on behalf of the senior house officer.

Vasectomy — subsequent birth of child — no negligence

In 1980 a surgeon, a member of the Society, was consulted privately by a 30-year-old man for vasectomy. He and his wife had a boy and a girl and wished for no more children. The member, under local anaesthetic, excised approximately 3 cm of each vas, turned back each cut end of the vas, tied it with chromic catgut suture and allowed the cut end to retract into the sheath. Two negative sperm counts were obtained.

Approximately two years later the patient's wife became pregnant and in February 1983 she was delivered of a healthy boy. Blood tests indicated an overwhelming likelihood that the patient was the father. The parents brought a claim against the member for damages for the wife's loss of earnings occasioned by the delay in her returning to work, the expenses associated with the birth, and the cost of bringing up the child.

The Society resolved to defend the claim and in 1987 the matter proceeded to trial in the High Court. On the first day of the trial, the plaintiff's expert witness conceded in cross examination that, although when he had performed vasectomies in 1980 he had excised a section of vas, cauterized the ends, looped them and tied them with non-asborbable sutures, and placed the looped ends in different fascial planes, it was nevertheless reasonable in 1980 for a surgeon to have performed the operation using the operative technique described by the member.

The patient had been warned that the operation carried a small risk of failure. The plaintiff's expert witness conceded that it was not appropriate in 1980 to warn of the possibilty of late recanalisation.

On the second day of the trial, the plaintiff's counsel indicated that the claim was being withdrawn. There was no order as to costs. As the parents were legally aided, the defence costs could not have been recovered in any event.

Misfiled histology report

A 53-year-old woman was admitted to a teaching hospital for a dilatation and curettage with polypectomy. The curettings were sent for histological examination and the histology report stated that there was a well-differentiated adenocarcinoma present. However, the patient went home on the day after the operation, before the histology report arrived in the ward. This report was then filed away and overlooked and no post-operative out-patient appointment was kept.

The oversight was overlooked for five years by which time the patient had developed a well-established malignancy for which total abdominal hysterectomy, bilateral salpingo-oophorectomy and lymph node dissection was performed.

The patient brought a claim against the teaching hospital and the matter was carefully examined by experts acting for the Society and its sister organisation. The Society's interest was on behalf of the senior house officer in gynaecology, one member of the hospital team. It was agreed that the claim, overall, was indefensible and that a settlement should be negotiated. The claim was settled for £4,000 plus costs and the cost of the settlement was borne in equal shares between the Health Authority and the protection and defence organisations. The Society made a small contribution to the medical settlement figure on behalf of the senior house officer.

The importance of reviewing and acting upon abnormal investigation results is stressed once again.

Third degree perineal tear

A 31-year-old nursing sister was admitted to hospital to be delivered of her first child. During the course of the confinement she sustained a third degree tear which was repaired by a consultant obstetrician, a member of the Society. A few days post-operatively the patient developed faecal incontinence. Three months later she consulted another specialist who diagnosed that the internal sphincter mechanism was not intact. She was then referred to a surgeon who carried out a repair of the sphincter.

litigation was commenced against the consultant. The matter was carefully considered by the Society's obstetric advisers and initially the view was taken that the claim should be defended. However, it became apparent that there was a weakness in the failure to diagnose and treat the ruptured sphincter mechanism and the member informed the Society that he could not be certain that he had carried out both a vaginal and a rectal examination after his repair. He felt that he would have to make this damaging admission in Court. In the circumstances the Society's Cases Committee decided that it was in the best interests of all concerned for the matter to be settled out of Court and this was achieved for a sum of IR£37,500 plus costs.

Diathermy burn

The importance of scrupulous attention to "theatre drill" cannot be over-emphasised. Attention is drawn to the new edition of the booklet ***"Theatre Safeguards"*** produced by the three British protection and defence organisations in cooperation with the Royal College of Nursing and the National Association of Theatre Nurses. Copies of this booklet are available to members of the Society upon application.

A 65-year-old lady was admitted to hospital in Ireland for a total hip replacement. The operation was performed by a Registrar assisted by the Consultant, a member of the Society. Post-operatively 2 full-thickness burns were noted over the inner posterior-medial aspect of the lower right thigh. The patient was referred for plastic surgical opinion and subsequently underwent excision of the burned area with skin grafts.

A claim for compensation was made and upon due enquiry it was learned from the Consultant that he did not use a quiver to contain the diathermy forceps when not in use and it was further learned that the operating pedals of the diathermy machine were positioned so as to make them vulnerable to inadvertent contact. These considerations led the Society to the conclusion that the claim was indefensible and a settlement, out of Court, was negotiated in the sum of IR£7,750 plus costs.

The section from ***"Theatre Safeguards"*** dealing with diathermy equipment is set out below:

"Staff should have learned and be familiar with the use of diathermy and other electrical equipment. Manufacturers' instructions should be available, read and followed. The patient electrode must make good contact with the patient's body; shaving the site may be necessary. The calf is not a suitable site.

The live electrodes or cautery should, when not in actual use, be kept in an insulated quiver; it should not be left exposed on drapes, the patient or on the instrument tray. The insulation on diathermy forceps should be checked before and after use.

The Diathermy/cautery footswitch should be positioned so that it cannot be accidentally operated. The equipment should have both audible and visual alarms which operate whenever current flows. The current should be set at a level which achieves only desired and not unwanted results.

Regular checks should be made that equipment has been maintained at the due dates."

Retained swab

A female patient underwent excision biopsy of breast lumps. The operation was uneventful and at the end of the operation the specialist surgeon, a member of the Society, was advised that the swab count was correct. Post operatively the patient suffered discomfort and discharge from the right breast wound and on the tenth post-operative day the surgeon re-operated to find a small swab in the wound. It was removed and the patient made an uneventful recovery.

Her claim for compensation was regarded as indefensible and a settlement was negotiated for A$3,687 inclusive of costs. This sum was divided in equal shares between the Society on behalf of the Surgeon and the hospital authority on behalf of the nursing staff in the operating theatre.

Pregnancy, unsuspected or undetected at laparoscopy — a potential hazard

A number of instances have come to the Society's attention where early pregnancy has co-existed with laparoscopy undertaken for sterilisation or other purposes Some surgeons make it a routine to carry out a curettage at the time of laparoscopy. However, there are others who would hold that this procedure is only indicated if the patient complains of abnormal bleeding. Indeed, a curettage designed to remove an unplanned pregnancy might not conform with the provisions of the Abortion Act, 1967. It is also well-known that even the most determined curettage can, on occasion, fail to dislodge a very early pregnancy from the uterine cavity. Hence we believe it essential that surgeons should satisfy themselves that those patients undergoing laparoscopy in the second half of the menstrual cycle have employed reliable contraception up to the time of their admission. If there is doubt, it is best that the laparoscopy be deferred until any question of pregnancy can be confidently ruled out.

The following brief summaries are provided to highlight the problem.

Case 1: A multiparous patient was referred by her general practitioner for elective sterilisation. This was agreed to by an experienced registrar and his consultant. The patient was admitted for sterilisation and, when being interviewed prior to surgery, made no mention to the admitting house surgeon that she was pregnant, though she subsequently claimed that she did. It is recorded on the case notes that there was a failure-rate attendant upon sterilisation. The sterilisation was carried out without difficulty by the registrar under the supervision of his consultant about the 19th day of the menstrual cycle. Two months after operation the patient was re-admitted, stating herself to be pregnant, which fact was confirmed. On the day following, a ten week pregnancy was terminated by the consultant and a check laparoscopy confirmed the correct siting of the occluding clips on the fallopian tubes. Liability has been denied. If the claim is pursued it will hinge upon the patient's word against that of the house surgeon that she did, in fact, suspect pregnancy, having had six children previously, claiming to know almost immediately after conception that pregnancy had occurred.

Case 2: In 1981, a multiparous patient was booked for sterilisation by a consultant gynaecologist who had treated her previously on several occasions, following one of which she had developed deep vein thrombosis. She was advised to discontinue the contraceptive pill six weeks prior to admission for surgery, and to employ some other means of contraception. The patient was admitted for operation and specifically asked if there was any possibility that she was pregnant, which she denied. The operation was undertaken late in the first cycle following discontinuance of the pill. Laparoscopic sterilisation only was carried out, without curettage, the only possibly significant finding being the presence of what was described as "a good corpus luteum". The patient returned for follow-up rather later than usual, when she was found to be pregnant. She declined termination. Following delivery, it was estimated that conception indeed occurred in the cycle immediately prior to the laparoscopic sterilisation. Her claim for compensation against the health authority and the consultant, a member of the Society, was vigorously defended. At trial in the High Court in 1987, the patient lost her case, the Judge ruling that on the balance of probabilities the patient had not, as she asserted, been told to abandon all contraception prior to surgery. He also accepted that she was asked prior to operation if the possibility of pregnancy existed, and further accepted that there was no indication to perform a curettage with the laparoscopy. Her claim was dismissed but, being legally aided, the Society was unable to recover the costs of the defence which amounted to £11,646.25.

Missed ruptured achilles tendon

A patient attended the accident and emergency department with a history that, on rising from a sitting position, he had heard a "snap" and felt pain in his left calf. He was able to walk and he presented without delay to the hospital.

He was seen by the senior house officer, a member of the Society, who noted "Slightly tender over body of gastrocnemius muscle". The patient was advised to rest and he returned home with a supply of analgesics.

Over the next five weeks he continued to experience increasing pain in the left leg and the ruptured achilles tendon was eventually diagnosed by his general practitioner. The case was considered indefensible because the casualty doctor had omitted to perform Simmond's test. (The patient lies prone. The calf is squeezed tranversely. If the tendon is intact or incompletely ruptured, the foot, which should project beyond the couch, is seen to plantarflex. If the tendon is completely ruptured, the foot remains still). The claim was settled for £12,000 plus costs.

Missed glass foreign body

A 3-year-old child was taken to the accident & emergency department of a city hospital with a history of having fallen off a wall onto the ground. The child had sustained a cut to the right hand and was seen by the casualty officer, a member of the Society. A superficial 1cm laceration was noted on the right thenar eminence and there was no evidence of any nerve or tendon damage. The wound was cleansed and examined under local anaesthetic and no foreign body was found. The wound was sutured and no radiograph was taken.

One week later the sutures were removed by the child's general practitioner and the wound was noted to be infected. Antibiotics were prescribed.

Three weeks later the child was taken back to the accident & emergency department with a persistent redness and induration at the site of the laceration. The child was admitted to the Children's Hospital and a radiograph of the hand revealed a foreign body in the wound. This was removed under general anaesthetic whereupon the wound healed quickly. The child was left with a short scar but no loss of function.

Legal proceedings were commenced and the claim was reviewed on behalf of the Society by a specialist surgeon. We were advised that the case could not be defended. The possibilty of glass or a sharp piece of stone having entered the wound was not sufficiently considered. We were also advised that the indications for a radiograph were present. It was felt to be in the best interests of all concerned to negotiate a settlement and this was achieved for £750 plus costs.

Drug interactions

1 Lithium and diuretics

A 55-year-old female patient with a long history of manic depressive psychosis was admitted to hospital where treatment with lithium was commenced. The serum lithium levels were monitored and the patient was stabilised on a dose of 800 mg per day. The patient suffered from hypertension and obesity and was thrice admitted over a period of 4 years for in-patient treatment and, as an out-patient, was followed in the Lithium Clinic.

During what proved to be her final admission to hospital, with an exacerbation of manic depressive psychosis treated with haloperidol and chlorpromazine, she suffered also from a chest infection. For this she was treated with ampicillin and ephedrine. The treatment with lithium was continued in a dose of 800 mg.

The patient's physical condition deteriorated and the consultant psychiatrist, a member of the Society, invited an opinion from a consultant physician. The physician, having assessed the patient, advised that she should not stay in bed because of the risk of deep vein thrombosis and pulmonary embolism. In view of the hypertension (200/120 mm Hg) various investigations were suggested. The physician recommended the use of a diuretic and suggested either Dyazide or Aldactide.

The physician's advice was accepted and the patient was changed from frusemide to Dyazide but the lithium was continued. Three days after the change of diuretic the serum lithium was 1.05 mmol/l and one week later the laboratory telephoned with the information that the serum lithium was now 2.70 mmol/l. The patient looked non-specifically unwell and drowsy and had generalised coarse tremors and continually kept her tongue out. The lithium treatment was discontinued.

On the following day the patient slipped in the toilet and fell. Her serum lithium level was 2.55 mmol/l. The case was discussed with the physician in charge of the local dialysis unit and the patient's transfer was arranged. On admission to the district general hospital the patient was found to be dehydrated and in congestive cardiac failure with probable lithium toxicity. The patient died suddenly 9 days later.

At necropsy she weighed 110 kg (height 5' 9"); her lungs were congested and the pulmonary arteries contained emboli. The trachea, bronchi and pulmonary parenchyma were otherwise normal. A small amount of thrombus was present in the right femoral vein. The cause of death was given as pulmonary embolus due to deep vein thrombosis due to lithium toxicity. At the subsequent inquest the Coroner returned a verdict of misadventure.

Legal proceedings were commenced against the health authority and the consultant psychiatrist, a member. Included in the allegations of negligence were a failure to appreciate the dangers of drug interaction or adequately to monitor the serum lithium levels. It was alleged that there had been a failure to discontinue the lithium timeously and a failure to treat the patient's hypertension with drugs other than diuretics.

Detailed consideration of the claim by several expert advisors led to the Society taking the view that the claim was indefensible. Although lithium was given intermittently, the loop diuretic frusemide was started without performing any tests of renal function in spite of the fact that long term lithium therapy might have caused renal damage and there was a possibility that the patient was suffering from urinary infection. Lithium was given concurrently with Dyazide without any reduction of dosage and with only weekly monitoring of the serum lithium levels, despite the well-documented drug interaction. It was regarded as a complex case and further noted that the physician, consulted by the psychiatrist, had predicted the possibility of death from DVT and pulmonary embolism if the patient remained in bed. However, it was regarded as surprising that the physician had not warned the psychiatrist of the hazards of combining diuretics with lithium.

A settlement of the claim was negotiated. The damages plus costs amounted to a little over £4,000 of which the Society bore 80% on behalf of the psychiatrist and a sister organisation bore 20% on behalf of the physician.

2 Anticonvulsants and 'the pill'

A substantial number of drugs, notably certain anticonvulsants, may reduce the efficiency of the oral contraceptive pill. Doctors should be aware of these interactions and either provide alternative contraceptive advice or increase the strength of the contraceptive as appropriate. Failure to do so may result in unplanned pregnancies with expensive consequences. Such a case is illustrated below.

A young woman attended a provincial casualty department having fallen after losing consciousness. The casualty officer referred the patient to the medical senior house officer (SHO) who concluded that she had epilepsy and prescribed carbamazepine and referred her for a neurological opinion.

The patient claimed to have asked a male nurse if the new medicine would render the pill ineffective. She was reassured to the contrary after he apparently looked up the information in an outdated source. The medical SHO, a Society member, made no attempts to check the data sheet provided for the anticonvulsant before prescribing it. Had he done so, he would have seen that there was a risk of pregnancy when this drug was prescribed with low dose oral contraceptive pills. An unplanned pregnancy and a term pregnancy ensued.

The patient sued the health authority in respect of loss incurred because of this. A settlement was negotiated for £15,000 plus costs. The Society contributed 70% on behalf of the casualty officer. The remainder was contributed by the health authority in respect of the erroneous information provided by the nurse.

Prescribing errors

1. Chlorpropamide instead of chlorpromazine

A 77-year-old man was discharged from hospital after investigation for incontinence of urine and several falls. His mental function had deteriorated and he was given a supply of chlorpromazine, 25 mgm. tablets, to take home.

His general practitioner, a member of the Society, was asked by the patient's son for a supply of chlorpromazine to continue after the hospital tablets had finished. The doctor intended to prescribe chlorpromazine, 25 mg. tablets, 1 to 4 to be taken each night. Instead he wrote 1-4 tabs. chlorpropamide 25 mgs. nocte 100. To compound the error, the chemist dispensed chlorpropamide 250 mg. tablets. Before giving any of the tablets the patient's son took the opportunity of a visit from the district nurse to query the different tablets. He was assured that they were the same drug and the patient was given the first of the chlorpropamide tablets.

During the evening he became more agitated and, following instructions, the son gave more chlorpropamide tablets. The next day the general practitioner's partner visited on request but advised that no further action was necessary. A few hours later the patient had a grand-mal attack and was admitted to hospital. There was little improvement with intravenous dextrose. He had suffered a severe mental deterioration and where before his life expectancy would have been several years, it was now only months.

The ensuing claim was considered indefensible. After negotiation the patient's solicitors accepted the sum of £43,500 in settlement together with costs of £7,100. The Society contributed 40% on behalf of the general practitioner; another protection organisation contributed similarly in respect of the partner who visited on the day after the chlorpropramide was mistakenly started; the remaining 20% was borne in equal shares by the chemist and health authority (for the district nurse).

2. Daonil instead of De-Nol

A patient with a known duodenal ulcer attended his general practitioner, a member of the Society, with a letter from the local hospital suggesting treatment for an exacerbation of symptoms. The hospital slip read *De-Nol* (tri-potassium di-citrato bismuthate) *5 ml. q.i.d.* A practice receptionist wrote *Daonil* (glibenclamide) *tabs 5 mg. q.i.d.* and the member signed the prescription which was duly dispensed.

Three days later the patient was admitted to hospital for 48 hours complaining of dizziness, sweatiness and confusion. The hypoglycaemia was treated and no further problems developed.

The patient's solicitors wrote to the general practitioner requesting compensation in respect of their client's unnecessary suffering and hospital admission. The mistake could not be defended. The claim was settled for £1,000 plus £268 costs.

3. Chloramphenicol dose miscalculated — death

A child aged 10 months was admitted to hospital following a febrile convulsion. A clinical diagnosis of bacterial meningitis was made and penicillin and chloramphenicol were prescribed.

The child weighed 7.2 kg and the senior house officer, a member, calculated the dose of penicillin to be 200 mg four-hourly but took advice from the senior registrar regarding the chloramphenicol. The recommended 50 mg/per kg of body weight was thought to be insufficient and therefore the dose worked out was based on 100 mg per kg of body weight. The senior house officer came to the conclusion that the dose should be 1.2 g six hourly intravenously, and unfortunately the senior registrar agreed.

Over the following 36 hours, the child initially improved but suddenly collapsed soon after and was transferred to a larger unit for investigation. During the emergency transfer by ambulance, the senior registrar recalculated the dose and suddenly realised the error. Despite full supportive therapy, the child died late that evening of presumed chloramphenicol toxicity.

There was no defence to this claim, the settlement of which totalled £4,426.38 including costs shared equally between the Society on behalf of the senior house officer and those who represented the senior registrar.

4. Amoxicillin given to penicillin-sensitive patient

A 35-year-old school teacher attended her general practitioner, a member of the Society, with an upper respiratory tract infection. Despite the fact that recorded in orange on the case notes was the warning "Allergic to penicillin", the doctor prescribed amoxicillin.

Six days later the patient's rash appeared and spread rapidly, though there was no permanent ill-effect. She claimed damages in respect of loss of time at work and loss of enjoyment of her Christmas and New Year holiday. The claim was considered indefensible and was settled by the Society for A$660.

Gentamicin and vestibular nerve damage

A 48-year-old patient was admitted to hospital with pyrexia and a persistently-elevated erythrocyte sedimentation rate. An apical, ejection, systolic murmur was found and, with negative blood cultures, a diagnosis of culture-negative endocarditis was made. A nineteen day course of penicillin and gentamicin was given, with monitoring of blood levels of the latter.

The patient's pyrexia resolved but she became unsteady and bilateral, vestibular nerve damage was confirmed. The patient alleged that this was due to negligently-prescribed gentamicin.

At trial the judge was satisfied that there had been no negligence in the amount of gentamicin prescribed or the period for which it had been administered. He accepted the belief of the defendant's medical expert that it was possible to sustain ototoxic damage with normal trough levels of gentamicin. In this case the patient had been simply unfortunate. Judgment was given in favour of the defendant doctor.

Forceps delivery in the presence of unrecognised relative disproportion — another brain damaged baby

A tall 24-year-old primagravida was in August 1978 admitted to hospital for induction of labour, ten days beyond term. The first stage progress to full dilatation took just over eleven hours. After one hour in the second stage, the senior house officer was called. He summoned his registrar, who decided to deliver the mother of her baby with forceps.

The extent of the force required to achieve forceps delivery was seemingly the cause of comment at the time. The registrar in writing his notes specifically mentioned that 'no undue force' had been required but, in a later-written letter, a consultant who had made certain enquiries wrote that 'some of those observing the delivery were of a different opinion'. Certainly, after delivery the baby was noted to have suffered a factured left clavicle. Eight hours after delivery the baby had a convulsion and in due course severe brain damage was diagnosed.

Another consultant, who saw the patient subsequently and arranged radiographs (which showed a narrow mid-cavity), concluded that the difficult delivery had been due to relative disproportion.

It was not until 1982 that a Statement of Claim was served, alleging negligence in the application of the forceps and in their use with excessive force. Reports from the senior house officer and the midwives who had been present at the delivery suggested that the baby's head had been delivered in the oblique position. This was considered to be a case where it was likely that there would be

criticism of the registrar from those who were watching his performance. After a careful review of the facts and appropriate legal and medical expert opinion, the Society authorised a negotiated settlement. Damages of £468,400 were agreed and paid.

Forceps delivery — perinatal death

A Society member, an obstetric registrar, elected to deliver a multiparous patient vaginally at 9 cm dilatation because of slow progress in labour and type I dips on the CTG. His efforts, including Pajot's manoeuvre and at least 3 hard pulls, were unsuccessful. A 'flat' baby was subsequently delivered by caesarean section.

