The Medical Protection Society

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ANNUAL REPOR

The Medical Protection Society

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REPORT OF THE CHAIRMAN OF THE COUNCIL

To be presented at the Annual General Meeting, to be held on October 5th, 1988.

The principal object of the Society is to protect members' professional interests. As part of the discharge of that obligation, the benefits of membership include complete indemnity for claims arising out of professional negligence. The financial implications for providing this complete indemnity cover are, in the present climate of litigation, serious indeed, not only for the Society's United Kingdom membership, but to the medical and dental professions as a whole throughout the world. In this age of consumerism, members are increasingly being called to account for the consequences of their professional judgement. Complaints may allege negligence or unprofessional conduct and may be processed by Courts of Law, Statutory Tribunals or Registration Authorities, procedures varying from jurisdiction to jurisdiction. Apart from payment of compensation, the provision of the best service for members in such circumstances demands skilled support from the medical, dental and legal expertise of the Society, for which a price has to be paid. This is not a luxury — it is essential, but it does require the loyalty of all members of the medical and dental professions. Mutuality must be the corner-stone of the Society's philosophy. In the opinion of your Council, those who seek to promote a 'cheaper' insurance-based scheme for cut price indemnity are doing themselves and their professions great harm.

No-one can seriously dispute the benefits of the principle of professional mutuality within the framework of a non-profit making organisation, but the admitted variations of expenditure for different specialities and sections of the professions raises serious questions as to how the rates of subscription can be most fairly determined. There will never be an answer which completely satisfies each individual member, yet I do urge the membership to retain faith in the concept of mutuality and to resist the overtures of commercial interests.

The superficial attractions of a so-called "cut-price, no frills" indemnity-only scheme demand careful examination if a short-term gain is not to become a medium-to-long-term disaster for the profession. Exclusions and limitations on practice may combine with other more sinister "small print" contractual pitfalls to make for later rueful regret. Contrary to popular belief, general practice is by no means a "low-risk" specialty as the cases reported in the pages to follow will show. Nor will a "no-frills" scheme assist the practitioner who faces a problem of professional accountability, such as a formal complaint or disciplinary matter, an increasingly common source of applications by members for assistance in the consumer and employer-oriented times in which we practise.

What is your Council doing? For the first time the Doctors' and Dentists' Review Body in the United Kingdom has received evidence from the Society concerning the financial implications of professional indemnity, which has achieved limited concessions on behalf of members who are employed whole-time in the National Health Service. Further representations will continue to be made to appropriate bodies. Also, approaches have been made to patients' organisations to seek to establish the problems that the consumers -- our patients — have concerning the delivery of health care.

The aim of your Council remains to provide a totality of medico-legal care for members of the Society. It remains concerned to avoid unnecessary expenditure, to support subscribing members with advice, legal representation and indemnity in an ethical and responsible fashion, and to develop a fair subscription policy. Additionally, we see ourselves as having a duty to the public by encouraging the highest standards of practice and by the equitable settlement of those cases where Members are responsible for avoidable harm to patients.

J. J. Bradley
Chairman of Council

PRESIDENT'S COMMENTARY

The effects on litigation of changes in medical education

The Society's evidence to the Doctor's and Dentist's Review Body contained a very clear account of the circumstances which necessitated the increase in the full subscription to over £1,000 in 1988, including points which the Society had already drawn to the attention of the Department of Health and Social Security.

It was therefore not entirely surprising, but very gratifying, when the Review Body subsequently recommended that two-thirds of the medical rate of subscription should be reimbursed as an expense to all whole-time employed practitioners or part-time practitioners working wholly for the National Health Service, paying the medical rate, with effect from 1 January 1988.

Last year the Society made efforts to obtain a clearer picture of the degree of risk and the nature of problems with which each group of doctors was confronted. This showed amongst other things, that Junior Doctors made up some 30% of the home membership of the Society, but accounted for less than 30% of its subscription income and some 40% of the Society's expenditure.

Junior Doctors are by no means all Junior Hospital Doctors (they include those in training for General Practice) and some, though still classed as Juniors, have been qualified 10 years or more. A majority however, are paying reduced subscriptions and the lower the subscriptions paid by them in the first six years after qualification, the higher must be that paid by those qualified seven years or more.

It is not of course surprising that many of the cases referred to the Society involve Junior Doctors. Even in the days, not so long ago, when most clinical problems in this country consisted of acute, florid easily-recognised organic disease, and remedies were few and relatively simple, mistakes were made when the young took their first steps into clinical practice. But they did so then as students. Nowadays, young doctors who have had next to no clinical experience as students find themselves confronted for the first time with acute illness requiring prompt decisions — and the clinical problems they face are much more complex than those of thirty or forty years ago and the chance of errors of commission or ommission far greater. The circumstances under which decisions have to be taken are also often much less easy than those under which students gained their experience in the past.

Not all cases involving junior doctors relate to the care of patients. In recent years new problems have emerged. Not infrequently the Society is called upon to help juniors who find themselves in difficulty or conflict with employing authorities or with those responsible for their training. There can be little doubt that this, too, is a consequence of the revolution that has taken place in medical education whereby so much of what formerly made up the medical school course has been translated to the years after graduation. Students are no longer part of the working world but more in a world of their own, a world within a world, with little opportunity to learn how to balance their private concerns with professional demands. The task of coming to terms with the vocational world has been translated to the years after medical school and those who have difficulty with it find themselves not students in the Dean's Office but young doctors in conflict with other authorities and the Society finds itself confronted with problems which would make a significant demand on its professional and financial resources.

Cases involving junior doctors are therefore, to a considerable extent, a natural outcome of their training process, and near to inevitable if staffing levels prevent close supervision. The cost of them is part of the cost of training. It is hardly fair that the trainers, who receive little or no financial reward for training, should also pay through their subscriptions to the defence societies for the cost of mistakes arising as a consequence of the training process. Repaying part of the subscriptions of members employed whole-time in the National Health Service goes some way towards remedying that situation but the great majority of part-time consultants are also engaged in training and should receive concessions similar to those of their whole-time colleagues.

Meanwhile the study of what leads cases of complaints and claims to arise must continue so that factors which contribute to medical mistakes can be identified and prevented. The progress of the research on which the Society is engaged in collaboration with University College, London, is reported elsewhere. It is of course a difficult field of research. Inevitably time and money have to be spent at the outset developing tools which can be used in later enquiries, but the nettle has been grasped and a good start made.

Sir John Ellis
President

ADVICE TO MEMBERS

Explanations and apologies

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.

Nota bene

- 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.

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 representative 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 practice 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 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 nurse, dispenser, physicist, radiographer physiotherapist, or dental auxilliary, 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 available indemnity schemes, 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 the member's 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.

COMMUNICATIONS WITH THE SOCIETY

Members should not incur legal expenses without the Society's prior 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)

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.*		Messrs. Hayes & Sons 15 St. Stephen's Green North, *Dublin 2.*	
Telephone:	Belfast (0232) 244951	Telephone:	Dublin 688399
Telex:	74550	Telex:	90369 HSS
Facsimile:	(0232) 245768	Facsimile:	Dublin 612163

Overseas

- By letter, telephone, telex or facsimile to the Registered Office in London, or
- Through the appropriate Scheme of Co-operation (see list on pages 62 and 63)

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

Disposal of 'sharps'

Members are reminded of the need to dispose safely of hypodermic needles and other 'sharps'. The Society continues to receive notice of instances where avoidable injuries have been caused through inappropriate disposal of 'sharps'. Members are referred to guidance on the safe disposal of 'sharps' in secure containers intended for incineration. Injuries caused to waste-disposal personnel leave practitioners vulnerable not only to claims for compensation but also to criminal prosecution under Health & Safety legislation.

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.