The baby died 16 hours later. Autopsy showed bilateral tentorial tears. A claim followed. Expert advice concluded that the attempt at forceps delivery was unacceptable practice and that the labour itself was inappropriately managed. The Society accepted this advice and settled the claim for £8,000 to which a sister organisation made a contribution of 10% in respect of their Consultant member's failure personally to ensure that his policy for the management of prolonged labour was followed. The place of attempted mid-cavity forceps delivery when disproportion has been signalled by prolonged labour must be seriously called into question except in the most expert hands.

Post-operative haemorrhage: deficient post-operative care

A Society member carried out a complex neurosurgical procedure in an effort to remedy a traumatic carotico-cavernous fistula. In the early post-operative phase the patient developed bleeding into his neck causing shock and cardio-respiratory arrest. He was ultimately resuscitated and his neck wound explored, revealing bleeding from an unsutured carotid arteriotomy site thought to be controlled by proximal and distal ligations. The bleeding was believed to arise from an aberrant superior thyroid artery and was successfully arrested by suture and ligature of a small vessel. The original ligatures were found to be intact. However, the patient was left with a mild hemiparesis, principally affecting his right arm.

A suit was mounted on behalf of the patient alleging, *inter alia,* that the arteriotomy in his neck should have been sutured *de novo.* Expert advice was received from several sources that it was not negligent to leave the arteriotomy unsutured if its blood supply was occluded by ligature and the incision was dry at the conclusion of prolonged and exacting surgery. Accordingly preparations were made for trial. When the hearing commenced, it became obvious that the plaintiff's attack was directed not only at the Society member but at a junior doctor, a member of a sister organisation, who was vulnerable to a charge of failure to respond effectively and rapidly to the early signs of the concealed post-operative haemorrhage. As this doctor was not available to give evidence leading counsel advised that the case be settled, which it was in the sum of £20,000 plus substantial costs, apportioned between the protection organisations.

Large pack left in the vagina post-partum

A 29-year-old woman was referred to a consultant obstetrician, a member of the Society, for the total care of her pregnancy. Six days after the expected date of confinement the patient was admitted for induction of labour and this was performed by the consultant. The patient had a normal vaginal delivery conducted by the consultant under epidural anaesthesia. An episiotomy had been performed but in the course of the repair the consultant was called urgently to see the infant because of a sudden cyanotic attack. The infant responded to suction and oxygen and the consultant returned to complete the repair of the patient's episiotomy. At the end of the repair he inserted a vaginal pack, as was his normal practice.

Five days later the patient was discharged home with no complications. Three days after that she attended her general practitioner complaining of pain at the site of the episiotomy and a copious brown vaginal discharge. The general practitioner found and removed a vaginal pack and noted severe vaginal infection which he treated with antibiotics and pessaries. A few days later she complained of abdominal pain and the general practitioner found the uterus to be tender and continued treatment with antibiotics. Some months later the patient was referred to a specialist psychiatrist with psychosexual difficulties, notably in her relationship with her husband.

The patient commenced a claim for compensation against the Health Board and the consultant. It was alleged that the negligent failure to remove the vaginal pack led to pelvic infection. The consultant informed the Society that it was his normal routine to put a swab in the vagina and that he normally left a certain amount sticking out. The patient was instructed to remove the swab some four hours after delivery, or sooner if she wished to micturate. The consultant did not perform a vaginal examination before the patient was discharged from hospital and he did not recall if he instructed the nurses to remove the pack.

The claim, plainly indefensible, was eventually settled out of Court for the sum of IR£12,500 plus costs.

Failed vaginal termination of pregnancy — pregnancy continued

A 24-year-old female patient was seen at a district general hospital requesting termination of an unwanted pregnancy. Her husband was unemployed and she already had two children.

One week later a vaginal termination of pregnancy was performed by the senior house officer, a member of the Society, utilising suction curettage. The SHO thought she had evacuated the uterus but the suction bottle contained only a small amount of tissue and so the SHO discussed matters with the consultant. He examined the curettings and felt that some placental tissue was present and instructed the SHO to arrange an outpatient review in two weeks time. The SHO wrote up the notes, sent off the histology specimen and arranged an outpatient appointment. The SHO never saw the patient again.

Two weeks later the patient was reviewed in the outpatient clinic by the locum registrar, also a member of the Society. His note read "She had TOP (two weeks ago) — well — no complaints — V/E NAD discharge". The histology report, however, showed decidua only but this was apparently not noticed or acted upon by the locum registrar.

The patient subsequently consulted her general practitioner because her symptoms of pregnancy persisted. She was referred back to the consultant who confirmed a 24 week pregnancy. A termination was offered and the situation was fully discussed. The woman and her husband decided to continue the pregnancy. Because of placenta praevia and a transverse lie an elective caesarean section was performed. The woman was delivered of a healthy girl. Post operatively the patient developed severe bilateral pneumonia and was transferred to the Intensive Care Unit. She was treated with anticoagulants for a possible pulmonary embolus.

The patient commenced legal proceedings against the Health Authority, alleging that she should have been more carefully assessed by a more experienced doctor at the outpatient review following the termination of pregnancy. She alleged that an ultrasound scan should have been performed and that there was a general failure in follow-up arrangements to ensure that the termination of pregnancy had been successful. She pointed out that she had suffered distress and pain associated with the birth by caesarean section and subsequent complications, and that she had suffered financial difficulties.

By the time the claim was made the locum registrar was untraceable and it was not possible to obtain a statement from him. Following expert review the Society was of the view that the best interests of all concerned would be served by a settlement out of Court. Following negotiations lasting two years the claim was settled for £30,000.

Brain damage from mis-set controls

A female patient aged 56 years underwent a general anaesthetic for the manipulation of fractures of her tibia and fibula. The anaesthetic was given by a senior house officer, a member of the Society. He induced anaesthesia with Brietal, and experienced some difficulties in maintaining a clear airway.

The patient was taken into the operating theatre and was connected to a Blease Pulmoflator connected with a Magill circuit. The senior house officer assumed that the controls were set in the correct position. However, a tracheal tug and, later, wheezing were noted and the patient became cyanosed. At this time the registrar entered the operating theatre, noticed the slow rate of breathing and that the control on the Pulmoflator was wrongly set to "ventilator" rather than "Magill" position. The control was re-set. The patient was intubated. Although the heart did not stop, the patient remained unconscious for 18 hours. It was estimated that she had been rebreathing for 20 minutes.

The senior house officer had commenced his appointment one month prior to the incident, and had used the Blease Pulmoflator on about twelve previous occasions. The patient suffered profound brain damage and solicitors acting on her behalf instituted legal proceedings. The Society obtained expert anaesthetic opinion and was advised that the claim was indefensible. Solicitors were instructed to negotiate a settlement out of court. An examination of the patient by a neurologist showed that she was severely disabled as a result of brain damage, and was left with severe visual difficulties and physical handicaps, speech defect and restricted limb movements. Her intelligence and intellectual faculties were preserved.

Three years after the incident an interim payment into court was made of £10,000. Settlement was eventually reached in 1987 and the delay was largely attributable to the fact that the solicitors acting for the patient were extremely late in submitting the documents which were essential for a proper assessment of quantum. The claim was settled for £250,000, which was borne by the Society on behalf of the anaesthetist.

Awareness under anaesthesia

The Society continues to receive a number of claims in which it is alleged that the patient was aware of both discomfort and severe pain during the operation. In last year's Annual Report (Number 94, p.33) we reported that the defence of the anaesthetist was not possible in the majority of these claims for three main reasons:

1 there was a failure to adhere to generally accepted clinical practice in the choice of anaesthetic technique;
2 there was a failure to keep any record, or minimal records only, of the anaesthetic procedure;
3 faulty equipment.

The failure of the anaesthetist to check apparatus before the patient is attached to the ventilator may lead to prolonged periods of awareness which could have been avoided. Examples include the identification of faulty connections, empty vapourisers, empty nitrous oxide cylinders, as well as the inadvertent leaving on of the emergency oxygen control.

A 66-year-old housewife was admitted for elective left hip replacement. The consultant anaesthetist used a ventilator with which he was not very familiar, but which had been used successfully by a colleague on the previous morning list. The apparatus had been inspected by a senior operating department assistant at lunchtime. The anaesthetist did not check the machine himself. Approximately half-an-hour after induction of anaesthesia, and fifteen minutes after the patient was attached to the ventilator, the anaesthetist noticed the tube connecting the gas source and ventilator was absent. The patient was being ventilated with room air. The patient was immediately connected to a Boyle's machine and hand ventilated until a replacement machine could be found. The patient endured painful awareness for some fifteen minutes.

Subsequently it was believed that the rubber tubing had inadvertently been removed with the vapouriser, although despite investigations a satisfactory explanation did not emerge. The Health Authority and Society agreed to apportion the damages on a 50:50 basis and the action was settled on payment of £4,000 plus £420 costs.

Both partial and complete disconnections account for many cases of awareness reported to the Society. Checking of anaesthetic apparatus at the start of every list is essential.

If members (whenever possible) ensure that they adhere to accepted techniques, and keep full anaesthetic notes (including details of pre-operative assessment, gas flows, delivery volumes, physiological parameters, circuit used, and the concentration of volatile agents selected, together with timing and usage), then and only then, may it be possible to defend a claim that awareness was due to negligence on the part of the anaesthetist. Any complaint of awareness should receive immediate and sympathetic consideration. It is recommended that an anaesthetist, ideally of consultant grade, should see the patient and offer an appropriate explanation. In many cases if the facts are carefully explained and the patient's complaint is taken seriously and handled compassionately, later complaints and claims may be reduced or avoided.

Dental damage during anaesthesia

Cases of dental damage associated with anaesthesia continue to be reported to the Society and the costs are high. It must not be assumed that laryngoscopy is the only factor in cases involving damaged teeth. There are several other causes, including the insertion of throat packs, the injudicious use of suckers, unsupported endotracheal tube connections, and the use of oral airways. The oropharyngeal airway cannot only damage loose teeth, crowns or bridge work during anaesthesia, but, as most probably occurred in the case below, can also be a source of damage during the recovery period. During recovery after anaesthesia restless patients may bite on the endotracheal tube or oropharyngeal airway. The force supplied by the returning tone of the muscles of mastication is extremely great and dental damage may ensue. Furthermore in an endeavour to remove the airway or the endotracheal tube still further injury may be inflicted.

A fit 35-year-old woman was admitted as a day case for elective surgery on varicose veins. She was not examined pre-operatively by an anaesthetist, and the presence of porcelain upper central crowns and a six-unit bridge was not noted.

The anaesthetic was administered by a senior registrar and proceeded uneventfully using a spontaneous ventilation technique. It was subsequently brought to the anaesthetist's attention by recovery staff that the patient's crowns had become detached. In fact part of the six-unit bridge had also been fractured. It seems probable that damage occurred when the restless patient bit on the airway in the recovery phase. The anaesthetist had routinely used a Guedel airway even though the patient's airway was not difficult to maintain. The anaesthetist did not see the patient post-operatively.

The anaesthetist agreed that the matter was indefensible and the patient's claim was settled for £945.

At the pre-operative visit the anaesthetist should ask about the condition of the patient's teeth. The oral cavity should be examined and the presence of poor dentition or caps, crowns and bridgework recorded in the notes. If there is a risk of damage, the patient should be warned of this risk and this fact recorded. If any dental damage occurs, the patient should be visited post-operatively and given a full explanation. Any teeth knocked out or deliberately taken out should be retained for inspection. If part of a tooth or whole tooth is missing the patient may require a radiographic investigation. A full and detailed account should be made in the notes of the incident. Dental advice should be arranged before the patient leaves hospital as very often the damage can be repaired. By no means all cases of dental damage during anaesthesia are indefensible, and the following of the above guidelines by anaesthetists would greatly reduce harm to patients, anxiety to themselves and a drain on the Society's funds.

Fitness to practise: who should supervise?

A member of the Society received notification from the General Medical Council that it had received information from his former employing Health Authority raising a question of whether his fitness to practise might be seriously impaired by reason of alcohol-related problems. The member had been suspended from work by his former employing authority on disciplinary grounds, but by the time he had received the General Medical Council's letter he was employed by another authority in a different part of the country.

The General Medical Council sought the member's agreement to undergo examination by two medical examiners who would then report to the General Medical Council on his fitness to practise. Whilst denying that his fitness to practise was in any way impaired, the member agreed to this and was duly examined by two psychiatrists. Both took the view that the member was fit to practise but both suggested that he should be subject to "medical supervision" for a period. The General Medical Council then wrote to the member asking him to undertake to place himself under the regular medical supervision of a psychiatrist. The member's response was that, whilst he was quite prepared to put himself under medical supervision, he wished this to be carried out by a physician rather than a psychiatrist since no-one had suggested that he was suffering from any form of psychiatric disorder, whereas he had suffered from a physical illness. The General Medical Council refused to review its decision that the member could only be supervised by a psychiatrist and indicated that if the member did not agree to this, then he would have to appear before the Council's Health Committee. The member declined to be supervised solely by a psychiatrist and, when he was subsequently summoned to attend before the Health Committee, the Society instructed its solicitors to arrange his representation there by Counsel. The hearing duly took place, a year after the first communication from the General Medical Council to the member. At the hearing, the contention put forward on behalf of the member that his fitness to practise was not seriously impaired was accepted by the Committee and accordingly the case went no further. The case did not therefore decide the question of whether only psychiatrists should be allowed to supervise practitioners suspected of having alcohol-related problems.

An expensive anatomical error

A Society member undertook, at the direction of his consultant, an operation for resection of a cervical rib for relief of thoracic outlet syndrome. At operation, the surgeon noted the outer border of the scalenus anterior muscle was thicker and more fibrous than usual when divided.

Immediately after operation the patient complained of weakness to the right arm and shoulder with loss of sensation over the C6 dermatome. At reoperation the roots of C6 and C5 were found to be divided and despite cable grafting there has been an incomplete recovery.

Following expert advice and leading counsel's opinion it was thought that the inevitable claim should be settled. This was effected by the Society in the sum of £82,646 plus costs, reflecting the role of the operator and his supervisor consultant, also a Society member.

Lumbar disc decompression performed at incorrect level

A 50-year-old woman was referred urgently to a consultant orthopaedic surgeon with severe back pain radiating down the right calf. A period of conservative treatment including rest and traction failed to relieve her symptoms. Radiographs confirmed lumbar disc degeneration and a lumbar radiculogram revealed a disc impression at the L4/5 level. The consultant orthopaedic surgeon, a member of the Society, recommended operative treatment by L4/5 disc decompression. The operation was performed apparently uneventfully by the consultant and the operation note commenced "Exploration L4/5 space".

The start of the operation was delayed because of the need to catheterise the patient's bladder, she having had difficulties in passing urine for the first time that morning. The bladder problems persisted post-operatively. Five days post-operatively the patient complained of numbness in the right leg and buttocks and objectively there was weakness of the peronei and gluteus and dorsi-flexors of the foot. There was also altered sensation in the leg from the L4 to S3 levels. The patient continued to experience difficulties with walking and severe back pain.

It was subsequently learned that some three to four months later the patient attended another surgeon with continuing symptoms. Myelography showed a complete block at the L4 level and a full laminectomy of L4 and L5 was performed. At operation dense and thick scar tissue was excised.

Legal proceedings were commenced against the first surgeon and when the Society's advisers came to review the papers and radiographs it was evident that the original operation had been performed at the L3/4 level, not at the L4/5 level as intended. The Society was also advised that the problem was one of root canal stenosis and not of disc prolapse.

Expert medical and legal opinion following a detailed review of the case and examination of the patient persuaded the Society that the claim would be indefensible. A settlement of the patient's claim was eventually negotiated for £215,000. The patient had been left with severe pain and disability including numbness in the saddle area, the need for the use of two sticks when walking, no bladder sensation, no bowel sensation and a general feeling of mental frustration and demoralisation. She also suffered from intractable pain for which her attendance at a pain clinic had failed to provide relief. Arachnoiditis was considered to be present and her disability was judged permanent.

Operation in the wrong cervical disc space

A consultant neurosurgeon treated a 50-year-old woman who had suffered motor and sensory changes in her right arm. These were attributed to osteo-arthrosis of the C5/6 disc space and the consultant performed a foraminal decompression at what was considered to be the C5/6 level on the right side, using a posterior approach. The patient's symptoms failed to improve and a subsequent radiograph, some months later, revealed that the operation had been performed at the C4/5 posterior intervertebral joint space.

The patient's subsequent claim for compensation was adjudged indefensible and the Society authorised the exploration of a settlement.

Paraplegia following surgical correction of scoliosis

In 1983 a 34-year-old lady suffering from a severe, rigid scoliosis of 90° was seen by a consultant orthopaedic surgeon. He considered it might be possible to improve the curve to approximately 60° although the extensive procedure would involve multiple osteotomies and distraction prior to refusion. An attempt was made to correct the curve by traction. One year after the first consultation the consultant operated, exploring the entire spine, performing osteotomies and multiple rib resections. A Harrington rod was inserted. Post-operative instructions were given to continue halo-femoral distraction.

Immediate post-operative progress seemed satisfactory, the patient being nursed in a Stryker frame. However, on the evening of the fourth post-operative day the nurses recorded a complaint of numbness in the left leg and that the left foot was red and slightly swollen. The pre-registration house surgeon was called and saw the patient at 11 p.m. He noted that the swelling had reduced, that the redness had gone and that sensation was returning. He considered that the symptoms had probably been induced by vascular occlusion. On the following morning, diminished movements in the patient's left foot were recorded and she was found to have loss of sensation to touch in the limb. The senior house officer in orthopaedics was called who immediately contacted the consultant. A diagnosis of progressive paraplegia was made. There was reduction in the power of the muscles in the right leg and anaesthesia from approximately T10/11 downwards. A radiograph showed the lower end of the Harrington rod detached out of the retaining hook.

The consultant performed an emergency exploration of the spine to decompress the cord. He found an obvious recent fracture of the previously grafted area. A new Harrington rod was inserted. No recovery took place and the patient became completely paraplegic.

In seeking an explanation for the complication that had occurred, the consultant considered relevant a history he obtained from the patient of her having, on the day on which the first symptoms of the numbness were experienced, pulled herself up by the cross-bar of the Stryker frame at which time she had 'heard and felt a crack in her back'.

A claim was made. Negligence was alleged in respect of the decision to attempt correction, in the performance of the operation itself and in the post-operative care. Much discussion took place and

eminent experts in the field of scoliosis correction surgery were consulted. The Society considered it reasonable for the surgeon to have attempted correction and it was noted that there had been a very high standard of care taken in ensuring the patient was fully counselled and warned concerning operative complications. It was further believed the patient had had explained to her the function and purpose of the Stryker frame. However there was agreement amongst the experts about the delay which it could be said had occurred between the onset of symptoms and recognition of them as heralding paraplegia. After the most careful consideration a decision was taken to try to negotiate a settlement of the claim which was achieved in the sum of £150,000. On behalf of the medical staff concerned the Society contributed 90% and the Health Authority paid the remainder.

Injury from falling instrument

A specialist radiologist practising at a private clinic arranged a series of radiographs to try to demonstrate the small joints between the cervical spine and the skull of an adult male patient. A metal localising cone was used on the x-ray machine but this fell off and caused a cut to the patient's chin. It transpired that the two retaining screws had worked loose permitting the metal cone to fall from the machine. The cut was a 3 cm laceration which was sutured with 4/0 silk sutures. A permanent scar remained and the patient's claim for compensation, judged indefensible, was settled for R700.

Members in private practice are reminded that it may be their responsibility to ensure that equipment which they use is adequately maintained and serviced.

Swallowed meat bone — œsophageal perforation

A 51-year-old woman choked on a lamb bone and attended a district general hospital where she was seen in the accident and emergency department by a senior house officer A radiograph of the chest and neck was ordered which was subsequently reported upon by a consultant radiologist, a member of the Society, who was unable to detect a foreign body. The radiograph request form included the words *"lamb bone in oesophagus"*. The patient was discharged.

Approximately ten weeks later the patient was referred by her general practitioner to the ear, nose and throat clinic with a complaint of a swollen, painful lower pharynx for two days after swallowing the lamb bone, which had subsided on antibiotics. However, pain persisted and was acute on swallowing. The patient was seen two weeks later by the ENT registrar who arranged investigations and wrote to the general practitioner *"I do not think there is a foreign body there after all this time"*. New radiographs were reported upon by another consultant radiologist: *"There is pre-cervical swelling opposite C3/C4. Barium swallow: no lesion seen . . . Opinion: I note that she has a history of radio-opaque foreign body. The appearances are likely to indicate inflammation in the pre-cervical region"*.

Approximately six weeks later (and five months after the original incident) the patient was seen by a consultant ENT surgeon, still complaining of neck and throat symptoms. A barium swallow was reported as normal and thyroid function tests were normal. The radiographs showed a pre-cervical swelling opposite C3 and C4. A laryngoscopy and pharyngoscopy was performed by the ENT registrar. No abnormality was detected. The patient was reassured and sent home with no follow up.

Three months later the patient was seen by another consultant surgeon with a tender lump in the neck. An abscess was diagnosed and de-roofed. A subsequent sinogram showed no calcified foreign body but tomography was recommended. The subsequent tomogram confirmed the presence of a radio-opaque foreign body 3 cm by 1 cm. The patient was admitted to hospital for exploration of her neck. However, a piece of lamb bone was extruded spontaneously on the eve of operation. The patient then made a satisfactory recovery and was discharged.

Her subsequent claim for compensation was judged indefensible. An expert review of he lateral radiograph taken on the date of the original attendance in the accident and emergency department showed a post-cricoid swelling and air in the tissues. The radiograph also demonstrated retro-pharyngeal air at the base of the skull. This was a classic picture of perforation of the oesophagus and it was thought wisest that the claim should be settled out of Court. Settlement was finally achieved for £4,000 shared equally between the Society and a sister defence organisation on behalf of the several practitioners concerned with the care of the patient.