Falsification of case notes

Disciplinary proceedings can result from dishonest acts committed by a doctor against patients or colleagues. The General Medical Council has issued the following statement:

"The keeping of accurate medical records is essential to the maintenance of a high standard of patient care, and can be vital to necessary communication between one doctor and another. To this end it is recognised that a doctor may have occasion to amend or supplement an entry in the casenotes of a patient, in good faith, in order to confirm or reject an early tentative opinion or to correct inaccurate information. Casenotes may also in certain circumstances need to be revised, for example after discussion with the patient has clarified some point. Alterations of this kind are entirely proper, but should always be correctly initialled and dated. A doctor who, with intent to deceive, makes an entry in a patient's medical records, knowing it to be false or misleading, or amends an entry by adding or substituting false information or by deleting genuine information, is deliberately falsifying the casenotes. This is unethical and a doctor so doing will be liable, if the matter is reported to the Council, to disciplinary proceedings."

ADVICE FROM COUNCIL

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."

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.

There 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 9).

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 fully 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 alway 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.

ADVICE FROM COUNCIL

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.

'Pharmacy' — a statutory meaning

A general practice partnership which operated a dispensing practice published a brochure in which was explained the dispensing facilities available for patients. The Practice referred in the brochure to "The Pharmacy". The brochure came to the attention of the Pharmaceutical Society which took issue with them and threatened a criminal prosecution under the Medicines Act 1968 because the word 'pharmacy' is defined and its use is restricted in law by virtue of that Act.

The Act [Section 78(4)] restricts the use of the title 'Pharmacy'. It can be used only in respect of a registered pharmacy or in respect of a pharmaceutical department in a hospital.

The moment the doctors heard from the Pharmaceutical Society they stopped issue of the brochure and revised the text for subsequent publication. The Pharmaceutical Society accepted the doctors' swift retraction and no more was heard.

Diagnostic radiology and laboratory medicine request forms

Clinicians who seek assistance from colleagues in laboratory medicine and in diagnostic radiology are reminded of the need to provide adequate clinical information on the request forms. Abnormal findings may be missed, or their significance may not be appreciated, where basic clinical information is absent from the request forms. One example of this is described on page 30 in the case entitled *'Missed depressed malar fracture'*.

In another case reported to the Society, a general practitioner referred an elderly lady to a Department of Diagnostic Radiology with a request for 'cervical spine X-rays' but no indication as to the reason for the request. Thanks to the acumen of the hospital department, a history was taken from the old lady from which it was learned that she had sustained an injury. Therefore an odontoid peg view was taken. But for the acumen of the radiographer, an odontoid peg view might not have been taken and a peg fracture missed. Furthermore, in interpreting the X-ray films the radiologist might have missed the significance of a rather subtle compression of C6.

Failure to provide adequate clinical information on the request form may lead either to an incomplete examination being performed or to some important aspect of interpretation being overlooked, to the detriment of the patient.

Shortfalls in resources

The Society remains concerned about the effects on patient care of economies imposed in response to limitation in funds, facilities and resources. We repeat the advice given in our 1984 Annual Report (No. 92 page 22) 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.

Whilst the law requires the exercise of a reasonable standard of care and cannot expect doctors to do more than their reasonable best, the standard is a high one and deviations from it may result in findings of negligence. Threats to the standard of care which members can provide for their patients should be carefully discussed between colleagues. Where shortfalls are considered to impose an unacceptable risk to safe patient care representations should be made to those responsible for managing the service, for example the appropriate administrators in the National Health Service. Whilst verbal discussions are most helpful, members' concern should be confirmed in writing as should their professional advice for appropriate action.

It is likely to carry greater weight with those responsible for managing the service if the reservations of the medical and dental professions are conveyed collectively, through appropriate professional advisory machinery such as consultant staff committees, specialty division committees, local medical and dental committees, etc. Careful and considered representation made through proper channels and, of course, documented adequately in writing will be of the very greatest assistance to members if their professional decisions are challenged by or on behalf of patients — e.g. in complaints or claims. If it can be demonstrated that avoidable harm to patients was a direct consequence of unheeded professional advice, then the Society is well placed to argue, on behalf of members against whom criticism is made, that the legal consequences and financial penalties should be borne by the health authority and not by the Society.

ADVICE FROM COUNCIL

An acquiescence (often by silence) in cuts which are harmful to standards of patient care may leave members vulnerable to criticism and their protection society liable to pay compensation because health authority managers and administrators are not slow to point out that professional staff raised no objection to cuts, and so may be taken to have agreed them and to have accepted the legal and financial consequences thereof.

We list below a few examples of the problems which members have brought to the attention of the Society and on which advice has been sought. The list is not comprehensive nor in any particular order of priority but is intended to illustrate something of the nature and extent of the problems facing members and the Society.

(a) Shortage of hospital medical staff to provide adequate screening of letters of referral from general practitioners resulting in a lack of capacity to identify those patients who should be seen urgently;

(b) Withdrawal of bacteriological checking of incubators after cleaning thus presenting unacceptable risks of infection to new-born babies;

(c) Cessation of ENT services at a general hospital without prior consultation with the medical staff and with no provision made for the follow up of existing patients;

(d) Cuts in routine laboratory services and in the level of medical staffing, nursing and allied services;

(e) Reduction of the number of beds at a hospital with the consequent necessity of admitting patients to inappropriate wards, or leaving them for unacceptably long periods of time in the Accident and Emergency Department;

(f) Withdrawal of the provision of radiographs for out-patient clinics because of lack of the necessary secretarial and clerical staff;

(g) Closure of wards in a hospital resulting in difficulties over admitting emergency cases and concern about the necessity of transferring some of those cases to another hospital;

(h) Closure of a peripheral GP maternity unit with consequent extra strain on the resources available to the main unit in the hospital, the necessity to introduce a quicker discharge of patients at the hospital and the need to delegate decisions on the discharge of patients to midwives and nursing sisters;

(i) Closure of sole remaining ward resulting in intravenous pyelograms being transferred to another hospital;

(j) Unacceptable decision by hospital management to place rheumatology patients in orthopaedic wards;

(k) Transfer of 45 long-stay beds at one hospital to the geriatric department of another hospital resulting in considerable extra work load on junior staff required to give 24-hour medical cover;

(l) Decline in clinical support services at a hospital resulting in increasing difficulties in providing safe and adequate clinical services;

(m) Re-organisation of psychiatric services leading to increasing difficulties for junior staff in providing safe medical cover.

(n) Secretarial services.

THE MPS RESEARCH PROJECT

Professor R.J. Audley, PhD, FBPsS,
Head of Psychology Department and Vice Provost, University College London.
C.A. Vincent M Phil PhD,
Research Fellow, University College, London.

In December 1984 the Council of the Society awarded a contract for a two year pilot project to study mishaps in medicine. Following reports of the research, and the submission of plans for future work, the Council decided to renew the contract. The award was increased to allow for a second research worker.

The research is seen by the Society as being an essential component of its increasingly-important risk management programme. The broad aims of the research are:

(i) To develop an understanding of the nature and causation of medical errors and mishaps.
(ii) To determine the incidence of such errors and mishaps.
(iii) To consider how errors and mishaps might be reduced through changes in education, training and procedures.
(iv) To assist members of the Society engaged in similar work.

The Pilot Project

The work carried out during the pilot project is described in detail in an unpublished report to the Society (Avoidable mishaps in medicine, Audley, R.J. and Vincent, C.A.). The report briefly reviewed the existing literature on medical audit, medical error and the general literature on accidents and error before describing work carried out by the research team. Research was initiated within the MPS and observational studies were carried out in Accident and Emergency departments.

(a) Research within MPS

An important component of the project as originally conceived was the analysis of existing MPS records. Records of serious obstetric cases are being reviewed (see below). However, because of difficulties inherent in working from medical records, an alternative approach to collecting data on incidents reported to the Society is being devised.