Basal cell carcinoma

Delay in the diagnosis and treatment of basal cell carcinoma may lead to the condition becoming untreatable and causing death by arterial erosion. A 65-year-old man attended his general practitioner regularly for National Insurance certificates for chronic bronchitis. He also complained of a lesion near his left eye for which chloromycetin ointment was prescribed. Unfortunately, the practitioner's

medical records noted only the dates of the patient's attendances but little else. It was recorded that the patient attended on 7 occasions over a period of 2 years and received repeat prescriptions for the eye ointment. At some time the patient was provided with a letter of referral to the local eye hospital but there is no record of this event, nor of the letter being received or acted upon.

Six months later the patient attended the accident and emergency department with what proved to be a basal cell carcinoma which had spread from the eyelid to involve the eye and orbit. Radiotherapy was deemed inappropriate because of the size of the lesion. The patient was offered an operation which would have been disfiguring and which he refused. He died 18 months later and a subsequent claim pursued by the personal representatives of his estate was judged indefensible and settled for £18,500. The absence of adequate medical records was a significant contributory factor to the Society's decision that the claim was indefensible.

Ligation of the wrong vein

A 32-year-old woman was admitted for surgical treatment of her varicose veins. The member, a senior house officer in general surgery, ligated the common femoral vein instead of the long saphenous vein in a Trendelenburg procedure.

On his behalf the Society settled the claim for damages of £2,500 with £650 costs.

Delayed diagnosis of meningitis — bilateral deafness

A general practitioner in Northern Ireland, a member of the Society, was called at 1.00 a.m. to see a 14-year-old girl. Her parents stated that they told the doctor their daughter had convulsions and was hot and, further, that another member of the family was currently being treated for meningitis. The doctor examined the child though not for neck stiffness. He did not take the temperature with a thermometer and made a diagnosis of hysterical reaction, giving intravenous diazepam. He arranged for a re-visit that morning.

The repeat visit was carried out by another general practitioner, a member of a sister defence organisation. He agreed with the diagnosis of hysteria, noted "fits" and administered chlorpromazine.

The next day another visit was made by the first practitioner. He diagnosed meningitis and admitted the child to hospital. Meningococci were cultured from the cerebrospinal fluid and, with high doses of antibiotics and steroids, the patient made a good recovery except for the profound, bilateral, sensorineural deafness which she still has.

Both protection organisations considered this claim to be indefensible and it was settled for £200,000, of which the Society contributed 50% on behalf of the first practitioner.

Intrathecal penicillin

In last year's annual report (number 94, page 44) we reported the case of a child aged 2½ years whose pneumococcal meningitis was treated with intrathecal penicillin. By mistake the house officer injected 300,000 instead of 10,000 units intrathecally. The mistake was recognised immediately and remedial measures taken to control the convulsions. The child made a rapid recovery from the meningitis but became deaf. The parents brought legal proceedings, alleging that the deafness was due to the intrathecal penicillin overdose and the Society defended the claim on the grounds that the deafness was attributable to the pneumococcal meningitis and not to the intrathecal overdose. The judge at first instance decided that the deafness had been contributed to by the overdose and awarded damages of £102,000 but, as reported last year, this decision was reversed on appeal. The President of the appeal court was severely critical of the judgment, holding that it was quite indefensible and that it was *"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 . . ."*.

Members may be interested to know that a further appeal was made by the plaintiff to the House of Lords. In a unanimous decision in May 1987, the Law Lords dismissed the appeal, finding that the weight of the evidence was that the deafness was caused by the meningitis and that there was no causal connection between the deafness and the intrathecal overdose of penicillin. Members are, however, reminded once more of the need for care in the calculation of dose and administration of drugs given by the intrathecal route.

Advertising — 1

A member in Malaysia found himself before the local Medical Council following a complaint of advertising and canvassing. Upon the commencement of his practice he had distributed cards to members of the public which contained such information as his professional qualifications and his

place and hours of practice. He had modelled the cards on a card that he had received from a doctor friend in the United States of America. The member had also held a celebratory party at his home in conjunction with the commencement of the practice.

The member was assisted in the presentation of his case by an advocate provided by the Society. Following a hearing, the Medical Council found the member guilty of infamous conduct in distributing the cards and in holding the party. He was suspended for one month.

The case illustrates the point that the concept of infamous conduct may well vary from country to country and members should acquaint themselves with the local conditions and norms when setting up practice.

Advertising — 2

A member met a journalist friend whom he had not seen for several years since their days together in university. They had lunch together at the member's home and in the course of their conversation exchanged information about the developments in their respective careers since leaving university. The member brought out his scrapbook which he had maintained since his university days and which contained various newspaper and magazine clippings relating to his student activities and his professional career achievements.

The journalist was interested in the scrapbook as it related in part to a period when he was in the university. With the member's permission he took the scrapbook away to read at his leisure.

Later, the journalist telephoned the member saying that his current affairs magazine wanted to publish an article on the member as it would serve as an inspiration to rural children who shared the member's background to emulate the member's achievement. The member reluctantly agreed to an article touching on his student activities in which he had excelled in various aspects. He did not give permission for information relating to his practice and his professional career to be published. The member's wife agreed to an interview regarding her role as a wife and mother. The member also agreed to write for the magazine a regular column on health issues under a pseudonym.

Although a photographic session was undertaken in regard to the article on the member's wife, the journalist did not conduct any interview at all. One day, to the member's surprise, the journalist came to the member's house carrying an armful of copies of the magazine containing articles about the member and his wife. He had made liberal use of the contents of the scrapbook including photographs and excerpts from press reports. He had written a glowing account of the member's excellent record as a medical student and his extra-curricular activities in university as well as his medical career. He had mentioned details regarding the member's place and hours of practice and that the magazine will publish a medical column in which the member will answer reader's questions on medical matters. He had used a large amount of the information acquired in the course of his conversation with the member.

The articles clearly did promote the member's professional advantage and in the ensuing proceedings before the Medical Council, the crucial question appeared to be whether the publication of the materials had been authorised or sanctioned or acquiesced in by the member.

The Medical Council found the member guilty of infamous conduct in a professional respect in that:

1 he had supplied information to the journalist; and

2 the information related to his professional skills and knowledge and hence he had obtained an unfair professional advantage.

Doctors should be careful in their dealings with journalists. It may be permissible for a doctor to disclose information relating to his practice or career to a journalist on a social occasion, but where subsequently an article in the press is contemplated, the doctor should warn the journalist in clear and express terms not to publish such information. To avoid doubt, it would be preferable to give the warning in writing.

In the instant case, the member, knowing that his friend intended to publish an article about him based in part on the materials in the scrapbook, should have warned him not to touch on the member's professional career and practice and that he was not to use the information acquired informally in a social context.

There was some delay in the matter coming before the Medical Council and by then the journalist could not be found. It was clear that the journalist, too, had acted unwisely and the member alone could not be blamed for the publication of the offending material. In mitigation, counsel emphasised the member's excellent record of service to the community and the profession and the journalist's role

in the episode. In the result, the member received only a reprimand. The member was advised and assisted throughout his ordeal by legal counsel provided by the Society.

Inadequate cosmetic surgery and aftercare

A member practising as a surgical specialist overseas undertook to carry out an abdominal lipectomy and incidental repair of a ventral hernia. The operation was carried out apparently uneventfully and the patient discharged on the third post-operative day, though the patient later claimed that the skin sutures "looked inflamed" from the outset.

On the tenth day the sutures were removed and the wound gaped. Local treatment with Eusol to be applied by the patient was prescribed with the advice that "it will come right". This treatment failed, and the patient claimed she was then asked by the surgeon's receptionist to attend his consulting rooms for re-suture under local anaesthesia. She declined this advice and underwent remedial surgery elsewhere.

The Surgeons who revised the initial operations advised that the incision was too high and the umbilicus misplaced. A claim resulted. The allegations of negligence were denied by the member who also claimed that he offered hospital rather than outpatient re-suture. Expert opinions for the plaintiff were strongly supportive of her case. The papers and photographs were reviewed by a consultant plastic surgeon acting for the Society who concluded that the claim was indefensible. This advice led the Society to instruct its agents to negotiate a settlement which was finally effected in a sum equivalent to £2,300.

The Society has previously expressed concern that members have undertaken major plastic surgery without formal supervised training in this speciality and it deprecates such practice. (See page 11).

Consent; risks and warnings for cosmetic procedures

Judgment was given for the defendants, two consultant plastic surgeons (one deceased) in an action brought by a patient for damage sustained following a reduction mammaplasty. Prior to the matter reaching trial, allegations of negligence in respect of the performance of the operation itself had been pursued in addition to allegations of failure to warn the plaintiff of the risks of such an operation. The former allegations were dropped at trial. The Judge accepted the evidence of the defence that the patient had been advised in accordance with a responsible body of medical opinion at the time in question, both in terms of the nature of the operation and the scarring which would result and in terms of the possible complications which could arise, namely infection, bleeding and some loss of sensation. The surgeon's recollection was considerably better than the recollection of the patient and her husband as to what had been said, the surgeon stating that he gave fuller information than he usually did at that time. He denied that he would ever tell a patient that there would be no complications from such a procedure, particularly when a good result could not be guaranteed. The defence was assisted by a good, full set of hospital records which documented in detail her treatment and the resulting problems caused by infection.

Where it is recognised that a patient may be expecting superlative results from a procedure, which the surgeon cannot guarantee to provide, although a good result may be obtained, it is important to warn that patient of all the possible risks and complications arising from the procedure and making sure they understand them. At the same time it is important fully to document such discussions and the subsequent treatment. In the charged atmosphere of a court room, contemporaneous documentation generally carries more weight than imperfect, vague recollection after the passage of time. Express guarantees as to the success of surgery should never be given. Especial care is necessary in the field of plastic and cosmetic surgery in counselling the patient before consent is obtained.

Missed intra-ocular foreign body

The patient, a 48-year-old bakery worker, attended the accident and emergency department. Before he was seen by a doctor the following was recorded on his record card:— "working on car . . . oil splashed into R eye . . .? black spot noticed ?floaters".

He was seen by the registrar in ophthalomology, a member of the Society, who found a corneal abrasion and diagnosed chemical keratitis. A prescription for chloromycetin eye ointment was given and the patient was instructed to attend the following day. When he did so, vision in the affected eye had deteriorated markedly. There was corneal oedema and anterior chamber exudate. Eye x-ray films revealed a metallic foreign body.

The patient had no perception of light in the injured eye and the case was considered indefensible because the doctor had not obtained the clear history that the man had been beating a bearing with a hammer while working on a car. A settlement of £11,000 with £1,220 costs was agreed.

Late diagnosis of rectal carcinoma

A 60-year-old patient attended his general practitioner's surgery with a year's history of altered bowel habit. She was seen by the trainee who examined the patient's abdomen but did not perform a rectal examination. This consultation was recorded on a Lloyd George card and filed at the back of the A4 record. The patient was asked to re-attend for the rectal examination but did not do so.

Three months later the patient was reviewed by one of the partners. The trainee's notes were not referred to and the partner treated the patient on an *ad hoc* basis in view of his previous knowledge of this lady. She complained of weight loss though on this occasion she made no mention of bowel problems.

Over the next nine months there were six more consultations which included investigations of thyroid function because of the observed weight loss. At the end of this time, one year after the patient's initial presentation to the trainee, an abdominal mass and marked hepatomegaly were noted. An urgent referral to hospital established the diagnosis of rectal carcinoma with widespread liver metastases and the patient died eleven months later.

The trainee's note, being filed at the back of the A4 folder, was not seen until too late and the patient was not examined rectally or fully screened in view of the two stone weight loss. The claim was settled for £6,700 including plaintiff's costs.

Death from dehydration

A ten-month-old child was brought to a general practitioner member's evening surgery with diarrhoea and vomiting. The baby's mother alleged that the doctor failed to examine her son, not taking him out of his 'buggy' or removing his clothes. A prescription of Dioralyte was given, to replace milk and solid food for 24 hours.

The child's condition worsened overnight. He was brought again to the surgery the following evening where he died waiting to see the member's partner. A settlement of £3,000 with £1,200 costs was negotiated.

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.

General Practice Complaints — A look at both sides

by C A Owen BSc MPhil MBBS MRCGP
Member of Secretariat, Medical Protection Society

Introduction

It has long been common for the Society to receive written and telephone requests from general practitioner members for assistance with complaints. The numbers are large and growing. Over the past 3 years members of Secretariat have received about 2,000 written requests for help with general practitioners' complaints. These are usually complaints made by patients to Family Practitioner Committees and Health Boards about family doctors. In a small number of cases the patients have written letters of complaint direct to their general practitioners but the more common way for patients to complain is to write about their doctor to the appropriate Family Practitioner Committee or Health Board.

This article deals with arguably the two most important aspects of a complaint to the Family Practitioner Committee. First, the reasons why patients complain and second, the ways in which to construct a letter of reply to the complaint.

Why do patients complain about family doctors?

Through general practitioners being involved in complaints the Society sees many letters of complaint from all over the world. Small parts of just a handful of such letters, all written within the last year, are reproduced in *italics* throughout this article. The letters of complaint may be handwritten or typed; they may come from the patient, a friend or relative. Sometimes patients will seek professional help from a solicitor or Community Health Council official. Naturally, the styles of the patient's letters vary enormously, but they are surprisingly uniform in the underlying reasons for the dissatisfaction. Quite simply, patients complain because they feel the doctor has not responded in the way they wished, with sympathy and understanding.

1) Failure to visit

This is the commonest reason why patients complain about their family doctors. Indeed, it is the single complaint in around 25% of all cases notified to the Society. The doctor may not have visited because he felt that either the patient could have come to the surgery or, alternatively, that a consultation was not necessary at all.

> *"The doctor came on the phone and told me I had to take him to the surgery as he didn't make home visits."*

The doctor may have completely forgotten to visit. With increasing sizes of partnerships, there is sometimes confusion about who is supposed to be carrying out the visit, resulting in so long a delay that the patient goes off to casualty or calls an ambulance in the meantime.

> *"I was called in to their consulting room and both doctors informed me that my wife was in a very serious condition and should have been taken to hospital before and that their recommended treatment was an immediate brain scan. The result of this brain scan showed my wife to have a large tumour on the brain and recommendations were made for her to be transferred to another hospital. Further brain scans were taken there and the tumour was found to be malignant. Needless to say, my wife's condition was deteriorating all the time. On August 1st, my wife died.*
>
> *I want to stress that 4 doctors visited my wife on 7 occasions within a week and I had repeatedly pointed out that my wife was incapable of using the left side of her body and at no time was this ever considered, nor were any of my pleas for practical assistance for her answered."*

Sometimes the delays in visiting are such that the patient dies before the doctor arrives. Receptionists may give advice over the telephone and the visit request as such is not recorded in the practice message book. Sometimes the doctor cannot be contacted or has left a message on his telephone answering equipment that patients should be taken direct to casualty. Finally, the doctor may decide not to visit, preferring to give telephone advice.

"The doctor was very sharp with me and told me that he didn't think I was important enough for him to worry about, as he had enough to worry about without people like me bothering him with unimportant things.

Now I have to live with the thought that if he had come out when I asked him for his help I might have not lost my little baby, but because he didn't come out I will have to live with the torture of losing my dear little baby, when it could have be saved."

There may be good reasons why a visit was thought unnecessary or why there was a six hour delay. But one thing is clear; the FPC will view such complaints seriously. Better then to try to minimise the chances of a complaint being made in the first place. It is wise to ensure receptionists clearly understand the boundaries of their responsibilities.

"Sometime during the morning of 1st April my father 'phoned the doctor's surgery as he was unwell. He was told by the receptionist not to eat anything that day and ring tomorrow if he did not feel better. In the afternoon in desperation he 'phoned his neighbour. She went in to see him and was so worried she called in other neighbours who immediately decided my father needed treatment. They thankfully took it upon themselves and called for an ambulance. I understand he left for the hospital at about 4.30 p.m. and he died suddenly with his heart in the intensive care unit at 6.05 p.m.

I did not consider it right that medical advice was dispensed by a receptionist to an unknown patient and that surely the onus was with the receptionist to obtain a name and address especially with a practice dealing with a large proportion of aged people. I find it appalling that a receptionist is allowed to give medical advice over the telephone to an unknown patient. I fully realise my father was 89 and death could have occurred at any time. However, had a doctor responded to my father's 'phone call his life may have been prolonged and he most certainly would have been saved the distress and agitation during the day and also the necessity for a post mortem."

If you think the patient's condition does not require a visit and give telephone advice instead, try to ensure that the patient clearly understands the reasons and, particularly, how and when he should recontact you if he remains concerned. It is wise to make and keep a careful note of telephone calls and advice. Should the patient be unhappy with the telephone advice or should he ring again requesting a visit, bear in mind that a complaint is now a distinct possibility. If there is likely to be a significant delay before the visit can be made, try to give the patient an indication of this.

2) Failure to treat or incorrect treatment

About 20% of patients' complaints are because the patients feel that their family doctors have not given them the correct treatment or have offered no treatment at all.

a. *"When she saw the doctor the following day, he refused to give the injection and queried why she was taking the various tablets that he had prescribed. When my wife reminded him that he not only originally prescribed them, but gave her repeat prescriptions every month without further examinations, he told her do scissor jumps in the surgery. His further advice was to lay on her back each day (after doing 50 scissor jumps) and pray to Jesus.*

Not surprisingly, my wife passed out from the pain both in the surgery, and in the shopping precinct outside. After a weekend of extreme pain and two visits to the emergency dept., we arranged a visit to the consultant. Following a comprehensive examination and various x-rays, he diagnosed torn ligaments resulting from a slipped disc. He instructed her that she should take no exercise, wear a lumbar support jacket and continue to take the arthritis tablets.

I am extremely worried that her own family doctor could be so far out in his diagnosis and that he could suggest treatment that could only cause harm."

b. *"On 16th March I was suffering from a sickness virus. I am a diabetic so I rang the doctor on Wednesday night and was told not to do my insulin injections. The doctor did not come out.*

On Thursday I was still being very sick and my husband called the doctor out. When he arrived at lunchtime he gave me an injection to stop the sickness and gave me a prescription for some Rehidrat sachets, and still he insisted I must not do my insulin.

This treatment did not work. My husband rang for an ambulance and I was taken to hospital. I was put on a saline drip and an insulin pump, because I had dehydrated. I was also told that on no account should my GP have told me not to do my insulin because this could have been fatal.

I feel I would never have ended up in hospital if the doctor had not told me not to do my insulin. I was extremely ill. If he carries on telling diabetics not to do their insulin when they have sickness the next person might not be so lucky as I was."

3) Failure to refer or investigate

This is the sole source of dissatisfaction in about 15% of complaints against general practitioners. It is neither feasible nor desirable to refer or investigate all patients and part of the skill of general practice is knowing when to use these options. It is an important part of educating patients too. But if the patient is unhappy and indicates that he would like a second opinion there is much less likelihood of a complaint if you offer a referral gracefully rather than grudgingly. After all, a second opinion can only be beneficial: if you are wrong the patient will receive appropriate treatment but if you are right, your diagnosis will be confirmed and you should rise in the esteem of the patient.

"During the next few months the mark continued to grow and was causing constant concern but I had been reassured that "It is nothing to worry about", so obviously further visits were discouraged by the previous response to my complaint. However, concern over the leg forced me to return yet again. On this occasion I was once again assured that it was nothing. By this time my concern gave me the courage to ask for a referral to a specialist which I did. The doctor's response was "Well I can send you up there but he won't do anything".

On my visit to the consultant I was informed by him that the growth was malignant, and that further surgery was advisable. To say that my world crumbled around me would be an understatement. For months I had visited my doctor and was calmly informed "It is nothing to worry about". The mark had been growing all the time; I had commented on the fact that it irritated and that also it was causing concern.

I have now been subjected to surgery on two occasions and anxiety to an intolerable degree. Surely in medical terms this should not have occurred. Any doctor who has doubt has the facilities of the specialists to refer to; if there is no doubt then the doctor must be sure of his diagnosis."

4) Failure to admit

Approximately 10% of patients' complaints are for this reason. Sometimes the patient dies or, quite often, the family will telephone another doctor or take the patient to an accident and emergency department. Whether a complaint follows will often depend on the outcome. If the patient gets better at home as a result of your treatment there will probably be no complaint. But if the patient dies or is admitted via accident and emergency for an appendicectomy, a complaint about your alleged failure to admit is quite likely to follow.

"He went upstairs to look at my wife and demanded to know from her why she thought she was an emergency and should be treated as an emergency case. My wife was in no condition to give him any reply at all and with that the doctor stormed out of the house saying that he did not think that she was in any way to be treated as an emergency. His whole attitude and demeanour was such that I felt that my wife had been attended by a regimental sergeant major and not a doctor. No examination at all was carried out.

It is with sadness that I feel I have to write to you requesting that the whole case be investigated. I realise that the outcome may have been the same but I feel that my wife's problems could have been handled in a more dignified manner."

Very commonly a patient's motivation in complaining in such circumstances is to try to prevent the same thing happening to other people and, indeed, the letter of complaint will often say as much.

"I apologise this is such a lengthy letter and realise nothing can be done to erase our memories of the 18th of May. However, if this letter prevents someone else suffering in the hands of this doctor it will have been worthwhile."

The reply to the complaint

If the patient makes a written complaint about you to your Family Practitioner Committee and if the complaint discloses reasons for believing that you may have been in breach of your Terms of Service, then the FPC is bound to investigate the complaint. It is important to realise this. Once a formal complaint is lodged then provided it is within the specified time limit and concerns your Terms of Service, the FPC has a duty to investigate it and you will be required to reply to the complaint. The general practice complaints procedure is governed by a complex set of rules made by Parliament. The rules are currently the subject of review.

It is beyond the scope of this article to describe the actual complaints procedure and the Society publishes a booklet ***'General Practice Complaints Procedure'***, available to members on request, which summarises the procedure and offers advice.