A second component of work within the Society was the devising of a scheme of confidential reporting which would enable doctors to report worrying incidents to the Society without prejudice. The scheme has now been put into operation with MPS members working in obstetrics and gynaecology (see below). Depending on the response and the focus of future research, it may be extended to other specialties.

Three projects were begun during the pilot project.

(b) Accident and Emergency

One of the main aims of the first study was the exploration of methods of working in accident and emergency departments. In particular it was necessary to determine what level of staff involvement in the collection of data was feasible in a busy accident and emergency department. The two later studies however bore directly on the most important source of reports to MPS from accident and emergency — diagnostic error. The principal findings from each study are briefly described.

(i) The use of the accident and emergency department

A high proportion of patients attending accident and emergency departments have non-urgent complaints. This inevitably detracts from the care given to more severe cases, with potentially serious consequences. This suggests there is a need to reduce the number of inappropriate attenders either by educating the public or by screening patients attending departments. The study confirmed that patients cannot accurately assess their need for urgent treatment, and that it is unlikely that a method of reducing inappropriate attendance could be implemented that did not involve risk to a proportion of patients. The role of accident and emergency departments may have to be extended to provide more general primary care.

(ii) The interpretation of radiographs by junior doctors

This study assessed the ability of junior doctors in accident and emergency departments to detect abnormalities on radiographs. Their assessments of 505 radiographs taken at nights and weekends over a period of eight months were examined. Each assessment by an SHO was compared with the subsequent diagnosis of a radiologist. An error rate of 35% was found. For abnormalities with clinically significant consequences the error rate was 39%.

Although this error rate is high, the results are consistent with those of earlier studies in that missed positive radiographs constituted 2.8% of the total number of radiographs taken in the period. It was considered that the proportion of missed abnormalities gave a truer index of SHOs' abilities. No improvement in performance was evident over the six month period of the SHOs' tenure of post. It may therefore be unrealistic to expect accident and emergency SHOs to acquire this complex skill simply through experience; more formal training and guidance may be needed.

THE MPS RESEARCH PROJECT

(iii) The use of second opinions in the diagnosis of abdominal pain in accident and emergency departments.

Accident and emergency SHOs are required to seek a further opinion from a colleague (usually senior) before a patient can be admitted. This study examined the value of this system of patient management, and provided an audit of the diagnostic skills both of SHOs and advisers.

The diagnoses and referrals both of SHOs and their advisers were examined in 711 patients presenting with abdominal pain. Accuracy of diagnosis was 62.7% for advisers and 54.1% for SHOs. The SHOs, however, referred to the correct specialty in 94% of cases and the advisers improved the SHOs' referral in only 1.1% of cases. It can be argued that the time-consuming process of calling a surgeon away from the ward or theatre to advise in accident and emergency departments is of little value. If accident and emergency SHOs were granted admission rights (in respect of abdominal pain) patients would be admitted more efficiently.

The current project: work in progress

Since the beginning of the second stage of the research in October 1987, work has continued in accident and emergency medicine. Previous studies have been extended, with a greater emphasis being given to the development of procedures for reducing diagnostic error. The principal focus of the research for at least the coming year, will be obstetrics, an area of major concern.

(a) Accident and Emergency

(i) Training in radiographic interpretation

The study described above and the cases reported to the Society show that there is a need for more formal training in radiographic interpretation. Training varies widely between hospitals, but SHOs seldom have more than a brief introduction to the interpretation of radiographs. While there are many comprehensive texts for radiologists, there is no book or manual aimed specifically at accident and emergency SHOs. In response to this need a short, pocket-sized manual of radiographic interpretation for accident and emergency SHOs is being prepared.

(ii) An audit of the diagnosis of acute chest pain

This study is a parallel but more comprehensive investigation to the study on the diagnosis of abdominal pain described above. The diagnoses of both SHOs and advisers will be examined both for admitted and discharged patients. Discharged patients will be followed up. The influence of several aspects of the patient's history and presentation on the accuracy of diagnosis is also being studied.