Undoubtedly, the doctor's reply is of the greatest importance. Short of a Service Committee hearing, this is the only chance the doctor will get to put his or her point of view and respond to the complaint. When the FPC receives the doctor's written reply to the complaint, it is copied, usually unchanged, to the patient. Naturally, your letter of reply should be written with this in mind! Having read your reply to the complaint, the patient has a further 'bite of the cherry' and has the opportunity of commenting to the Administrator on the content of your reply. This usually completes the round of correspondence in the investigation of a formal complaint.

The Chairman of the Medical Service Committee will decide what happens next, following his perusal of the correspondence. If he or she is satisfied that the papers disclose no breach of your Terms of Service, the complaint may be dismissed. The patient has a right of appeal against this decision and complainants frequently exercise that right of appeal. Otherwise, the Chairman of the Medical Service Committee will order a Service Committee hearing.

There are three main reasons why a hearing is convened. First, the papers disclose a clear possibility that the practitioner might have been in breach of his Terms of Service. Second, there is a dispute of fact between the patient's complaint and the doctor's reply. Third, the doctor does not address the actual complaint in his reply.

The doctor's Terms of Service and especially Paragraph 13 are discussed on page 41 of this Report. Turning now to the second and third of these reasons, should there be a dispute as to fact between patients' and doctors' letters, the only way the matter can be resolved is to convene a hearing to test the evidence. Therefore, in your written reply to the complaint try, so far as is possible, to avoid disputing the patient's statements unless the fact is of importance. In situations where there is a dispute as to important facts (for example, the actual time of a telephone call; whether or not you listened to the patient's chest), the Service Committee may well incline to the complainant's version unless you can substantiate your account with notes of the consultations made at the time. This is understandable. For the complainant, contact with the doctor is a relatively infrequent occurrence whereas you see dozens of patients a day. Good, contemporaneous note-keeping is so important. If you have a note of the consultation and if you are able to support your reply with this, it will strengthen your hand appreciably.

It will also remove the possibility that, aside from the patient's complaint, you are found in breach of your Terms of Service for failure to keep adequate records of consultations, as you are required to do under paragraph 30 of the Terms of Service.

> *"On attempting to obtain clear dates of my visits from the doctor I was simply told that no record was made, except the last visit where I asked to be referred. I asked as to why no report of this growing mole-like shape* (malignant melanoma) *had been recorded down on my medical card to which she replied "I only make notes for these kinds of things if I consider it worthwhile, which in your case I didn't". Had I put my complete trust in this doctor who knows what the end result could have been?"*

Commonly, the substance of a complaint will centre around messages for visit requests etc. taken by a receptionist on your behalf.

> *"I 'phoned up the surgery to speak to the doctor and the receptionist said that I wouldn't be able to speak to him, so I told her it was very important and explained what the problem was. I told her I was about 10 or 11 weeks pregnant and that I had been losing blood and clots so she said that when the next patient had gone she would make sure and tell him to 'phone me back, but if he didn't think it was important he probably wouldn't bother to 'phone back."*

It is sound and sensible practise to ensure that your receptionists keep careful records showing patient attendances and non-attendances (whether to appointment or open surgery) and, additionally, patients' messages and requests for visits. It is important to include times in these entries. The appointments book and message book need to be faithfully maintained by receptionists (and doctors!) and we advise that when the books are full they are retained by the practice in case they be required for documentary evidence.

In writing your reply to the complaint it is helpful to begin by saying with whom the patient is registered in the practice and for how long the person has been registered. This flows fairly naturally into the next part of the letter which is a brief outline of the patient's past medical history. It is important, however, to be sure to keep this short, highlighting only the major aspects of the complainant's history and, as always, remembering that he or she will be sent a copy of your reply to read. You should then come to the main part of your reply which is your answer to the actual

complaint. The first thing to do is to read the letter of complaint so that you can be sure to address in your reply each aspect of the complaint. (This is obvious advice but it is surprising how often doctors fail to comment on all the various aspects of the complaint). The advice is the same as the maxim so often instilled into examination candidates; read the question! This part of your letter of reply therefore will be a concise, chronological account of your consultations with the patient for the period in question. You should give, for each consultation, your history, examination and management and try, so far as is possible, to answer the criticisms in the patient's letter of complaint.

Finally, a rounding paragraph to close your letter needs to summarise your view that you have not neglected the patient's care. It is good policy in this closing paragraph to offer a note of condolence or, as appropriate, an appreciation of the patient's suffering or inconvenience. This need not in any way be an admission of fault on your part. Sincerely expressed, it will be appreciated by the complainant, casting you in a good light as a considerate family doctor. Taken with a good explanation of your care of the patient, the letter may impress the complainant to the extent that he no longer wishes to pursue his complaint on reading your comments. Additionally, your letter should be such that it demonstrates clearly to the Chairman of the Medical Service Committee that you could not be considered to be in breach of your Terms of Service.

The importance of taking care to write a good letter of reply to a complaint cannot be over-emphasised. Family Practitioner complaints should always be taken seriously; at the very least they are distressing for the practitioner and his family and at worst they can be the subject of an enquiry by the General Medical Council.

> *"As to the vigour with which I shall now pursue this matter, let me ask you whether you would be happy with one of your own loved ones in this man's care."*

The key is your letter of reply to the complaint and the aim is to stop the complaint at this stage, either by the patient being satisfied and withdrawing the complaint or by the Service Committee Chairman seeing that there can be no breach of your Terms of Service and dismissing the complaint. The further a complaint proceeds beyond this stage the greater is the cost to you in terms of time, stress and, possibly, embarrassment.

> *"I stopped him at this point and told him we had not come to be insulted but to be treated. He was still abusive and I repeated that we had come for treatment and not abuse. He still carried on so we left his room and went back to reception where I asked to see another doctor. I waited a few minutes and then the first doctor came out and asked me back to his room. This I did and when I got there he said, "I am going to tell you this once only, so listen. I am going to treat your wife this time, then you will receive a letter telling you to change to another practice". I told him if that's how he felt not to bother because he's not much of a doctor. He said he would still give my wife a prescription which he started to write then stopped. He became abusive again at which point I had a row with him. He then said he hoped to meet me out in the street one day at which I said come out now, but he declined. We got up to leave and the doctor tore up the prescription. I said "The trouble with you Doctor, is you have a big mouth and head". He then punched me in the face and tried to kick me. I hit him back and we had a small fight in the surgery which stopped when I got him in a headlock and told him to pack it in or he would get hurt. He said okay, at which point I left and went to the Police Station."*

The above paragraphs offer a skeleton for the construction of your reply to an FPC complaint. Try not to be late in submitting your reply to the FPC. You are usually required to submit your comments on the complaint within 28 days of receiving notice of it from the FPC. Naturally, if you are away from the practice or ill the FPC will understand this. If there is likely to be any delay in your reply to the complaint, you should acknowledge the FPC letter, explain the reasons for the delay and tell the FPC Administrator that your written reply to the complaint will follow as soon as possible. In general though, you should take care to get your reply back to the Administrator in time. If, as is so often the case, the substance of the complaint is about a delay in visiting or a delay in arranging a referral, it does you no good at all to be needlessly late in replying to the complaint!

Try if at all possible to have your reply typed and ensure it is free of factual and spelling errors. Carefully check consultation dates to make sure they are accurate. If you are asked to appear before a Service Committee at a hearing it will be your aim to convince the Committee that your version of events is correct and does not disclose reasons for your being considered to be in breach of your Terms of Service. It is a shaky start to have to admit to factual inaccuracies in your letter. Tact and courtesy should require that you do not mis-spell the patient's name.

Do not write your reply to the FPC Administrator on paper from a drug-house note pad; it looks careless and the manufacturers would probably not wish to be promoted in this way. Always keep a copy of your reply for future reference. Try to resist making disparaging remarks about the patient

because it is hardly a professional way of responding. The patient will read them and, in any case, your letter will be scrutinised by the Medical Service Committee and Family Practitioner Committee and might be seen by the Department of Health and Social Security, General Medical Council and even a High Court Judge. Finally, if you quote other doctors such as hospital colleagues in your reply, it would be courteous for you to ask their permission beforehand. Remember that if you disclose hospital letters and other documents they will be read by the complainant and Family Practitioner Committee.

The Society receives many requests from members for assistance in connection with complaints made to Family Practitioner Committees and Health Boards. The Secretariat staff are pleased to help by explaining the procedures and by reading the complaint and advising and assisting the member with his reply. Also, your Local Medical Committee Secretary may be a most valuable source of advice and assistance and well worth consulting.

Terms of Service — a closer look

by C A Owen BSc MPhil MBBS MRCGP
Member of Secretariat, Medical Protection Society

Ignorance of the law is no defence

It is not intended here to give a complete guide to general practitioners' Terms of Service. General practitioners providing general medical services under the NHS are presumed to know their Terms of Service and there is no substitute for a careful, detailed reading of the Terms of Service which are set out in the first schedule to the National Health Service (General Medical and Pharmaceutical Services) Regulations 1974. This is a Statutory Instrument (S.I. 1974 no. 160) available from Her Majesty's Stationery Office. It relates to England and Wales only. Different regulations apply in Scotland and Northern Ireland. This article highlights some aspects of the Terms of Service with which doctors commonly encounter difficulties.

Responsibilities of deputies, locums, trainees and principals

Under civil law a doctor is responsible for his own tortious acts and omissions, whatever his status in the practice. In other words, if a patient wishes to bring a civil action alleging negligence then he may do so against any of the above categories of practitioner. If the defendant practitioner were a locum or trainee, then the action need not necessarily involve the principal.

However, in relation to his contractual obligations under his Terms of Service the situation is different. Let us imagine that the patient, rather than pursuing a civil action, brings a complaint against his doctor. For a complaint to be investigated by the Family Practitioner Committee the doctor must be a principal on the FPC list or, if not, must agree to be a party to the complaint. If the complaint involves a deputy whose name is on the FPC list the complaint is deemed to be made against both doctors (i.e. the patient's own doctor and the deputy). If the doctor complained of is not on the FPC list (e.g. some salaried partners, trainees, deputising service doctors etc.) then the complaint is deemed to be made against the principal on whose list the patient's name is to be found.

The General Medical Council may be involved following a civil action or complaint as both may raise the question of serious professional misconduct ("Professional Conduct and Discipline: Fitness to Practise", GMC, April 1987, para. 38).

Members are reminded that they have a responsibility to inform their Family Practitioner Committee of any standing deputising arrangements, unless the deputy is an assistant of the doctor or is a doctor included on the medical list of the FPC.

Removing patients from your list

You may remove any patient from your list by asking the Family Practitioner Committee to do this. The removal takes effect on the date of acceptance by, or assignment to, another doctor or on the 8th day after the Committee is notified of your wish, whichever first occurs. However, if at the date when removal would take effect, you are treating the patient at intervals of less than seven days, the situation is slightly different. Under these circumstances the removal shall take effect on the 8th day after you notify the Committee that the treatment has finished or, alternatively, upon acceptance of the patient by another doctor, whichever first occurs. So far as temporary residents are concerned the same considerations apply.

Service to patients

Paragraph 13 of the Terms of Service for doctors is in some respects the most important of all. If a patient complains about you and this results in an FPC investigation, the Committee will almost certainly consider the complaint in the light of paragraph 13. Because complaints by patients are becoming increasingly common this paragraph of your Terms of Service is the one under which your acts and omissions are most likely to be evaluated. We make no apology for reproducing it here in full.

> *"13. Subject to paragraph 3, a doctor shall render to his patients all necessary and appropriate personal medical services of the type usually provided by general medical practitioners. He shall do so at his practice premises or, if the condition of the patient so requires, elsewhere in his practice area or at the place where the patient was residing when accepted by the doctor, or, if a patient was on the list of a practice declared vacant, when the doctor succeeded to the vacancy, or at some other place where the doctor has agreed to visit and treat him if the patient's condition so requires, and has informed the patient and the Committee accordingly. The doctor shall not be required to visit and treat the patient at any other place. Such services include arrangements for referring patients as necessary to any other services provided under the Health Service Acts and advice to enable them to take advantage of the local authority social services. Except in an emergency, this paragraph shall not impose an obligation on the doctor to provide maternity medical services unless he has undertaken to do so."*
>
> *"3. Where a decision whether any, and if so what, action is to be taken under these terms of service requires the exercise of professional judgement, a doctor shall in reaching that decision not be expected to exercise a higher degree of skill, knowledge and care than general practitioners as a class may reasonably be expected to exercise."*

As explained elsewhere in the Report (p.36), failure to visit is the commonest complaint made by patients about their general practitioners. It is important to understand that paragraph 13 of the Terms of Service does not require you automatically to visit patients on demand. But, if you decline to visit and a complaint is later made, you will be expected to demonstrate that, at the time of the visit request, you put yourself in a position to make an adequate assessment of the patient. If you have done this over the telephone and made a note of it, well and good. The patient may still complain about you but if your telephone assessment has been appropriate and your decision to offer an alternative to a visit reasonable, you may be considered not to have been in breach of paragraph 13. Whether the patient actually requested a visit is not relevant to this consideration. The question is whether "the patient's condition so requires" a visit. Do be cautious; the safest way to assess patients is to see them. Visit first and argue later!

Changing your appointments

A doctor who intends to set up an appointments system or who wishes to alter an existing appointments system is required to give prior notice to his Family Practitioner Committee. Even with an appointments system you must make provision to see patients whose condition requires it e.g. urgent cases which may be fitted in as "extras".

Records

Your Terms of Service require you to keep adequate records of your patient's illnesses and treatment. The Society has long urged members to make good, contemporaneous notes; apart from the obvious advantages to patient care, the defence of a complaint or claim may often hinge on the adequacy of the notes. Surprisingly, record keeping is hardly ever itself the object of a patient complaint to the FPC but when the Committee investigates complaints made for other reasons, the relevant clinical records frequently come under scrutiny. Moreover it is common in Service Committee reports of investigated complaints to see criticism of the doctor's standard of note-making and a finding of no breach of paragraph 13 may be spoiled by finding a breach of paragraph 30 (which requires that notes be kept).

Fees and Certification

Under Paragraphs 32 to 34 of the Terms of Service, the basic rule is that a GP providing general medical services to an NHS patient must not demand or accept a fee or any other remuneration for any treatment provided unless the fee in question falls into one of the specified categories set out in the Terms of Service. As well as being a breach of Terms of Service, improper fee charging may result in criminal proceedings. This applies equally to the claiming of fees from the Family Practitioner Committee; in our experience claims for night visits, provision of contraceptive services and post-natal visits are the ones which are most commonly made inappropriately and it is most

important that members making such claims are not only aware of the precise terms of the relevant paragraphs of the Statement of Fees and Allowances, but also ensure that their administrative system enables them to justify such claims should they be subjected to scrutiny.

You are required to issue to your patients free of charge the certificates prescribed in Schedule 3 to the Regulations. Broadly speaking, such certificates relate to work incapacity, proxy pensions, establishment of pregnancy, registration of still births, unfitness for jury service and registration as an absent voter. This obligation to issue schedule 3 certificates free of charge relates essentially only to your practice patients. If you charge a fee for a schedule 3 certificate you are liable to prosecution.

Prescribing

Paragraph 36 of the Terms of Service requires that the practitioner shall himself sign the prescription form in ink with initials, or forenames, and surname in his own handwriting and not by means of a stamp, and shall so sign only after particulars of the order have been inserted in the prescription form. The use of blank, pre-signed prescription forms is still, unwisely, practised by a few doctors; like signed, blank cheques they are always to be eschewed. It is a serious breach of the Terms of Service and may lead also to charges of serious professional misconduct by the General Medical Council.

Again, the Terms of Service require that you use a separate form for each patient except where you are prescribing in bulk for a school or institution. Tempting though it is, for example, it may be a breach of your Terms of Service to treat for scabies the whole family on one prescription form in the name of one of the children.

These are some of the common areas of difficulty in which members of the Society ask for advice or find themselves in conflict. We advise general practitioners to read the Terms of Service carefully and, as always, to ask the advice of the Society if there are any areas of interpretation which present difficulties.

Cases from general practice

Practice nurse breaches confidentiality

All members of the general practice team are privy to confidential information. Some months ago a general practitioner member telephoned the Society for advice about a serious breach of confidentiality involving his practice nurse.

The member's patient, a mother of three, had been forced to have sex by her estranged husband. A fourth pregnancy resulted. The member agreed to the woman's request for a termination of pregnancy and made the necessary referral arrangements. The practice nurse was aware of the situation and, astonishingly, chose to discuss it with her husband and the patient's father when the three met socially at the local Conservative Club.

The patient complained to her general practitioner, directly rather than to his Family Practitioner Committee. The Society assisted with advice about two letters of apology, one from the practice nurse and one from the member, which were sent to the complainant. Clearly, it was also necessary for the nurse to be counselled. Fortunately, the patient accepted the apologies.

Members' attention is drawn to the guidance given by the General Medical Council in its "blue booklet" 'Professional Conduct and Discipline: Fitness to Practise' (paragraph 81(b), April 1987).

> *"To the extent that the doctor deems it necessary for the performance of their particular duties, confidential information may also be shared with other persons (nursing and other care professionals) who are assisting and collaborating with the doctor in his professional relationship with the patient. It is the doctor's responsibility to ensure that such individuals appreciate that the information is being imparted in strict professional confidence."*

Controlled drugs registers

From time to time the Society is asked to give advice on a general practitioner's responsibility to maintain a register for his controlled drugs. The regulations relating to controlled drugs are contained in Statutory Instrument 1985 no. 2066 available from Her Majesty's Stationery Office. These regulations specify in Schedules some 160 substances and products. The Statutory Instrument is fairly

detailed and gives advice not only on the keeping of registers but also on the requirements for prescriptions of controlled drugs and destruction of the drugs. The Society is pleased to help with members' specific queries relating to controlled drugs. Previously, guidance about controlled drugs regulations was given in the 1985 Annual Report (no. 93, p.54).

"What sort of a record do I have to keep?": A practitioner is required to keep a register, which must be in the form of a bound book, in which he enters particulars of every quantity of a controlled drug obtained and supplied by him. He should make the entry on the day in which the transaction takes place. The entry must be in ink and no obliteration or alteration is permitted; corrections should be made by way of marginal notes or footnotes countersigned and dated. A separate register must be kept for each of the premises at which the practitioner works and the register must be kept on the premises to which it relates. Finally, registers must be preserved for a period of two years from the date on which the last entry was made and the practitioner must be prepared to produce them for inspection to persons acting with the authorisation of the Secretary of State.

Member sentenced to 6 months imprisonment for improper signing of passport photographs

A general practitioner member of 30 years' standing contacted the Society stating that he had been arrested at his home, taken to his local Police Station and charged with conspiracy to obtain British passports by deception. He was asked by the police to give a statement. At the Magistrates' Court committal proceedings, eleven charges were brought under Section 36 of the Criminal Justice Act 1925. The allegations were that the member had not known the passport applicants for the requisite period of time or had not seen them at all before signing documents which enabled the applicants to obtain British passports.

In the later trial at the Central Criminal Court the member was found guilty and sentenced to 6 months imprisonment.

There followed a referral to the General Medical Council. The matter was considered by the Professional Conduct Committee. Fortunately, the Committee only admonished the doctor. The determination of the Professsional Conduct Committee was as follows:—

> *"By law, doctors' signatures are required, or accepted, on certificates of various kinds on the presumption that the public can trust in the truth of any statement which a doctor has certified. The Committee take a serious view of the offences of which you are convicted because they show that you have been prepared, on payment of fees, to abuse that trust in a cynical and irresponsible manner.*
>
> *The Committee have felt bound to consider whether your conviction would justify a direction to the Registrar to suspend your registration to erase your name from the Register. However, the Committee have also felt able to take account of the custodial sentence imposed by the court, the representations made on your behalf, your expressions of regret, the assurances given as to your future conduct and your lengthy and previously unblemished career.*
>
> *They have accordingly determined on this occasion to admonish you in the strongest terms and to conclude the case. In thus concluding your case, however, they wish me to emphasise that, if you should ever appear before them on another occasion to face a charge of similar gravity you should not expect to be treated so leniently again."*

Advice on the importance of properly countersigning passport application forms has been given in previous Annual Reports (No. 91, 1983 and No. 94, 1986).

The Work of the Society's Solicitors in England and Wales

Readers paying their subscriptions to the Society rightly expect value for money and the purpose of this article is to explain some of the behind-the-scenes work which provides members with advice. The Society's solicitors in London, Le Brasseur and Bury, handle the Society's work in England and Wales and have extensive connections with the Society's lawyers in many other countries. The firm has acted for the Society almost since the Society's foundation in 1892. The Society itself has a professional secretariat working closely with the solicitors where members require legal advice.

The Society maintains a network of legal advisers throughout the world (except the USA and Canada) and it is through this network that members receive legal advice. It is part of the Society's particular style of working for the professional secretariat to remain closely involved in a case throughout, since it is the Society's belief that the member receives the best possible help through the combined efforts of secretariat working with the solicitors. Cases referred to the Society can range from the telephone enquiry from a member which needs but brief research and advice, through to the major hospital enquiry, criminal defence or negligence claim which spans several years and involves hundreds of hours of work by a team.

What kind of work do the solicitors do? No two days are the same and the occasion when one sits down to anticipated calm paperwork is the day which brings the unexpected emergency. As most readers know, solicitors in the United Kingdom work mainly on advice and preparation of cases while advocacy is handled generally by barristers who are specialist advocates. There is much overlap and the Society's solicitors frequently undertake advocacy, especially in the many specialised Health Service Tribunals at which members of the Society have to appear. On a typical day, perhaps only a minority of the solicitors will be at their desks. We find a senior solicitor in the High Court with counsel defending a negligence action against a consultant gynaecologist who is being sued for damages following an unwanted pregnancy after a failed sterilisation. Another solicitor is at a Coroner's Court, assisting an accident and emergency senior house officer who had a part in the care of a drunken patient admitted with head injuries but who had also an insidiously-presenting subdural haematoma which unfortunately progressed to a fatal stage before diagnosis and treatment. Another solicitor is at the Society's Regional Office in Leeds where a number of members based in northern England are booked to see the solicitor in the management of their cases.

This example day happens also to be one of those on which the Society's Cases Committee has a regular meeting, when one or two senior solicitors attend the London offices to advise the Committee on legal aspects of their decisions on defensibility of claims. For example, where the expert reports on defensibility are evenly balanced, the Committee will wish to be advised of the consequences for the member if they decide to defend the action to trial. Would a settlement compromise the member's professional reputation? Or would it be prudent to settle if, at the end of a trial, a negligence finding were to be made against the member in open court with consequent publicity? Clear advice must be given to the specialists on the Committee.

Another solicitor has travelled to interview a member who is held in custody in prison after being charged with serious offences under the Misuse of Drugs Act involving forgery of prescriptions and obtaining pethidine for self administration. The member is clearly ill and instructions must be obtained to arrange psychiatric examination. A detailed statement has to be taken dealing, not only with the member's addiction, but also with his underlying problems, with the collapse of his practice and with the near-collapse of his family life. Preparations for defence in the Magistrates and Crown Courts have to be made. Medical examinations have to be arranged. An 'eye has to be kept' on the reference of this practitioner to the General Medical Council Health Committee.

Another solicitor is in the office preparing papers for submission to leading counsel for a conference which is to take place two weeks hence with a consultant anaesthetist and a consultant colleague, acting as independent expert, to consider defensibility of a claim for damages made on behalf of a patient who has suffered grave brain damage in an operating theatre mishap following a cardiac arrest. But preparation of this case is interrupted by a telephone call from a member of the Society's secretariat after a member in the Middle East has telephoned the Society. A patient has died following post-operative haemorrhage but, owing to local customs and procedures, there was fatal delay by the hospital in obtaining blood. There are problems in assisting members practising in some parts of the world where legal systems, customs and social attitudes are very different from those in the United Kingdom. The doctor's passport has been impounded and he has been suspended from employment. A telephone call is made immediately and instructions sent by facsimile transmission to the Society's local legal agents who will see and counsel the member and conduct the defence. Within

quite a short time of a telephone call to London for help, the member has been put in direct contact with a local lawyer who will advise and assist him.

Another solicitor has travelled to the north of England the previous night to be ready to represent a dental member at an appeal to the Secretary of State for Social Services against a finding of breach of terms of service after supply of allegedly inadequate crown and bridge work. Travelling with the solicitor is one of the Society's dental experts, who has examined the offending prosthesis and will give expert opinion to the appeal committee appointed by the Secretary of State to hear the appeal.

At other times of the year a substantial number of Le Brasseur and Bury's team are engaged in defending members who have been referred to the Professional Conduct or Health Committees of the General Medical and Dental Councils. These cases require substantial enquiries involving interviewing the members themselves, witnesses, obtaining medical reports and arranging character evidence. These, more than other cases, emphasise the vulnerability of practitioners and it is always a matter of great concern that the worst outcome for a member can be erasure from the professional register. Counselling the practitioner whose name has just been erased or suspended from the professional register is one of the desolate moments of professional experience.

Younger members of the firm of solicitors are frequently involved in travelling long distances at short notice, to represent members in Coroners and Magistrates Courts. Frequently, they see members at unsocial hours, to be ready to appear at a hearing the following day. The member may be in a state of some distress where, for example, a junior hospital practitioner has been dismissed following an alleged offence and has been suspended from duty. Much of the work done by the Society's solicitors for members is 'low key'. Indeed, while the major damages claims which go to trial attract headlines, these are only a tiny proportion of overall cases. The majority of claims made against members are either resisted successfully in correspondence, or the Society's Cases Committee decides that they cannot be successfully defended and settlement is negotiated. A large and unseen segment of legal work for the Society involves commissioning reports on condition, obtaining details from plaintiffs and other claimants' solicitors of expenses incurred, for example in connection with remedial treatment, and negotiating settlements. A key part of case preparation involves members faced with claims being interviewed by a solicitor jointly with a member of the professional secretariat and very often too with a member of the Cases Committee or another expert in the relevant speciality. This may seem a labour-intensive way of analysing a claim, but in fact it enables an early and accurate assessment to be made of the possibilities of successful defence.

The work we have just described involves representation of members who are faced with claims or professional conduct allegations, or in some way are involved in the judicial process. As readers know, one of the benefits of membership of the Society is that they can refer any practice-related question to the Society for advice. Provision of this service by the Society's professional secretariat occupies a large amount of their time and those enquiries with a legal element are referred to Le Brasseur & Bury. In turn provision of an accurate service is an unspectacular but time-consuming and important part of the service given.

Employment and disciplinary cases

Re-engagement ordered by Industrial Tribunal

The Society assisted a locum associate specialist in an application to the Industrial Tribunal for unfair dismissal by his employing Health Authority. The member had been dismissed after investigations into the manner in which he made claims for extra duty allowances, the implication being that the member had been fraudulent. After an unsuccessful internal appeal to the Health Authority, application was made to the Industrial Tribunal. This held that, although the Health Authority had very good grounds for serious suspicions, the manner in which they had conducted the investigation and disciplinary proceedings was such that it was not reasonable in all the circumstances for them to have believed that the doctor's actions resulted from deliberate fraud. The Tribunal criticised the Health Authority for having assumed from the beginning that incorrect completion of the forms indicated a fraudulent over-claim *per se* when in fact further consideration of the form should have caused the Authority to take into account the possibility that the instructions on the form were open to misinterpretation and that the over-claims could have arisen through genuine error. The Authority was also criticised for not having involved the member's consultant in the disciplinary proceedings.

As the Authority had not given the member the benefit of the doubt in the disciplinary investigation, the Industrial Tribunal unanimously decided that the member had been unfairly dismissed and ordered arrears of pay and re-engagement with the title of locum associate specialist or locum senior

registrar. Orders for re-engagement are very seldom made by the Tribunals. The Authority did not obey this order. Compensation was awarded.

Fairness of hospital internal disciplinary proceedings

A clinical assistant, who was remunerated on the basis of 11 sessions per week to cover extensive on-call duties contrary to the spirit of the "clinical assistant" grade, was dismissed for failure to carry out on-call duties over a weekend period. Following an appeal hearing at which both sides were represented by counsel, the member was reinstated, the appeal committee deciding by a majority to substitute a reprimand and formal warning for the dismissal. The committee found that the member had failed to carry out his on-call duties on the weekend concerned; however, events prior to that weekend had demonstrated differences of understanding of his contract of employment. As a result, reliance by management on breach of the contract as a basis of dismissal was put in doubt. Underlying circumstances must always be considered before an employer is able justifiably to impose a penalty as severe as dismissal. The "punishment must always fit the crime".

The Ambit of Paragraph 190 of the hospital "Red Book"

The Secretary of State for Health and Social Services has ruled in two cases that he has no jurisdiction to entertain representations against dismissal made under Paragraph 190 of the Hospital Medical and Dental Staff (England and Wales) Terms and Conditions of Service on behalf of doctors who have been summarily dismissed, i.e. without notice and without payment in lieu of notice by their employing Health Authority. In one case the representations were put in before the doctor was dismissed, in the other case immediately following the dismissal. This means that representations cannot be made during the period of suspension as suspension is not a final decision, is not supposed to impute blame, and does not necessarily lead to dismissal. The consequence of this decision is that a practitioner in a senior hospital grade against whom serious allegations may have been made is not able to take advantage of this possible route of appeal, although of course the dismissed employee is free to pursue any remedy he may have for wrongful dismissal in the Courts or for unfair dismissal in the Industrial Tribunals. In both cases dismissal was for allegedly gross misconduct. It is understood that three cases of summary dismissal are awaiting a decision by the High Court, to ascertain whether or not the Secretary of State is obliged to entertain appeals against summary dismissals.

Right to legal representation in disciplinary proceedings

The Society assisted an ophthalmic medical practitioner who had been suspended from attendance at medical eye centres four days a week to examine the eyes of customers of dispensing opticians. This action was taken by the Medical Eye Centre Association in response to complaints about his professional conduct. He was notified that the Council of the Association intended to invoke a procedure outlined in Article 8 of the Association's Articles of Association against him. That provided for an investigation into whether the member had conducted himself in a manner unbecoming to an ophthalmic medical practitioner and, if so, whether the Council should order that his name be removed from the Register of the Association. The member was informed that the procedure was within the discretion of the Council, that the meeting would be in private, that he could attend if he wished, but that legal representation would not be permitted. In addition, the actual charges and procedures the Association intended to follow were not particularised.

Proceedings were taken on the member's behalf to obtain an *ex-parte* injunction to restrain the Association from committing breaches of their contract with him by purporting to invoke against him a procedure which was in breach of the rules of natural justice. The Association then provided particulars of the charges against the member and the procedure to be followed. Although the Association agreed to permit the member to be assisted at the hearing by a "friend" it rejected a request for legal representation.

In a High Court judgment it was held that, as Article 8 was silent on the question of legal representation, it was impossible to over-rule the private rules of the Association by holding that the member was entitled to legal representation. The action was therefore dismissed. However, an appeal was made to the Court of Appeal which held that natural justice did require that the member should be legally represented. Where there was a discretion invested in a domestic tribunal to allow legal representation, it was considered to be probably a duty to allow representation where the allegations amounted to or could amount to serious professional misconduct. The appeal was therefore allowed with costs.

Far-reaching conditions imposed by General Medical Council

In 1986, the Professional Conduct Committee of the General Medical Council imposed far-reaching conditions on the registration of a single-handed general medical practitioner who admitted having

issued prescriptions for large quantities of controlled drugs and euphoriants over a period of some 10 years which were diverted for use by his wife and not for the *bona fide* treatment of his National Health Service patients. The doctor was found guilty of serious professional misconduct. Conditions were imposed upon his registration preventing him from prescribing or possessing not only any controlled drugs but also any other prescription-only medicines for a period of three years.

An appeal against sentence was made to the Judicial Committee of the Privy Council on the grounds that the conditions went far wider than were necessary for the protection of the member's wife, and that the effect of the conditions would be to prevent the member from carrying on the practice of a general practitioner as he would be unable to prescribe, *inter alia,* antibiotics. Their Lordships, and indeed the General Medical Council, agreed that the conditions would have the effect of making it impossible for the member to carry on general practice, however they considered that the conditions did not equate with a three year suspension, which was a much more serious penalty. The conditions were considered to be appropriate in that the member had displayed gross irresponsibility in making available to his wife, at public expense, an illegitimate supply of addictive drugs over a very lengthy period. In addition the member had continued to prescribe an addictive, although not controlled, drug to his wife right up to the time of the original hearing before the Professional Conduct Committee, notwithstanding written assurances he had given to the contrary.

Their Lordships accepted that the member had no right to require a resumed hearing of his case before the General Medical Council for the purpose of considering revocation or variation of the conditions; however they considered that if he were to request a resumed hearing the President would "be bound to consider that request and would have power, if he thought fit, to convene a resumed hearing." Their Lordships indicated that they could see no reason to suppose that the Professional Conduct Committee, whose membership included very experienced medical practitioners, did not fully appreciate the consequences of the sentence which they had decided to impose. The sentence was not held to be wrong and unjustified and the appeal was dismissed.

The Judicial Committee of the Privy Council hardly ever interferes with a penalty imposed by the Professional Conduct Committee of the General Medical Council; there has only been one successful appeal against sentence in the last 20 years, and that was a case immediately following a change of the Rules of the General Medical Council Professional Conduct Committee which provided a wider variety of penalties at the disposal of the Committee, one of which was substituted for the earlier decision to erase the name of the practitioner.

Action for harassment

A member, a general practitioner, approached the Society when he found himself the target of the unwanted attentions of an ex-patient. She wrote voluminous letters which, after the doctor rejected her approaches, became increasingly offensive and threatening. She frequently followed the doctor around the town where he both lived and practised. The doctor was unable to attend his surgery or simply go to the shops or out on social visits without fear of being harassed by the lady. In order to avoid her frequent telephone calls, the doctor had his telephone number changed and became ex-directory. The unrelenting lady attempted to bribe British Telecom employees in order to obtain the doctor's telephone number.

The Police, as is often the case in these circumstances, were reluctant to prosecute the lady without some evidence of physical violence. As a last resort the Society's solicitors issued proceedings in the High Court and an Injunction was granted, restraining the lady from interfering with the doctor. Unfortunately this did not deter the lady who continued to threaten, correspond with and follow the doctor. After eight months of constant harassment the member became agitated and anxious and his professional life suffered. The Society's solicitors therefore made an application to commit the lady to prison. After two adjournments and a hearing which lasted four days, she was finally committed to prison for a term of three months.

This case highlights the difficulties involved in conducting litigation such as this. Counsel's fees totalled just over £3,000 and other disbursements, including enquiry agents and handwriting expert's fees, were in excess of £1,000. The preparation of the case required numerous lengthy discussions between the member and the Society's solicitors. Although an order for costs was granted against the lady, the usual difficulties will apply in enforcing the order against her as she was legally aided.

The Importance of Good Communication

by M Grace BDS (Lond)
General Dental Practitioner, London

It is well recognised that most of the difficulties that end up in court could have been avoided if the two parties had communicated a little more and a little better before it became too late. Not only could the improved communication have resulted in a settlement before the costly and unpleasant procedure of going to court, but it is likely that the disagreement would never have occurred in the first place.

A patient requests full dentures from her dentist. In her mind the dentures will change her appearance, her attitude to life and her eating habits. In short, she is expecting a miracle. If the reality of the situation is not communicated to her at the outset she may blame her eventual disappointment either on the dentures themselves or the dentist providing them.

In either case she may decide to complain, to withhold payment, or to make a nuisance of herself. Whether or not the case ends up in the hands of solicitors, the dentist will still have aggravation, worry and unnecessary paperwork, all of which could have been avoided if the situation had been better explained at the outset.

Often it is the lack of appreciation by the dentist for the feelings, concerns and worries of the patient that is the real problem. A patient who has been told to expect pain and what to do if it occurs will be able to endure quite severe suffering. Patients who are told nothing about possible after effects will become concerned and be more likely to worry the doctor or dentist, and become angry if their concern is ignored or trivialised.

The disgruntled patient will often seek legal action because of a failure in communication by the doctor, dentist or nurse. In the example of the patient who complained about her dentures, she is more likely to become aggrieved if she is sent away without any attempt being made to listen to her problem by the dentist or staff. Someone with toothache who is treated discourteously on the telephone is more likely to be upset than if she received sympathy and understanding.

Yet, despite this fact, people continue to fail to communicate every day. Sometimes this is due to pressure of work, sometimes to an understandable clash of personalities, but most often because the health operator is unaware of some of the simple basic skills involved.

Why should this be? One of the main reasons is the lack of emphasis given to communication by the teaching profession in the schools and by many teachers in the medical and dental universities. In the few situations where the subject is taught at all, it is relegated to a minor position and receives a minimal allocation of time.

What does communication involve?

Communication is a skill. Like all skills it cannot be learned only by reading about it or listening to a lecture. Imagine trying to learn to drive a car by simply reading a book and you have some idea of the problem. As with all skills, knowledge of the subject is also required. This short article is intended to act as a framework upon which further knowledge and experience can be built.

At its simplest, communication is a two-way process involving a sender and a receiver. Obviously, for communication to occur some form of information must be passed from one person to the other. In the case of dentistry and medicine this information will often be the patient's history, the clinician's diagnosis and prognosis and any special instructions or advice during treatment.

The sender may be passing information but **communication will not occur unless the receiver is actually receiving and understanding the information.** All too often patients are unable or unwilling to admit they do not understand, and thus communication is failing even though to an observer everything might seem to be all right.

Thus there are three basic points:
1 the information must be sent
2 the information must be received
3 the information must be understood.

Let us consider what each one means in the clinical environment.

1 The information must be sent

Information is usually given to people through language, often spoken and occasionally written (in the form of pamphlets and handouts). We use words to transmit what we wish to say.

Obviously the actual words play an important role but the **meaning may be obscured by use of jargon.** An example would be the confusion caused by telling patients that you wished to measure their pockets, or estimate their bone loss. One lady became extremely concerned at the offhand way that her dentist advised her she had several 'leaky' fillings and then proceeded to ignore them. The patient imagined the dentist meant that mercury was leaking out of the fillings into her mouth with drastic consequences to her.

However, it has been estimated that words alone only count for 7% of understanding in the communication process.

More important than words is the tone. It is not so much what we say as how we say it. It is estimated that 33% of any message is transmitted through the tone. A simple experiment to demonstrate this can be carried out by repeating the phrase: *"Which tooth did you say was hurting?"* Each time the phrase is spoken the meaning can be changed by putting the emphasis on a different word in turn. This simple experiment illustrates that words alone have less meaning than the way they are spoken.

The final way that information is sent is through body language. **Body language is the most powerful form of sending a message, mainly because it is much harder to hide your true feelings.** Thus the dentist may say he really does not mind the way that his patient is continually coming back to complain about toothache which he, the dentist, cannot diagnose but his manner and body betray that he really wishes the patient would go away. He is transmitting a mixed message — and the patient will know that the body language is the true one!

An everyday example to illustrate the point is seen when you ask someone close to you, who seems upset, what the matter is. He replies *"nothing!"*. You are more likely to believe the manner than the words of the answer.

Sending information requires an understanding of the relative importance of words, tone and body language. Ways must be found to ensure that the words relate to the other person, that the tone is right, and that the body language is complementing the message. In other words you must know what you want to say, say it simply and clearly, emphasise the right words and actually mean what you are saying. You must **feel** right as well.

2 The information must be received

The reception of information involves both the person sending and the person receiving. It is not the responsibility of patients alone to ensure they understand, but also the responsibility of the health worker to make comprehension as easy as possible for patients. Hospitals and surgeries are intimidating places for the patient and under these circumstances people of all levels of intelligence find it difficult to question, to concentrate and to be assertive.

The person sending needs to understand the skills of giving information. These skills involve the following:

Speaking clearly
Avoiding jargon
Checking to see if understood
Putting points clearly
Repeating important points
Using written backup

The above may seem to be obvious yet rarely do health workers bother to ask patients to repeat what they have been told (to check if they have understood). Repeating the message at the beginning and end of the visit is an excellent technique as most people remember what is said at these times, and the skill of putting points clearly is one often missed.

The skill of listening is much harder than the skill of talking. The person receiving needs to listen. This is not as easy as it sounds because we tend to put our own interpretation on what we hear. The fact is we are often thinking of a reply or preoccupied by our own concerns.

There are several simple steps that can be taken to improve listening. Distractions such as music, external noises and other people in the room should be minimised. The listener should be opposite the patient, preferably at eye-level, and looking at the patient. Eye contact should be maintained for about 60% of the time. Too much eye contact appears threatening whilst too little shows a lack of interest. The listener should **look** interested by leaning forward slightly and checking that he or she has understood.

In the surgery environment there are several natural barriers to listening and communicating. The doctor often sits behind a desk, which masks body languages so neither can tell what the other is feeling. The dentist will often stand behind the patient or sit over the patient who is lying flat in the chair.

The message that the patient is trying to give can again be lost because the practitioner makes an assumption based on what he or she **thought** the patient was saying. The fact that we tend to assume that our interpretation of the world is the same as the patient's is certainly the most common cause of failure to communicate. Yet only a moment's thought will result in the realisation that we all see life and events, our relationships with others, our understanding and our feelings in quite different ways.

Yet, despite the fact that it is obvious we all see things differently, we acquire the habit of assuming that others see the way we do and that our interpretation of their world is the same as their own. Of all the skills required in communication, listening is the hardest to learn.

3 The information must be understood

Many of the points here are similar to the ones already mentioned. The main concerns are:

Avoiding jargon
Checking the person has understood
Using written backup.

Using leaflets, pamphlets and handouts is an excellent method of ensuring understanding. After a visit to the doctor or dentist most people find they are unable to remember whether they needed to take three or four tablets a day, whether to rinse out or not, and what to do if they have severe pain.

Control of the conversation

Controlling the conversation is not the same as spending the entire appointment talking at the patient, nor does it mean preventing the patient from passing on important information. All it means is that by asking the **right** questions the doctor or dentist can then listen to the answer and take appropriate action.

One argument often used by the busy practitioner is that there is too little time to allow effective communication due to pressure of patients. This is almost like saying that because there is time pressure there is no necessity to try to communicate. This is a short-sighted approach, not in the best interests of either patient or clinician.

Time pressures are a problem. It is also true that communication skills are difficult to remember and perform when you are already trying to diagnose the patient's problem. Thus, in order to be more effective it becomes necessary to understand the importance of controlling the conversation within the surgery whilst at the same time setting up an environment which encourages good communication and understanding.

Success in controlling the conversation relies on the skill of questioning technique. There are basically five types of interactions that can be used.

A Open questions
B Closed questions
C Hypothetical questions
D Justifying questions
E Support statements

A **Open questions** are questions designed to **open up** patients' problems and encourage them to talk. A typical question would be "What type of pain have you been having?" or "How do you feel about the treatment I've suggested?" Open questions get people talking which puts them more at ease and reveals to the clinician the attitudes and feelings of the patient.

B **Closed questions** require a simple "yes" or "no" as an answer; they limit the conversation or allow the subject to be changed. Examples would be "Is the pain worse at night or in the day?" or "Would you prefer to have surgery or not?"

C **Hypothetical questions** introduce new ideas to patients, or direct their thoughts along a line you wish them to go. Thus a hypothetical question would start with "What if . . ." or "How about . . ." and allow the conversation to move into an area where the patient can think about a new approach or suggested treatment.

D **Justifying questions** allow patients to explore their feelings or attitudes toward themselves or the suggested treatment. Examples would be "How do you explain your reaction to my idea?" or "Why are you so certain that you should take the advice?"

E **Support statements** are not really questions, but are extremely useful to support your suggestion for a particular line of treatment once the patient's needs have been identified. They let patients know you recognise their problems and thus they are excellent ways of communicating that you have understood.