(b) Obstetrics

(i) A review of serious cases reported to MPS

Serious cases reported to MPS that may be the subject of litigation are reviewed by a member of Secretariat and an outside expert. The expert (a senior obstetrician) provides a summary of the case and an assessment of the nature and causes of the mishap that has occured.

The research team will collate and review a representative sample of these expert opinions, concentrating first on reports that concern brain-damaged babies. The results of this survey will be prepared for publication and for the use of Society members.

(ii) Confidential reporting

A letter has been sent to Society members whose specialty is obstetrics and gynaecology. Circulation has initially been restricted to United Kingdom members of consultant, senior registrar and registrar grades. The letter invites members to suggest lines of research or to report any worrying incident in which they were involved. The replies will enable the research team to focus on aspects of obstetric care that are of especial concern to members, and may also lead to collaborative work with interested obstetricians.

Studies in clinical settings will also be carried out. The first of these is a survey of the skills and abilities of junior doctors.

(c) General

Perceptions of responsibility for medical accidents

This work aims to achieve an understanding of how perceptions of medical malpractice differ between lay and medical groups. A particularly important aspect is how attributions of causality and blame are affected by the severity of the case and the degree of negligence involved, if any. This in turn will shed light on the factors that influence a patient's decision to complain or claim compensation.

Concluding Remarks

Research on medical error and mishap is an important and fruitful area of study. The research team can only study a proportion of these problems, even with generous collaboration from medical colleagues. We hope that our work will stimulate further research by members of the Society. We would hope to assist such work in any way we could, whether or not a formal collaboration was involved. The research team can be contacted by writing to the Society.

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EXPERT EVIDENCE — CHANGES IN THE LAW

1: Criminal cases

Members who offer expert medical advice to the defence in criminal cases will be affected by a change in the law as from July 1987. Not only pathologists but any doctors who offer expert opinions to defence solicitors now need to prepare their correspondence with the lawyers with particular care.

The reason for this change is The Crown Court (Advance Notice of Expert Evidence) Rules 1987, a Statutory Instrument made under the provisions of the Police and Criminal Evidence Act 1984.

The Rules state that any party proposing to adduce expert evidence shall, as soon as practicable, furnish the other party with the findings and opinion — and also, where requested, provide copies of the record of any observation, test, calculation or other procedure upon which such observation or opinion is based.

In effect, this means that the prosecution can now obtain not only a formal opinion provided to the defence by an expert, but any working papers or even physical objects used to arrive at an opinion. Such papers cannot be edited and obviously if an opinion is contained in a letter from the expert to the solicitor, any other comments or observations in that letter must of necessity be disclosed to the prosecution.

It is therefore now prudent, indeed essential, that expert medical advisers to the defence should carefully consider the contents of any reports or letters to their instructing solicitors. Material which is not part of their definitive report should not be mixed with more peripheral matters, especially circumstantial, hearsay or more speculative comments about the case which could prove an embarrassment to the defence or its witnesses in court. If such matters are relayed to the solicitors, they should be contained in a separate communication, clearly headed **"Not for Disclosure"**, which should also be prefaced to any draft report prior to a final opinion being submitted. This safeguard will then protect the doctor should inadvertance or the incompetence of others lead to such material being disclosed to the prosecution.

As a matter of interest, these new Rules were introduced at the behest of a deputation of forensic pathologists to the Attorney-General following the trial of a paediatrician for the alleged murder of a baby, in which a 'surprise defence' based on histological material was sprung on the pathologist called by the prosecution at the trial. Prior to these new Rules, the defence was not obliged to reveal any aspect of its case, other than an alibi.

2: Civil cases

For the working memories of most practitioners in the medico-legal field, parties in medical and dental negligence suits could go to trial without having to disclose their experts' reports on liability at all. This meant that the first the opposing party might know of the opponent's medical expert opinions was when the expert stepped into the witness box. Skilful lawyers could use this non-disclosure to persuade their opponents that their case was in fact stronger than it was. Many people felt it was an anachronism and that it hampered the efficient conduct of litigation.