Support statements highlight a vitally important part of communication. **It is not enough to listen to patients. It is also important to let them know that you are listening to them.** Typical support statements could be "I agree that you have a problem . . ." or "I can understand how you feel . . .".

The important point to make is that controlling the conversation is not a way of directing the patient around to your way of thinking. It is more a technique of keeping on track to allow you and your patient time to explore their problem more fully, ensuring you are more likely to identify the real problems. You will have time for explanation and also time to discuss what you need to do to help your patients.

Conclusion

Communication is a complex subject that has immense significance in the clinician/patient relationship. It is a skill that can be learned (as with any skill) and can always be improved.

Communication skills are often taken for granted, or mistakenly believed to be inherent within people. Some people happen to be born better communicators than others but good communicators can be made.

The lack of proper training in the universities is still affecting the ability of most graduates to help their patients as much as they could and should. It is undisputed that with better training and facilities more clinicians could provide a superior and more caring service for their patients. The reduced number of complaints and problems that lead eventually to court action would make for happier dentists and happier patients.

Orthodontic Interface

by J C Bailey LDS DOrthRCS Eng
Orthodontist, Maidenhead, Berkshire

The National Health Service (General Dental Services) Regulations make provision for the referral of patients from one practitioner to another, where the one practitioner does not feel that he has sufficient expertise in a particular field. There was no specific provision made in the Regulations for specialist practices and it is probably unlikely that the establishment of so many practices limited to orthodontic treatment was envisaged. This development has occurred in response to the demand for such treatment both by dentists and parents. The orthodontic side of the General Dental Service is probably the most carefully and closely scrutinised part of that service, if not of the whole NHS. Careful adherence to the regulations is of the utmost importance if orthodontists are not to increase their workload unnecessarily or incur disciplinary reaction. The British Association of Orthodontists has produced a Code of Practice to advise its members on the correct course to follow. Some of the problems which arise are due to lack of communication.

Referrals

A dentist, when he or she accepts a patient for treatment under the GDS, is responsible for all the necessary treatment to make that patient dentally fit. Should the patient be a child then that duty includes provision of any essential orthodontic treatment. If the contracting dentist does not feel able to carry out that orthodontic treatment, he may refer the patient to a second practitioner willing and able to carry out the orthodontic treatment. It is also incumbent upon the first dentist to find that treatment under the NHS if the parent so desires.

The second practitioner acts in effect as the deputy of the first practitioner in carrying out this treatment. However, it would be unwise of the second practitioner to agree to treat the patient under the NHS "sight unseen" in case there is any possible doubt that the child may be unwilling to co-

operate. Lack of co-operation can be a potential area for bad feeling and possible disciplinary action. After examination the second practitioner may feel unwilling to accept the patient for NHS treatment. If so, the referring practitioner should be informed and given the opportunity to re-refer, if requested by the parents of the patient.

As there is an extra element superimposed on the practitioner/patient relationship due to the administrative bodies involved, difficulties do arise which may be due to lack of adequate all-round communication and failure to observe the appropriate regulations. I shall attempt to highlight some of the problem areas.

Communication between the referring dentist and the orthodontist

1 **Letter of referral.** This should ideally give the relevant facts and some indication of the likely level of co-operation. A prior explanation to the parents and patient of what orthodontic treatment is likely to entail will help to prevent misunderstanding. As orthodontic treatment involves considerable co-operation on the part of both patient and parent, it is essential to clear up this aspect before proceeding too far.

2 **Letter of reply.** After the consultation a letter from the orthodontist to the referring dentist, giving details of future management of the patient and whether treatment will be carried out under the NHS or by private contract, will be helpful.

3 **Particulars of extractions.** Where extractions are requested it is essential that the request is communicated in such a way that there can be no chance of error and as a result the wrong teeth removed. One could consider using not only a recognised dental notation but also a written description of the teeth, especially where a supplemental incisor or an erupted supernumary is involved. Under current NHS Regulations the extraction of teeth on orthodontic grounds is subject to prior approval.

Communication between the orthodontist and the patient

1 **Preliminary letter.** It is advisable to send a preliminary letter to referred patients and their parents giving a brief account of what the proposed orthodontic treatment involves and what will be the necessary commitment of the patient.

2 **Clarification of the treatment plan.** The treatment plan should be explained fully at a second visit and again the commitment should be stressed. Both these recommendations are made in the British Association of Orthodontists' Codes of Practice and would also comply adequately with the suggestions made by the Schanschieff Committee in paragraph 5.52 of their Report.

3 **Clarification of contract.** Where treatment is to be carried out by private contract, this should be clearly understood by all parties with the relevant details, including the fee, put in writing and agreement obtained in writing.

Communication between the orthodontist and the Board

One of the most difficult areas leading to misunderstanding is over the mixing of private and NHS treatment. It is better to examine the patient first and not to get an FP17 signed until the orthodontist and the patient have agreed that treatment will be under NHS regulations. If the orthodontist accepts the patient, the child must be treated to a standard of dental fitness agreed with the Board. There can be no 'topping up' by private contract afterwards. When giving reasons for wishing to treat privately one must be careful not to denigrate the NHS system, as this could certainly incur disciplinary action by the General Dental Council. If treating privately it would be unwise to charge the NHS for the initial examination; it is prudent to waive this fee.

Having agreed to provide orthodontic treatment under the NHS regulations prior approval must be obtained from the Board. Neither orthodontic treatment nor extractions should proceed until the treatment has been approved. The orthodontic diagnosis form FP(0)17 was introduced to try to obtain uniformity in the submission of estimates for orthodontic treatment. As the forms would be checked by clerical staff in the first instance, it is important that all boxes are completed, legibly, to prevent undue delay and possible rejection.

When replying to queries about the submitted treatment plan it is best to supply factual answers which will assist the Adviser and speed up the administrative process. Where there is an invitation by the Board to make substantial alterations to the treatment plan, one would be unwise to accede to change unless in complete agreement. Even if influenced by a third party the operator is still responsible for the amended treatment.

If one cannot agree with the Dental Estimates Board, it is probably better to withdraw on clinical grounds. It is not possible to withdraw because the fee is thought to be inadequate. In the past it was possible to apply for the payment of an interim fee after twelve months of treatment. This was a payment on account and did much to assist the cash flow of a practice and help defray some of the costs of long term treatment. This facility was withdrawn in October 1986 possibly as a response to one of Schanschieff's suggestions.

Inability to complete treatment

Where, due to non-cooperation, failure of the patient to return or for some other reason, treatment cannot be completed, it is prudent to get one of the parents to sign a letter saying they wish to discontinue. In any case likely to be controversial the orthodonist should also seek FPC agreement to withdraw from the contract. The details may then be submitted on DEA 194 or FP(0)17 paragraph 13 when a part-fee will be authorised by the Board.

Avoiding breach of the Terms of Service

Allegations by the Board of breach of the orthodontist's Terms of Service do unhappily occur. The paragraphs in the Terms most commonly cited are as follows.

Paragraph 2(a) (Alleged failure to employ a proper degree of skill and attention.)

There are bound to be differences in clinical opinion allied to the difficulties arising when the Board have to make an orthodontic diagnosis based on plaster models and radiographs. Problems may have been encountered by the orthodontist over patient co-operation during treatment. Should the final result show a discrepancy from that originally intended, it is wise to explain this to the Board when the models are submitted for payment.

Paragraph 7(2) (Alleged 'mixing' of NHS and Private treatment.)

The best advice is not to attempt to 'mix' orthodontic treatment. This is a most difficult 'grey area'.

Paragraph 9(2) (Alleged commencement of treatment before prior approval is received.)

Prior approval by the Board is necessary for treatment under item 24(a) (ii). Despite the delays that occur it is sensible to wait for approval, warning the parents that there may be delay before a 'contract' to treat is obtained. The 'ten day' rule, that is the requirement that estimates for approval should be submitted within ten days of the examination, is probably impossible to comply with where orthodontic treatment is concerned. This is particularly so if recommendation 37 of the 'Schanschieff Report' (to explain the proposed plan of treatment and its costs to the patient) is complied with. Unhappily, this regulation continues to be invoked.

Even in a well-run orthodontic practice inadvertent breaches and difficulties do occur. A speedy letter of explanation to the Board will usually help to resolve the situation. The help and advice of a colleague will be an advantage and should the situation appear to be deteriorating, the advice of The Medical Protection Society should be sought at an early stage.

References

Report of the Committee of Enquiry into Unnecessary Dental Treatment ('Schanschieff Report') (1986) HMSO.

Law, Ethics and the Community Dental Service in England and Wales

by Brenda Fox BDS DDPH Dip Soc
District Dental Officer and Divisional Manager Primary Care Services, Hillingdon Health Authority. Member of Dental Secretariat, The Medical Protection Society
and
Ian H Maddick MA BDS DDPH FIBM
District Dental Officer, Bloomsbury, Hampstead and Islington Health Authorities. Senior Clinical Lecturer University College and Eastman Dental Hospital, London

The Community Dental Service has a unique role in present day health care services, as it combines a public health role with treatment of individual patients. This combination of duties poses problems for today's community dental officer and to appreciate these it is necessary to understand something of the history of the service.

The beginning of the Service

The foundation of the service was the establishment of a treatment clinic in Cambridge in 1907. The dentist appointed by the Local Authority identified and selected children needing treatment by screening school children in maintained schools. National legislation empowered local authorities to set up similar schemes but it was not until 40 years later, following the Education Act of 1944, that a degree of uniformity in the organisation of the School Dental Service became a reality. However, this legislation could not fill the gaps in the service. A great shortage of dentists and a high level of dental disease in children meant that in less favoured areas, particularly in the north of England, the School Dental Service fell far short of meeting the need. Dentists approached this problem in different ways.

Uneven development of the Service

The history of the School Dental Service has mirrored the development of health services as a whole. Individual dentists pioneered new procedures and, for example, an Orthodontic Service was set up in Isleworth, Middlesex in 1938 in conjunction with the Royal Dental Hospital. Forward-looking municipal authorities who were able to recruit dentists recognised the urgent need of other groups such as nursing and expectant mothers and pre-school children and as early as 1921 were empowered to provide treatment services for them. Thus from its inception there have been inequalities of provision within the School Dental Service, renamed the Community Dental Service when in 1974 the newly-formed Health Authorities took over responsibility for the service.

Duties and responsibilities

The public health role and care of individual patients can be seen as three distinct activities.

1) **Care of Patients** which is carried out by clinical dental officers and comprises examination and treatment.

2) **Care of Groups.** This activity consists of screening populations, preventive programmes, dental health education and treatment of needy groups. This work is carried out by clinical dental officers assisted by ancillary staff but within a general policy put forward by the District Dental Officer and agreed by the Health Authority.

3) **Care of the Community.** This activity consists of survey, programme planning and programme management. It is largely carried out by senior staff, including the District Dental Officer and will be approved by the Health Authority.

In order to carry out these duties the community dentist will have to liaise closely, not only with dental colleagues in the three arms of the dental services but also with other health colleagues in primary care such as Health Visitors and District Nurses. Senior community dentists will have a close working relationship with the Local Authority Departments of Education and Social Services and the clinical dental officer will have day-to-day contacts with head teachers, teachers, parents and other Social Services care staff. Thus the role of the community dentist is complex, added to which is the interaction between the clinician and manager of the service, the District Dental Officer.

The Health Authority as employer

Senior staff whilst being employees also act as representatives of the Health Authority as employer and must be concerned with national employment legislation. They require a working knowledge of the Codes of Practice issued by the Commission for Racial Equality, Equal Opportunities Commission and the Advisory, Conciliation and Arbitration Service (ACAS). Job applicants who feel they have been discriminated against during interviews may take their grievance to an Industrial Tribunal.

The District Dental Officer as manager of the service should have an understanding of industrial relations and the role to be played by a trades union in the relationship between employer and employee.

Legal advice

While the Personnel Department in a Health Authority should be able to offer assistance regarding matters of contract, the importance of legal advice from solicitors retained by the Health Authority should not be overlooked. This is best sought at an early stage particularly if the issue is such that senior staff have had little experience of the problem.

Group care — the Public Health role

The public health role of the service is seen in relation to the care of groups in the community. Historically, care has been provided for groups identified as needing priority, such as pre-school and school children, nursing and expectant mothers and, since 1978, adults with a handicap. Whilst Local Authorities were encouraged to follow a model scheme there have always been local variations in procedure. These have rarely been written down and there may be merit in doing this, perhaps in some form of 'standing orders' so that new members of staff are clear what the procedures are and what is expected of them.

Whilst the local bureaucratic inheritance must be recognised and respected it is important to remember that, as social circumstances change, the way the services are organized must change. Parents now want more information about services and dislike the autocratic tone sometimes used in the past.

Documentation used in the School Dental Service may need review and new systems and appropriate forms will have to be designed as new patient groups come into care. As there is no nationally-prescribed documentation, except the annual statistical return to DHSS, this allows local collaboration and flexibility.

While the District Dental Officer is required to negotiate changes in the service for school children with the Local Education Authority, discussion with local general dental practitioners through the Local Dental Committee and District Dental Committee will promote active co-operation between services and should also reduce misunderstanding arising.

School Dental Inspections

School dental inspections are an important public health activity yet they can cause problems with parents, local dentists and teachers.

The legal basis of the school dental inspection was laid by the Education Act of 1944 when parents were required to submit their child for a medical and dental inspection. Parents were to be invited to the first school dental inspection but the School Health Service Regulations of 1959 state that a child should have a dental inspection on entry and then at such other times as is necessary. This has until recently been interpreted as annually. The National Health Service Acts removed the compulsory element to school dental inspections but the Health Authority has a duty to identify those children who need treatment, to notify their parents that they require treatment and to assist the children to obtain the treatment they need.

This legislation allows the community dentist to examine children in school without the specific consent of their parents but this same cover does not extend to pre-school children and institutions which are attended by adults. Care is always needed in looking at the legal basis of any screening or survey which is undertaken. As far as parents are concerned, a good guiding principle is that parents have the right to know what is happening to their child and should be given information about the school dental inspection system and preferably informed before each school dental inspection.

With the advent of preventive procedures such as fissure sealing, many community services take the view that children should be offered such care before disease develops. They have therefore modified the traditional school dental inspection to encourage all children to seek regular dental care from

either the Community Dental Service or General Dental Service. Traditionally parents were only informed if the child required active treatment and they were asked to sign a "consent form" if they wished their child to receive treatment from the Community Dental Service or to agree to make their own arrangements through the General Dental Service. This system worked well for many years and it enabled children to receive treatment even though no further contact was possible with their parents. In latter years, if a general anaesthetic was required a separate consent was obtained. However, this system is no longer considered satisfactory and parents should not be asked to consent to unspecified treatment after a school dental inspection. It is much better to alter the 'consent form' so that parents simply give a statement of their intent, that they wish their child to receive treatment from the Community Dental Service. A full examination and discussion should take place before consent is sought.

Conduct of inspections

There is a long tradition of carrying out surveys of dental health at the same time as a dental inspection in schools. Parents generally are willing to co-operate but should be informed particularly if, for example, gingival pocket depth may be assessed. It is often children's reports of what they thought had happened at the inspection which stimulates parents' complaints. For example examination by a fibre-optic light was interpreted as 'taking an x-ray'.

There is now much public concern about the transmission of infection and the conduct of inspections is giving rise to more complaints. Prudent community dentists would be well advised to demonstrate to teachers, children and parents that they are using appropriate sterilisation procedures. Five mirrors and a tumbler of 'Dettol' is no longer acceptable.

Communication with colleagues

Surveys require thought and care. Community dentists are aware of the ethical dilemma of raising expectations that cannot be met but should also be sensitive as to how their colleagues in general practice will interpret the activity if they are not properly informed, for their patients may be included in a survey.

Every district should have an Ethics Committee which will follow guidelines and have a set procedure for reviewing research projects. Epidemiologists will also be aware of the requirements of the Data Protection Act 1984.

Complaints

As described, problems may arise from public health screening activities which are presented as complaints either to the Education Authority or to the Health Authority. The special relationship which exists between the two authorities may mean that a complaint passes through many hands before it reaches the clinician concerned. A similar situation may arise when examination or treatment is provided for patients resident in Social Services establishments.

Generally speaking, Health Authorities when dealing with complaints follow the procedure outlined in Health Circular HC(81)5 (WHC(81)13 in Wales) and often produce local guidance for staff. The Health Service Commissioner may also consider non-clinical complaints. Neither of these procedures is intended for patients who resort to litigation through a solicitor but such action is rare in respect of clinicians in the Community Dental Service.

If the District Dental Officer receives a complaint he or she may require a report from the clinician concerned. It should be remembered that unless such reports and correspondence are prepared for the purpose of defending legal proceedings, they may have to be disclosed to the patient in due course.

Community dental officers are free-standing clinicians and are responsible in law for the clinical care they give to their patients. The Society is always willing to give advice to community dentists if they receive a complaint about their clinical practice. However it should be the responsibility of the District Dental Officer to agree and clarify procedures with the chief officers in the Local Authority, as the support of senior staff in the Education and Social Services Department is invaluable in smoothing day to day problems in the field. Finally, although community dentists are the responsible clinicians, they may well benefit from the experience and expertise of the District Dental Officer whose support should be enlisted at an early stage.

Records and record keeping

The Education Act 1944 introduced the 11M record card which DHSS now state is not statutory, thus giving Health Authorities an option for change. Health Authorities are taking this opportunity to

review their record system but will still be required to record treatment given. School health records accompany children if they move from the area and in theory provide a longitudinal record of a school life history. Because the records do not remain in the hands of the clinician when a patient moves, a copy should be kept in any case which is likely to prove contentious.

Records should be accurate, detailed, objective, legible and signed. Comments on a patient's behaviour require care; for although they may be properly recorded to chart progress, they may be subsequently disclosed to parents and cause distress. Care should also be taken at school dental inspections not to put records containing sensitive information into childrens' hands. For a child to read 'maladjusted' in red ink on the front of the dental record is not a good start to a relationship.

Care of patients

A dentist owes a duty of care to his patient. Lawyers consider that dental care has three parts; diagnosis, advice and treatment. Any person has the right to refuse dental treatment or some part of recommended treatment but equally a dentist may decide not to proceed with treatment if the limitations the patient wishes to impose are not compatible with good clinical practice.

A patient implicitly consents to an examination if he or she sits in the dental chair. We recommend that the taking of radiographs is dealt with as a separate item and the patients' or parents' consent is sought Once the examination has been performed the dentist formulates a treatment plan and the proposals would normally be put to the patient or parent. A dentist should explain the nature and consequences of the proposed treatment and this should also include advice about alternative courses of treatment if this is relevant. When the patient and parent have sufficient information about what is proposed they can make an informed decision as to whether to proceed with treatment.

The dentist should inform the patient of a significant risk but not those which the clinician considers are rare and remote. When the dentist and patient are agreed the patient usually signs the agreement and this is a consent to treatment. Consent should be obtained for each and every course of treatment. Parental consent which was traditionally sought at school entry is no longer considered sufficient cover throughout school life. How does the dentist stand if the patient is handicapped, particularly a patient who is intellectually impaired? With severely handicapped patients it may not be possible to carry out a proper examination and therefore the dentist will not have sufficient information to formulate a treatment plan. If the patient has an intellectual impairment, he or she will not be able to understand what treatment the dentist proposes to carry out.

In the past it has been assumed that people with a mental handicap could not consent to their own dental care. This paternalistic view is no longer acceptable and a dentist must now judge whether a person with a handicap can understand what is proposed and so give informed consent. Clearly some patients will not be able to comprehend such matters but in the past a variety of other people have given consent on their behalf. However, the law does not make any express provision for one adult to give proxy consent on behalf of another adult so there is doubt as to who, if anyone, can validly consent to the treatment of another.

The absence of any express provision for proxy consent means that a dentist who recommends some dental treatment for a profoundly handicapped patient cannot count on a consent form signed by a doctor, if the patient is in hospital, a parent or relative of the patient or anyone else to cover him. The dentist should of course consult with all, or any, of these people and must in the end accept final responsibility and be prepared to justify his action if subsequently challenged. If treatment is complex or contentious then the dentist is advised to seek an independent dental opinion as to the need for the proposed treatment and this should be recorded.

What is required to meet a possible challenge is evidence of the steps taken by the dentist to show that he or she acted in a conscientious and responsible manner, after careful thought and consultation where appropriate. Good, contemporaneous clinical notes are invaluable.

The approach we should adopt is nicely encapsulated in a statement made by Lord Colville, Chairman of the Mental Health Commission. He said: "Patients' rights have two aspects; the avoidance of treatment .... which is unlikely to help their condition and the availability of sound treatment to which, on a proper professional judgement, they should be entitled. The object was not merely to eliminate any abuses but positively to enhance the prospects for a patient to live the most fulfilling life that is achievable" (Bulletin of the Royal College of Psychiatrists, January 1985).

This is necessarily a brief overview but if community dentists understand the basic principles then they will find it easier to cope with practical problems which they experience in the field. For example, they may be providing care for children and adults in residential centres where parents are not readily accessible. They may be working in situations, perhaps in a mobile surgery, where parents find it difficult to attend or the family may not speak English. It takes time and effort for a dentist

who is caring for such patients to obtain a proper consent to treatment. Of course, emergency treatment should not be delayed but a prudent clinician will attempt to ensure that any such emergency treatment is reversible. Head teachers and education welfare officers can offer valuable advice and support when a dentist is trying to contact parents to obtain consent to treatment.

At the age of 16 children are able to consent to treatment on their own behalf but the Gillick Case has illustrated that this is not an absolute cut-off point. As Lord Scarman has said, "Parental right yields to a child's right to make his own decisions when he reaches sufficient un lerstanding and intelligence to be capable of making up his own mind". It is the dentist's duty to make this judgement about a child's maturity and to act accordingly. Indeed it is a basic tenet of health education that young people should be encouraged to develop a sense of responsibility for themselves and for their health and it would be inconsistent if the clinician did not take the time to explain the nature of treatment to young patients.

Ancillary Staff

A community dentist will have at least one surgery assistant who is directed by the dentist during patient care. Such an assistant will, under the instruction of the dentist, organize patients' appointments including school dental inspections. The responsibilities of a dentist towards ancillary staff should be clear, particularly if surgery assistants are supervised by a centrally-based senior dental surgery assistant.

The presence of a surgery assistant provides and allows a dentist to work safely and efficiently. If for some reason, such as sudden illness, help is not available, dentists should be prudent and provide only simple care.

Dental therapists and hygienists are employed in the Community Dental Service and the extent of their work and supervision is set down in the Dentists Act 1984. Dental therapists may undertake simple dental treatment and have until recently been trained to treat children. Therapists may form part of a team providing care for handicapped adults, who, while they may require simple technical work, often present difficult management problems and therefore their dental treatment is far from simple. The prescribing dentist should therefore assess whether such patients should be treated by a dental therapist.

In recent years dental health educators have been trained to teach dental health in schools. Whilst in the school they work under the aegis of the head teacher but when giving personal oral hygiene instruction they work within the guidance given by the General Dental Council.

Relationship between District Dental Officer and Clinical Dental Officer

Dentists consult the Society when they are worried or anxious and a significant number of problems are concerned with the relationship between the District Dental Officer and the Community Dental Officer.

The District Dental Officer as the chief officer and head of service in the Health Authority must be concerned with putting into action the Health Authority's policies. The outlook and approach of a community dental officer is clearly important and he or she must appreciate that working in the Community Service is different in some aspects from working in general practice. However, tensions arise and these can be best illustrated by referring to a now historic problem.

"The Health of the School Child" was an Annual Report produced by the Chief Medical Officer and until the middle 1970's referred every year to the dilemma which the school dental service then faced in meeting the needs of all children. It was a question of who got the jam and who got the butter. Should all children receive some basic dental care or should some children get the best that was available in restorative care and the remainder emergency treatment only. The reality was that dentists working in a public health service found that their clinical freedom in respect of treatment provided for individual patients was constrained. Similar issues are still with us and it is important that they are recognised and explored.

The District Dental Officer following the Griffith's management principles of efficiency, value for money and consumer satisfaction may now be concerned with 'quality assurance' and this is difficult ground where clinical care is concerned. Alternatively the argument may centre around the amount of time spent on restorative care versus preventive care or the amount of time which should be devoted to the care of the handicapped. Community dental officers are responsible for the care they provide for their patients. Nevertheless the District Dental Officer as head of service is responsible for overall standards of the service. How each party sees his or her role may sometimes lead to conflict.

If the District Dental Officer has reason to believe that a dental officer is not providing care of a proper standard then this is a matter he has a duty to investigate on behalf of the Health Authority. How this should be done is open to question but clearly the principles of natural justice should prevail and the District Dental Officer should not act as judge and jury. It may be that the assistance of an assessor should be enlisted who is a peer of the dentist concerned and may well be invited from an outside Health Authority. If the matter is not resolved to the District Dental Officer's satisfaction then he or she may well decide to follow the procedure outlined in circular HM(61)112 and bring the matter of professional competence to the attention of the Chairman of the Health Authority. This is a complex situation and further advice should be sought.

Changing Service

The Community Dental Service has changed within recent years from a treatment service for children to a service which is more complementary to the General Dental Service and Hospital Service. Indeed many community dentists work in both the community and within a hospital setting. As the patient care groups have widened the community dentist has faced more legal and ethical pitfalls. We hope that in this paper we have been able to review some basic principles to assist our colleagues deal with the special problems which they meet in the Community Dental Service.

Communication failures in dental practice

The articles by Mr Grace and Mr Bailey both emphasise the need for good communication between the dentist and the patient. Several cases have come to the Society's attention over the past year to illustrate the possible unfortunate effects of failure to listen and act upon the statements of patients.

1 It was necessary for a member working in the Middle East to extract a tooth for a lady who spoke no English. She was accompanied by her husband who explained to the dentist that his wife was diabetic, suffered from hypertension and was allergic to penicillin.

The tooth extraction turned out to be very difficult and lengthy, taking over an hour. The dentist prescribed amoxycillin to be taken post-operatively. The next morning the patient was shivering and covered in a rash which worsened over the next two days. She was admitted to hospital, given oxygen and detained for five days with breathing difficulties and peeling skin. Insulin was necessary for the diabetes which had formerly been diet-controlled.

A claim was lodged against the member and the Society had no choice but to pay compensation. The case emphasises the importance of carefully listening to a patient's medical history, especially a history of allergy.

2 A member attended a sixty-two-year old male patient and it was decided to extract $\overline{|4}$ for relief of acute pain. A medical history was recorded in which the patient stated that he had had rheumatic fever but averred that his doctor considered the resulting heart condition was not serious.

It had been the member's invariable habit to prescribe antibiotic cover in such cases. Seeing, however, from the record card that the patient had had numerous scalings and root fillings in the past ten years, the member decided to remove the tooth first and prescribe amoxycillin to be taken afterwards at the pharmacists, five minutes walk away. The extraction was lengthy but the tooth was eventually removed.

Five months later a claim alleging negligence was made. The patient had been admitted to hospital a few weeks after the extraction with sub-acute bacterial endocarditis, the treatment of which necessitated open-heart surgery and mitral valve replacement.

Expert opinion sought by the Society stated that the extraction would have precipitated a bacteraemia which could have infected the heart within 15-20 minutes. To cover this risk 3 g. of amoxycillin should have been taken in the presence of the dentist or nurse one hour before the operation to reach an effective blood level. The patient's acceptance of treatment without cover could not be a defence. The Society paid damages of £17,000.

3 In the past year misunderstandings have arisen in the orthodontic field resulting in the removal of the wrong teeth. These accidents have taken place even in the face of written advice from the orthodontist to the general dental practitioner.

A 15-year-old female patient was referred from the orthodontist for the removal of $\underline{|5}$ by the original dentist. $\underline{|5}$ designation was mistaken to be $\underline{|5}$ and this tooth was removed. Only later did it emerge

that a supernumerary /2 was present just erupted and that this was the tooth the removal of which the orthodontist had in mind.

4 A nine-year-old male patient with cleft palate and supernumerary upper lateral incisor was referred from the orthodontist for removal of /b/. The /b/ designation was read as /6/ and the latter tooth was extracted in error.

"He who comes to justice with clean hands . . ."

In the same way that justice must not only be done but must be seen to be done, so care in a dental surgery must be seen to be taken as well as actually being taken. A general dental practitioner found herself defendant in proceedings brought by a former patient who suffered a severe episode of facial cellulitis and septicaemia leading to an abortion and a lengthy period of in-patient hospital treatment. The infection developed some 22 hours after the patient had received dental treatment consisting of a local anaesthetic and the provision of two fillings. It was alleged that the standard of care and hygiene at the dental practice was below the proper standard and that as a result the dentist had permitted unsafe conditions to exist allowing infection to spread more easily.

At trial the Plaintiff said she could recall having smelt cigarettes on the member's breath at the time of the examination, and in addition she had never seen the member use a washbasin. The member at the time was using adjoining surgeries with washbasins in each and the judge accepted the member's evidence, which was supported by the evidence of her dental nurse, that she did realise the importance of careful hygiene, that she always washed her hands between patients, that she might have washed her hands in the adjoining surgery, and that she would never touch the connecting doors between the surgeries with her hands. The judge found there had been no breach of duty by the dentist and that the likelihood was that the patient had suffered from a needle track infection of an endogenous source. It was therefore possible in this case to say that the likely cause of the damage had nothing whatsoever to do with the alleged breach of duty.

The patient's feelings must be taken into account

A complaint was made against a dental practitioner alleging that he had been in breach of Paragraphs 2(a) and (b) of his Terms of Service.

Under Paragraph 2(a) the dentist is required to employ a proper degree of skill and attention in providing general dental services and under 2(b) is required satisfactorily to complete treatment necessary to secure dental fitness which the patient is willing to undergo. The case concerned the provision of treatment under anaesthesia. The member employed the services of a local general practitioner skilled in the administration of anaesthesia to provide anaesthetics for patients. The anaesthetist's preference was for giving gaseous induction of anaesthesia to child patients. The complainant, the mother of the 13-year-old patient, made it known to the member that her daughter required intravenous induction of anaesthesia rather than gas. Prior to treatment the member made this known to his anaesthetist. However, the anaesthetist started making preparations to give gaseous induction, the child panicked and the mother entered the surgery, abused both practitioners and removed the child from the premises without treatment being commenced.

The member was found in breach of Paragraphs 2(a) and (b) of his Terms of Service by a Dental Service Committee which investigated the matter and he was asked to comply more carefully in future with his Terms of Service. On appeal to the Committee set up by the Secretary of State for Social Services, the practitioner's appeal in respect of Paragraph 2(b) was allowed in that the form of treatment which materialised at the consultation was not a form of treatment which the patient was willing to undergo. The breach of Paragraph 2(a) was, however, upheld on the grounds that the dental practitioner had an obligation to his patient under the Terms of Service to ensure that the patient's attitude and feelings were taken into account when assessing the form that any treatment which he proposed was going to take. This affected the standard of the "proper degree of skill and attention" as referred to in paragraph 2(a) and a practitioner could be in breach of this Term of Service for having failed adequately to assess what treatment, or form of treatment, a patient was likely to be willing to undergo.

This would seem to over-ride considerations of clinical judgement, although it is probable that the Secretary of State's decision is not as far-reaching as would at first seem. Account should be taken of the patient's attitude and feelings where there are alternative methods of treatment, each clinically adequate in its own way, but it is suggested that a practitioner cannot be in breach of Paragraph 2(a) of his Terms of Service if there is only one adequate method of treatment and this is clearly explained to the patient or his/her parent or guardian beforehand.

The case also illustrates the point that a dental practitioner cannot abrogate responsibility totally under his Terms of Service to another independent contractor such as an anaesthetist. A degree of

responsibility remains with the dental practitioner providing the general dental services to the patient under the Regulations and the interpretation of a "proper degree of skill and attention" is far-reaching.

Case Reports

Showing the flag

A member was approached by a young man who said he had to have his teeth put in order before enlisting in the Royal Navy. Examination showed the upper right central and lateral incisors to be fractured and radiographs revealed large apical radiolucencies.

The patient was given the option of extraction and a denture, or root treatment and apicectomy followed by crowns. He chose the latter course. It was agreed that the member would carry out the root treatment and refer the patient to hospital for apicectomies. The pulps were extirpated and dressings inserted, but one of the teeth became acutely infected and three days later was placed on open drainage. Penicillin was prescribed at the same time.

Later that day the patient telephoned to say that his face was even more swollen and the member then referred him to the nearby dental hospital. The patient, it transpired, had developed acute cellulitis and he was admitted to hospital for three days. Subsequently his teeth were apicected and crowned at the hospital.

A claim alleging negligence was made against the member which the Society defended. Two years later the case came to court where it was maintained by the plaintiff that the member had not given adequate care and attention, that the member had refused to provide treatment when the patient returned in pain and that penicillin should have been prescribed at the commencement of the root treatment.

The first two claims were easily rebutted. On the third point the plaintiff's expert witness stated when questioned that the provision of antibiotics at the preliminary stage was not regarded as essential treatment. The judge pointed out that this statement effectively disposed of the plaintiff's claim and he entered judgment for the member.

Claim for multiple root perforations

A 35-year-old female patient attended a member for root-canal fillings to be inserted into /34_ and for porcelain-bonded-to-gold crowns to be fitted at /45_. The patient subsequently made a claim against the member.

Radiographs revealed a gutta percha root canal point lying between /34_ completely outside the body of either tooth. The attempt to re-root-fill the /3 had also failed, a gutta percha point perforating the tooth root. Two years after the original perforations in the mesial aspects of both /34_ the patient was still experiencing pain. It also emerged that the member had perforated /5 on the mesial aspect with a dentatus screw.

The patient was examined by an independent assessor on behalf of the Society. An occasional accident in the case of endodontic treatment is unavoidable because it is sometimes very difficult to determine the direction of the root canals. The advice given, however, was that three very severe perforations were far beyond an acceptable act of misfortune, and would undoubtedly be considered negligent in court. The prognosis for /34_ was very poor and there would be a major problem in the event of the loss of those two teeth. /5 was a non-vital tooth already carrying a root canal filling and a crown. It was not strong enough to act as a bridge retainer. In view of the marked class II division II malocclusion, any encroachment on the anterior teeth to retain a bridge would result in a very poor aesthetic appearance. The prognosis for /5 was poor, though no symptoms were as yet emanating from it.

It was agreed that the patient, without the need for proceedings, should be compensated. In the event of the loss of /34_ the appropriate replacement would be a chrome cobalt denture. Although the patient was at first strongly opposed to the idea of a denture, she accepted the view after receiving her own independent dental advice.

A try on

A general dental practitioner member of the Society recommended to his patient that he have /7 extracted. As this tooth had a carious hypoplastic crown and was, in addition, lingually and mesially

inclined, the practitioner took a pre-extraction radiograph. As expected, the extraction proved to be difficult, and had to be abandoned after approximately half an hour as the local anaesthetic began to wear off. As a substantial portion of the root remained in situ, the practitioner took another radiograph, dressed the wound with Alvogel and referred the patient to hospital where the roots were subsequently removed under general anaesthesia. Despite the care and attention the practitioner had given, a solicitor's letter was soon forthcoming alleging negligence and claiming compensation. The particulars of negligence included:

> He attempted to perform an extraction which was beyond his competence.
>
> He failed to give sufficiently strong injections.
>
> He persisted in attempting to extract the tooth for an unreasonable length of time.

The Society's Dental Advisory Board carefully considered the practitioner's handling of the case. The Committee felt that the practitioner, who was very experienced, had approached the extraction properly and resolved that liability be denied. The patient however continued to pursue the action and some two years after the extraction a court hearing date was set. The day before the hearing the patient lost confidence and dropped his claim. The practitioner greatly helped himself and the Society by taking (and retaining) good pre- and post-operative radiographs and keeping good written records.

Assault

Aggrieved patients occasionally take matters into their own hands and attack their dental practitioner, causing physical injury. One such member of the Society sought advice after an assault outside his surgery. His injuries were sufficient to cause him to be off work for three days, and during the ensuing six months he had to have further time off. The Society helped the practitioner to make an application to the Criminal Injuries Compensation Board. An offer in excess of £1,000 was accepted.

Confidentiality

Members should remember that the duty of confidentiality owed to patients extends to all their staff who have access to clinical information. Much unnecessary distress can be caused to patients and their relatives as a result of incautious and inappropriate comments by practice employees outside the surgery environment.

A young, unmarried patient volunteered the information to her dental practitioner that she was pregnant. An appropriate note was made on the record card. A few days later the patient's mother telephoned the practitioner in a distressed state and informed him that one of his dental surgery assistants had told somebody in a public house that her daughter was pregnant. The practitioner could only assure the irate parent that his dental surgery assistant had acted contrary to specific instructions, and offered his deepest apologies. The kind and sympathetic handling of the matter by the practitioner was clearly appreciated as the matter was not pursued, but such embarrassing situations are best avoided at the outset.

A stitch in time

It is very tempting not even to read let alone do anything about correspondence that one thinks may be unpleasant. Members occasionally find themselves under such pressure from the increasingly heavy administration load attendant upon running a dental practice that they cannot bring themselves to do other than put an offending envelope either in the waste bin or at the bottom of the 'pending' tray, never to rise again.

It is important to remember that strict time limits are in operation during investigations by Family Practitioner Committees and the General Dental Council and also in the legal processes occasioned by civil claims. Practitioners from time to time deny themselves the right to have their side of a matter properly presented simply by being "out of time". It is clearly in the practitioner's best interests to attend to all correspondence (even if unpleasant) promptly and, if appropriate, send it to the Society for advice and/or action. One member approached the Society only after judgement had been given against him in default, which denied the Society the opportunity of investigating the claim and resisting it, had it proved to be defensible.

The Society's secretariat are pleased to attempt to reduce the understandable anxiety suffered by members when faced with complaints and claims but can only do so if contacted in proper time.

Misread regulation

A member in Scotland was found in breach of one of the regulations in three separate cases. The fact that the regulation was misinterpreted was subsequently agreed by the Scottish Dental Estimates Board. The point at issue relates to paragraph 8(2) of the Terms of Service which states:

'Where the treatment which the patient is willing to undergo includes treatment so specified the dentist shall not later than 10 days after completing the examination send the estimate to the Board for approval and shall not proceed with any treatment so specified other than emergency treatment until such approval is received . . . . .'.

The Dental Service Committee maintained that the Society's member was in breach not because he provided prior approval treatment without waiting for prior approval, but because he provided any treatment even that not requiring prior approval.

The Society entered an appeal on the member's behalf in one case but was refused leave to appeal on the other two cases by the Secretary of State, who stated that the appeal was out of time and he would not allow an extension of time.

In the case where the appeal was permitted, the Scottish Dental Estimates Board conceded the point that only prior approval treatment was barred under paragraph 8. When the Society pointed out the injustice of allowing this appeal but continuing to find the member in breach in the other two cases, the Secretary of State replied that he was *'functus officio'* that is, he had discharged the responsibilities of his office, and could do no more.

The Society's solicitors were instructed to seek a judicial review in the High Court. Before the matter could come to Court, the Scottish Home & Health Office conceded the issue and the findings of breach were reversed.

Time limits

The Dental Estimates Board wrote to a Family Practitioner Committee about a general dental practitioner in England, suggesting that the Family Practitioner Committee might refer matters contained in the Board's letter for investigation under regulation 6(6) of the Service Committees and Tribunals Regulations. After the hearing it came to the Society's attention that the Dental Estimates Board had acted as complainant in the cases under paragraph 6(3) of the Regulations. The member was found in breach in two cases and recommendations were made for withholdings of £100 and of £1,000 with a period of 12 months prior approval respectively. The Society's solicitors pointed out to the Secretary of State that, while the Board's original letter providing information for the Family Practitioner Committee had arrived within the time limits in the Regulations, the complaints by the Board were outwith the time limits and that the Board had taken no action to seek the consent of the Secretary of State to a late hearing of the complaints. The Secretary of State upheld the Society's view and declared the Service Committee investigations to be nullities. The Secretary of State could take no action on the recommendation of the Dental Service Committee and had no jurisdiction to entertain an appeal by the Board.

In Brief

'Common Things Commonly Occur'

Swallowed dental instruments

An endodontic engine reamer was swallowed by a patient in England and required removal by laparotomy. The resulting claim was settled by the Society for £13,000.

Three other cases of swallowed dental reamers in England which did not require laparotomy were settled at £68, £500 and £750.

A similar case in Northern Ireland was settled for £500. Yet another case in Northern Ireland requiring surgery was settled for £1,500.

A swallowed dental bur in Eire which was passed naturally by the patient was settled at £1,000, and a similar case in Australia was settled at A$550.

Fracture of the mandible

A case of fracture of the mandible occurring during removal of the $\overline{4}$ in England was settled at £2,550. The practitioner carrying out the extraction in hospital failed to examine the patient pre-operatively, did not diagnose the fracture and did not take a radiograph when the presence of a fracture was eventually suspected.

A case occurred in Wales where the mandible was fractured during the removal of $\overline{7}$ under general anaesthesia. Since the case had been thoroughly assessed and the patient had been warned of the difficulty of the procedure, liability was denied on behalf of the member and the case was dismissed.

During the removal of /8 in another case the body of the mandible was fractured. The member's pre-operative intra-oral radiograph showed only the crown and a small portion of the root of the third molar tooth. In view of the inadequate pre-operative assessment the claim appeared indefensible and was settled for £2,500.

Endodontics

A patient in Northern Ireland complained of labial paraesthesia following root canal therapy of the 76/ with Endomethasone. A radiograph showed extrusion of Endomethasone through the apex of the distal root of 7. The Society settled the resulting claim in the sum of £4,500.

A similar case occurred in England where /6 was root filled with 'SPAD'. The resulting claim was settled for £3,015.80p.

A case in Australia, in which root canal therapy was provided to an incorrect tooth, was settled for A$500.

A further case in Australia involving lateral perforation of the root of 1/ was settled at A$1,500.

Orthodontic extractions

3/was extracted in mistake for C/. Settlement was effected in the sum of £1,750.

A second case in England where 5| and 5| were extracted in error for 4| and 4|, was settled in the sum of £1,000.

Mistakes over the 'wrong tooth' are avoidable and, if they do occur, are indefensible.

'Belt and braces'

The Society notes an increasing number of cases in England and Wales where patients attempt to test the validity of their complaint through the National Health Service complaints machinery before making a claim for damages through the courts.

A member was found in breach of his Terms of Service for providing two bridges and two crowns which were defective. The Secretary of State confirmed a withholding of £355. The patient subsequently made a claim which was settled by the Society in the sum of £5,000.

In a second case the member was found to be in breach for the provision of unsatisfactory conservative treatment. The Secretary of State confirmed a withholding of £1,000 and a period of prior approval. The patient subsequently made a claim against the member which was settled by the Society in the sum of £3,028.

Damage to circum-oral tissues

In England a case of a burn to the lip from a dental handpiece was settled for £900 and a laceration to the floor of the mouth from a carborundum wheel was settled at £1,000.

Eye damage caused by dental cement falling on the unprotected cornea was settled in the sum of £300.

Like the extraction of the wrong tooth, errors of this kind are avoidable and, when they occur, usually indefensible.

Root in the antrum

A member in Northern Ireland attempted removal of 6/ and, being unsure whether all the roots had been removed, asked a senior practitioner to inspect the socket. The socket was pronounced satisfactory. When the patient returned complaining of a bad taste in the mouth and a discharge from the nose he was referred to hospital with a suspected root in the antrum. No reason was given to the patient for the referral. Neither practitioner had examined the tooth to make sure that no fragment remained and no radiograph was taken when the presence of a retained root was suspected. A settlement was effected in the sum of £4,600.

Fractured reamer

The Society settled a claim in the sum of £400 when it emerged that a member had fractured a reamer in the 1/, without informing the patient that the reamer had fractured or that the fractured portion had been left in situ and had failed to make arrangements to follow up the case.

Crowns and bridgework

A member in Australia provided a four-unit bridge in the lower right quadrant which proved to be unsatisfactory. Having received a report from an independent expert who criticised the marginal fit of the bridge, the Society paid damages to the patient of A$10,000.

Another member in Australia provided for a patient four root treatments, one porcelain-bonded-to-precious-metal-crown and a three-unit bridge replacing /2. All the treatments subsequently proved unsatisfactory and the Society effected settlement of the patient's claim in the sum of A$16,000.

Exotica

Damage to the ear

Having removed the third molar teeth under general anaesthesia, a registrar in oral surgery attempted to remove a pearl earring from the right external auditory meatus. The registrar in ear, nose and throat surgery was unable to attend in the operating theatre. The oral surgeon attempted removal of the earring with standard ENT packing forceps but propelled the foreign body into the ear drum, causing a perforation. The resulting claim was settled for £3,000.

In a case which occurred in Eire a patient's ear lobe was trapped between the handle and the spring of a Mason's gag during anaesthesia. The patient sustained a cut about 5mm long into which a stitch was inserted to stop the resulting haemorrhage. The case was settled in the sum of IR£2,730.

Loss of sight

A patient was admitted to hospital in Australia having sustained a depressed comminuted fracture of the left zygoma. Following elevation of the zygoma under general anaesthesia, the patient complained that he was unable to see through his left eye. The surgeon in charge of the case did not carry out a ward round on the day following surgery. The registrar failed to take any action despite excessive pain and gross swelling of the left eye lid with dilatation of the left pupil. Sight in the left eye was lost. In retrospect it was realised that the left antrum had been overpacked in an effort to stabilize the zygomatic fracture. Settlement was effected in the sum of A$96,000 to which the Society contributed A$57,500.

Report of the Council

The Council has pleasure in submitting its report together with the accounts for the year ended 31st December 1986.

1 **Principal Activity**
The Society's business is to protect, support and safeguard the character and interests of medical and dental practitioners. The Society is non profit making and does not pay a dividend.

2 **Review of the Business**
The results for the year are stated in detail on pages 68-76.
The review of the business appears in the Treasurer's report below.

3 **Members of the Council**
The members of the Council are noted on page 2. Dr G J Myers retired on 8th October 1986. Dr A D G Brown was elected to Council on that date.

4 **Auditors**
Robson Rhodes have expressed their willingness to continue in office as auditors and a resolution for their re-appointment will be proposed at the forthcoming annual general meeting.

By order of the Council

50 Hallam Street
London W1N 6DE

P G T Ford
Secretary

15th July 1987

Treasurer's report

Subscriptions & Instalments

The further increase in subscriptions for 1988 is regrettable but necessary. The level of subscription is set to enable the Society to meet the anticipated claims, costs and administration expenses which arise in relation to the year in question. This is based on advice given by the Society's actuaries.

The recent reporting of a claim in excess of £1,000,000 indicates that the magnitude of this judgement will have an effect on the Society's contingent liability. This in turn will be reflected in future subscription rates.

The scheme whereby subscriptions can be paid by instalments in advance at the previous year's rate is under review. The amount of income lost to the Society by members paying at the previous year's rate is too great. For the meantime we will not be accepting any new entrants to the scheme and will shortly be writing to all members currently paying their subscriptions by this method.

Administration Costs

It is the Society's policy to keep administration costs to a minimum consistent with its ability to provide the service that members are entitled to expect. In an environment where patients are becoming more litigation minded it is inevitable that an increase in staff has been necessary to handle a greater workload. To accommodate the extra staff required, more accommodation has been obtained at 78 Great Portland Street, London W1 and whilst this will of course entail additional cost, it will enable a better service to be provided to members.

Recruitment Policy

Although a small proportion of the Society's costs on recruitment is reflected in the annual subscription, the Council decided that recruitment costs should this year be kept to a minimum in an attempt to halt an escalating expenditure. A letter to this effect has already been sent to final year students. Some of the monies saved has been redirected into a research programme on risk management which is likely to benefit all members in the future.

Census

In February 1987, each U.K. medical member was sent a form asking for details of their professional activities. It is proposed that until an adequate number of replies has been received to defer a statistical presentation.

30% of these forms have not been returned; it would be much appreciated if you would do this as soon as possible, to enable more meaningful statistics to be available.

Investment Management

Earlier this year the Council approved the appointment of Barclays de Zoete Wedd as Investment Managers.

D G A Eadie
Treasurer

Income and Expenditure Account

Year ended 31st December 1986

	Note	1986 £000	*1985 Restated £000*
Income			
Members' subscriptions and donations	2	18,659	*16,438*
Expenditure			
Costs and damages	1(h)	9,815	*7,687*
Legal expenses		3,399	*2,396*
Administration expenses	4	3,858	*3,242*
Exchange adjustments	1(e)	430	*1,058*
		17,502	*14,383*
Excess of Income over Expenditure		1,157	*2,055*
Income and Realised Gains from Investments	3	1,984	*2,159*
Surplus on Ordinary Activities Before Taxation		3,141	*4,214*
Tax on Income and Realised Gains from Investments	5	(599)	*(667)*
Surplus for the Year after Taxation available to meet future Liabilities and Charges	12	2,542	*3,547*

The notes on pages 71 to 76 form part of these accounts.

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

Income and Expenditure Account
Year ended 31st December 1986

	Note	1986 £000	*1985 Restated £000*
Income			
Members' subscriptions and donations	2	18,659	*16,438*
Expenditure			
Costs and damages	1(h)	9,815	*7,687*
Legal expenses		3,399	*2,396*
Administration expenses	4	3,858	*3,242*
Exchange adjustments	1(e)	430	*1,058*
		17,502	*14,383*
Excess of Income over Expenditure		1,157	*2,055*
Income and Realised Gains from Investments	3	1,984	*2,159*
Surplus on Ordinary Activities Before Taxation		3,141	*4,214*
Tax on Income and Realised Gains from Investments	5	(599)	*(667)*
Surplus for the Year after Taxation available to meet future Liabilities and Charges	12	2,542	*3,547*

The notes on pages 71 to 76 form part of these accounts.

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

Balance Sheet
As at 31st December 1986

	Note	1986 £000	*1985 Restated £000*
Fixed Assets			
Tangible assets	8	873	*536*
Investments	9	21,793	*16,601*
		22,666	*17,137*
Current Assets			
Debtors	10	364	*354*
Bank deposit accounts		5,753	*5,457*
Cash at bank and in hand		613	*1,135*
		6,730	*6,946*
Creditors: Amounts falling due within one year	11	(4,525)	*(3,891)*
Net Current Assets		2,205	*3,055*
Total Assets Less Current Liabilities		24,871	*20,192*
Accumulated Funds			
Income and expenditure	13	18,995	*16,453*
Revaluation reserve	13	5,876	*3,739*
Available to meet future liabilities and charges	12	24,871	*20,192*

D W Sumner — *Chairman of Council*
D G A Eadie — *Treasurer*
15th July 1987

The notes on pages 71 to 76 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 68 to 76 in accordance with approved auditing standards.

As stated in note 12, the Society has estimated the contingent liability for damages and costs in respect of claims undertaken up to 31st December 1986 at £95 million. No estimate has been made for potential claims for incidents which have occurred but for which no notification of a claim has been received.

Subject to the ability of the Society to generate income in future sufficient to meet the actual damages and costs, in our opinion the accounts give a true and fair view of the state of the affairs of the Society at 31st December 1986, and of the surplus and the source and application of funds for the year ended on that date and comply with the Companies Act 1985.

186 City Road
London EC1V 2NU
15th July 1987

ROBSON RHODES
Chartered Accountants

Statement of Source and Application of Funds

Year ended 31st December 1986

	1986	*1985 Restated*
	£000	*£000*
Source of Funds		
Surplus on ordinary activities before taxation	3,141	*4,214*
Items not involving movement of funds		
– Depreciation	163	*105*
– (Profit) on sale of fixed assets	(5)	*(3)*
– Realised gains from disposal of investments	(464)	*(503)*
	(306)	*(401)*
Funds Generated by Operations	2,835	*3,813*
Funds from Other Sources		
Proceeds from sale of investments	3,115	*3,980*
Proceeds from sale of fixed assets	15	*16*
Loan repayments	—	*2*
Total Funds Generated	5,965	*7,811*
Application of Funds		
Loans advanced	3	—
Purchase of investments	5,703	*7,281*
Purchase of fixed assets	510	*233*
Taxation paid	640	*564*
	6,856	*8,078*
Movements in Working Capital	(891)	*(267)*
Represented by:		
Increase/(decrease) in debtors	10	*(624)*
(Increase) in creditors	(904)	*(1,172)*
Decrease in subscriptions paid in advance	215	*1,098*
Movement in Net Liquid Funds		
(Decrease)/increase in cash and bank balances	(212)	*431*
	(891)	*(267)*

The notes on pages 71 to 76 form part of these accounts.

Notes to the Accounts

Year ended 31st December 1986

1 Accounting Policies

(a) Restatement of prior year

Up to 1985 the Society made annual transfers to the provision for liabilities and charges, which at 31st December 1985 totalled £19,200,000. In view of the fact that the whole of the Society's assets are available to meet liabilities and charges, it has been decided to dispense with that provision. The 1985 comparative figures have been restated onto this basis (see note 12).

(b) 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.

(c) Subscriptions

Subscriptions received by the Society and its agents during the year ended 31st December 1986 and due before that date are included as income of the year without apportionment.

(d) 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

(e) 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.

(f) Investments

Listed investments are included in the balance sheet at market valuation. Surplus on sale of investments comprise the excess of net proceeds over acquisition costs.

In 1985 the surplus on the sale of investments was calculated on the basis of opening market value and shown as an extraordinary item. The 1985 comparative figures have been restated on the new basis.

(g) 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.

(h) Costs and damages

Provision is made in the accounts and included in creditors for all agreed liabilities on cases notified before 31st December 1986.

Notes to the Accounts (Continued)
Year ended 31st December 1986

This includes expenditure incurred in the period to 31st March 1987 relating to the year ended 31st December 1986. Note 12 records the potential further liability for future costs.

(i) **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. Provision is made for tax deferred because of timing differences between the treatment of items for tax and accounting purposes, except to the extent that there is reasonable probability that such deferred tax will not become payable in the future.

2 Subscriptions

Subscription analysed by geographical area:	1986 £000	*1985 £000*
United Kingdom and Eire	12,439	*11,481*
Australia and New Zealand	5,091	*3,790*
South Africa	618	*606*
Far East	511	*561*
	18,659	*16,438*

3 Income and Realised Gains from Investments

	1986 £000	*1985 £000*
Realised gains from disposal of investments	464	*503*
Dividends: listed investments		
—franked	356	*269*
—unfranked	491	*650*
Loan and bank interest	653	*707*
Rental income	20	*30*
	1,984	*2,159*

4 Administration Expenses

Charged under this classification are:	1986 £000	*1985 £000*
Audit fee	18	*7*
Emoluments and expenses of members of Council (Note 6)	100	*96*
Depreciation on fixed assets	163	*105*

Notes to the Accounts (Continued)
Year ended 31st December 1986

5 Taxation

	1986 £000	*1985 £000*
Corporation tax at 36.25% (1985–41.25%) on income and realised gains from investments	495	*586*
Overseas tax payable	11	*9*
Overseas tax recoverable	(11)	*(9)*
Income tax on franked investment income	104	*81*
	599	*667*

No provision has been made for taxation of approximately £1,430,000 *(1985 — £1,030,000)*, which would arise should the Society's investments be sold at the market value recorded in the balance sheet.

6 Emoluments of Members of Council

	1986	*1985*
Chairman and highest paid member of Council	17	*10*

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

	1986	*1985*
£ 0 — £ 5,000	22	*25*
£ 5,001 — £10,000	4	*1*

Emoluments include fees, travelling and other expenses.

7 Employees' Remuneration

The average number of people employed by the Society during the year was 90 *(1985 — 72)*.

Costs in respect of these employees:

	1986 £000	*1985 £000*
Wages and salaries	1,421	*1,116*
Social Security costs	118	*66*
Pension costs	230	*171*
	1,769	*1,353*

Executive employees received remuneration in the following ranges:

	1986	*1985*
£30,000 — £35,000	10	*4*
£35,001 — £40,000	7	*4*
£40,001 — £45,000	1	*1*
£45,001 — £50,000	1	—

At 31st December 1986, there were loans outstanding to 11 employees *(1985 — 7)* amounting to £81,198 *(1985 — £144,495)*, £8,780 of which is included in investments (being mortgage loans).

Notes to the Accounts (Continued)
Year ended 31st December 1986

8 Tangible Assets

	Freehold property £000	*Leasehold property* £000	*Computers, furniture, fittings, and office equipment* £000	*Motor cars* £000	*Total* £000
Cost					
As at 1st January 1986	81	144	447	129	801
Additions	—	167	293	50	510
Disposals	—	—	(6)	(19)	(25)
As at 31st December 1986	81	311	734	160	1,286
Depreciation					
As at 1st January 1986	10	33	163	59	265
Provided in year	1	6	116	40	163
Released on disposals	—	—	(1)	(14)	(15)
As at 31st December 1986	11	39	278	85	413
Net Book Values					
As at 31st December 1986	70	272	456	75	873
As at 31st December 1985	71	111	284	70	536

The Council considers, 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 *(1985 — £Nil)*.
Capital expenditure approved and contracted for amounted to £Nil *(1985 — £Nil)*.

9 Investments

	1986 £000	*1985 £000*
Valuation at 1st January	16,601	*12,199*
Additions	5,703	*7,281*
Disposals	(2,768)	*(3,899)*
Loans advanced/(repaid)	3	*(2)*
Surplus on revaluation of listed investments	2,254	*1,022*
At 31st December	21,793	*16,601*
Investments at 31st December 1986 comprise:		
General fund—listed		
—on UK stock exchange	17,864	*13,997*
—on foreign stock exchanges	3,917	*2,595*
Loans to employees (secured)	9	*6*
Portraits	3	*3*
	21,793	*16,601*
Historical cost		
Listed investments	15,905	*12,853*

Loans to employees and portraits are stated at cost.

Notes to the Accounts (Continued)

Year ended 31st December 1986

10 Debtors

	1986	*1985*
	£000	*£000*
Overseas subscriptions owing	83	*23*
Employee loans	72	*139*
Other debtors	177	*154*
Prepayments	32	*38*
	364	*354*

11 Creditors: Amounts falling due within one year

	1986	*1985*
	£000	*£000*
Bank overdraft	42	*56*
Subscriptions received in advance	238	*453*
Corporation tax	378	*419*
Other taxes and social security	55	*37*
Other creditors and accruals	3,812	*2,926*
	4,525	*3,891*

12 Provision for Liabilities and Charges

Provision for Indemnity

The Society carries out the investigation and where relevant undertakes the defence of claims against members. When the Society accepts a case, the Council, in its discretion, has the power to indemnify the member against undetermined costs and damages. 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.

Up to 1985 the contingent liability estimate was based on cases reported to the Cases Committee of the Society. During 1986 an evaluation was made of the contingent liability arising from all cases being investigated by the Society regardless as to whether they have passed through the Cases Committee. The Society has estimated the contingent liability for damages and costs in respect of claims undertaken up to 31st December 1986 at £95 million. *(1985: £70 million).* These amounts represent the Society's estimate of the potential net cost (after recovery from the underwriters) of all current claims notified to the Society. No estimate has been made of potential claim 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 annual subscription.

Notes to the Accounts (Continued)
Year ended 31st December 1986

13 Accumulated Funds — Available to meet future liabilities and charges

	1986		
Movements in reserves:	Revaluation reserve £000	Income and expenditure £000	Accumulated funds £000
At 1st January 1986			
As previously reported	—	*992*	*992*
Prior year adjustments:			
—Unrealised surplus on listed investments	*3,739*	*(3,739)*	—
—Provision for liabilities and charges	—	*19,200*	*19,200*
As restated	*3,739*	*16,453*	*20,192*
Surplus on revaluation of listed investments	*2,254*	—	*2,254*
Less: Realised gains on listed investments sold (included in surplus for the year)	*(117)*	—	*(117)*
Surplus for the year after taxation	—	*2,542*	*2,542*
At 31st December 1986	*5,876*	*18,995*	*24,871*

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

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. 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.

Rates of subscription
(from 1st January 1988)

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

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.

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 annual direct debit is possible in the United Kingdom and the Republic of Ireland and is normally the most reliable method. A leaflet, giving full details, has been included with this Report.**

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.

Overseas membership; practice in Canada and the USA

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. 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 FAX. (08) 2675349

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
Fax: (03) 347 0029

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,
G.P.O. Box 1957, Hong Kong.
Tel: 5-278285, 5-278891, 5-278915
Cable — MEDICASSOC HONG KONG

Malaysia

Malaysian Medical Association,
4th Floor, M M A House,
124 Jalan Pahang, 53000
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,
Ground Floor, Housemen's Quarters,
College Road, Singapore 0316,
Republic of Singapore.

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) 2529866 (07) 2529006

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) 543-609

Singapore

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

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.
Consent, Confidentiality, Disclosure of Medical Records.
Statutory Notifications — A leaflet for U.K. Practitioners.
General Practice Complaints Procedure.
The Mental Health Act, 1983.
Damage to Teeth during Administration of General Anaesthesia.
The Abortion Act — comments and advice.
Medico-Legal Reports and Appearing in Court.
'Theatre Safeguards' — (Produced by the three British protection and defence organisations, The National Association of Theatre Nurses and The Royal College of Nursing).

Dental Publications

Self-Protection in Dentistry.
Consent to Dental Treatment. *(Revised 1987).*
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.

Films: 16 mm colour and Video cassettes

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

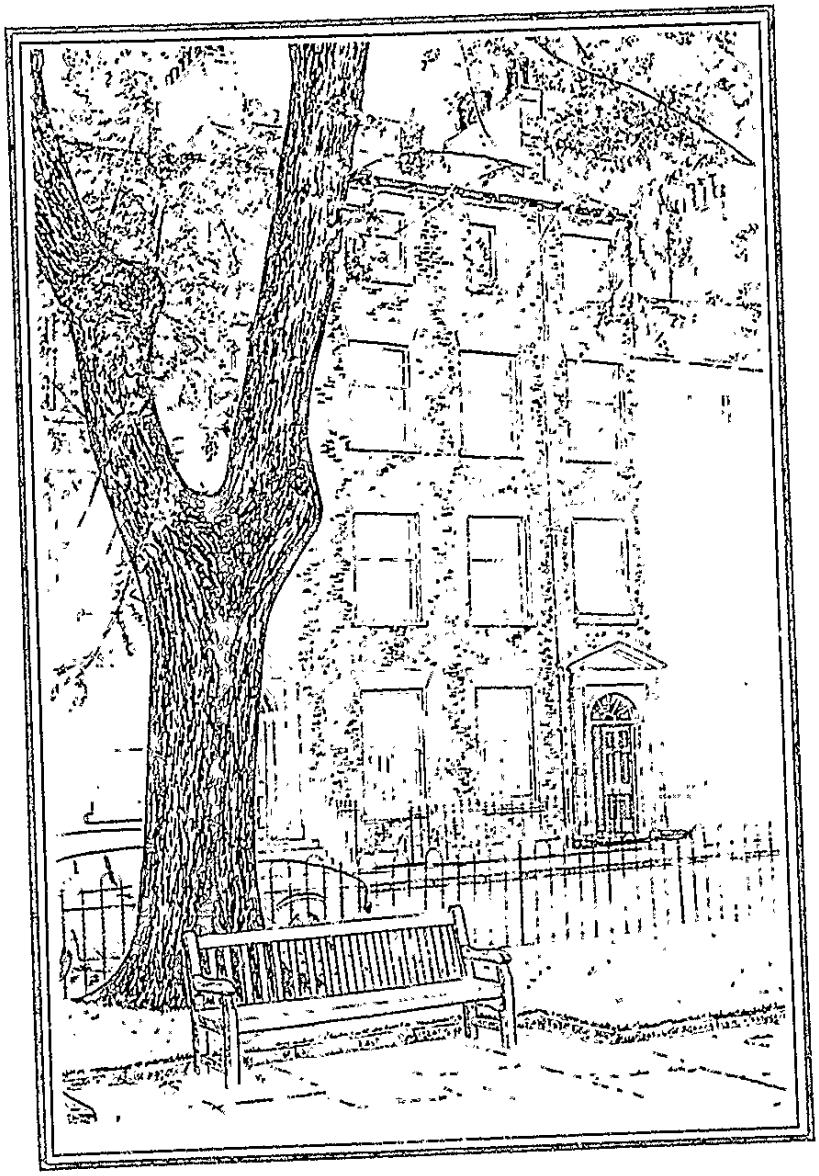
Dental
Medical Emergencies in Dentistry.
Radiation Dangers in Dentistry.
The Break.

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; Pitfalls in Suturing	9
Pitfalls in Management of Thyroid Disease	10
Medical Communication	11
Practice 'in the Bush'	11
Communications Check List	11
Problems of Medical Practice in a Multi-Cultural Society	12
Diseases of Immigrants	12
Medico-Legal A to Z	13
Guidelines for Obstetrical House Officers	14
Occupational History	15
Pitfalls in Vascular Surgery; The Doctor Victim	16
Drug Matters	
Digoxin	2
Chloroquine	3
Calciferol	5
Sodium Bicarbonate	7
Prescribing by House Officers	8
Epilepsy and the Pill	11
Drug Interactions in Psychiatric Patients	14



30 Park Square, Leeds LS1 2PF