In the case of *Naylor -v- Preston Area Health Authority (1987) 1 WLR 958* the old non-disclosure rule was overridden and since April 1987 the Court has had two distinct powers:

- first, that unless the Court considers there are special reasons for not doing so, it must direct that the substance of expert evidence is to be disclosed in the form of a written report a specified period before trial;
- secondly when the Court thinks fit it can direct that there should be a without-prejudice meeting of the experts on liability either before or after disclosure of their reports for the purpose of identifying those parts of their evidence which are in issue. When such a meeting takes place the experts can prepare a joint statement indicating on which parts of their evidence they are, and those on which they are not, in agreement.

OVERSEAS QUALIFIED DOCTORS: REGISTRATION WITH THE GENERAL MEDICAL COUNCIL

Introduction

If you have qualified overseas, you may at some stage wish to come to the United Kingdom to gain further professional experience and training in hospital appointments within the National Health Service. For this purpose you will, by law, need to obtain registration as a medical practitioner and membership of one of the medical defence organisations such as The Medical Protection Society. This article describes the various forms of medical registration which may be open to doctors from overseas. Because the registration procedures are complicated the following paragraphs have been designed to assist you in obtaining the registration for which you may be eligible, and to advise you on what you should do to avoid some of the pitfalls which may delay or frustrate registration.

Functions & purpose of the General Medical Council

Medical registration is a function of the General Medical Council (GMC), a statutory body whose primary role is the protection of the British public. It is responsible under the United Kingdom Medical Act 1983 for setting the standards of medical education in this country, and hence the standard required for entry to the Registers. It is also responsible for deciding cases in which a doctor's behaviour raises a question whether he should properly continue to enjoy the privileges which registration as a medical practitioner affords.

Immigration provision for entry to the United Kingdom

Doctors from overseas, other than European Community doctors, are subject to the Immigration Rules operated by the Home Office (Immigration and Nationality Department). In simple terms these rules will restrict you to a period of 4 years' residence in the United Kingdom with what is called Permit-Free status. This enables you to undertake employment in training grade posts within the National Health Service but precludes you from holding career posts.

Preliminary preparation

If you are thinking of coming to the United Kingdom to practise, do get in touch with the GMC well before you leave home, preferably 3 months or more in advance. This should give adequate time to complete the preliminary stages and deal with any difficulties which may arise before you leave for this country. There is nothing more irritating than to arrive here only to find that the GMC cannot grant you registration because, for example, the necessary documentation is deficient or is unacceptable to them. The address you should write to is *The General Medical Council (Overseas Registration Division), 153 Cleveland Street, London W1P 6DE, United Kingdom.* In response to your initial inquiry the GMC will send you an Information Sheet which you will be invited to complete and return. This requires you to provide details of your medical training, qualifications and professional experience. When the GMC have received your completed Information Sheet, they will then assess whether you are eligible for registration, and if you are, they will send you the appropriate form of application and an accompanying note of explanation. You will then know whether you can apply to the GMC for Full or Provisional Registration, or for Limited Registration, or for entry to or exemption from the test of professional knowledge and proficiency in the English language conducted by the Professional and Linguistic Assessments Board (the PLAB test) prior to obtaining limited registration. Further information about the test is given later in this article.

Professional conduct and discipline

When you have been granted registration, the GMC will send you, in addition to your Certificate, a blue pamphlet entitled *Professional Conduct and Discipline: Fitness to Practise.* It is most important that you should read this pamphlet carefully; it contains advice on matters which may lead to the initiation of disciplinary proceedings.

FULL AND PROVISIONAL REGISTRATION

Doctors qualified outside the European Community

There are 22 primary medical qualifications currently recognised by the GMC for full and provisional registration. The Universities awarding these qualifications are situated in Australia, Hong Kong, Malaysia, New Zealand, Singapore, South Africa and the West Indies. If you hold one of these qualifications and have completed your pre-registration year you may forward your application for full registration direct to the GMC while you are still overseas. There is advantage in doing so since your registration could thereby be approved before you arrive in the United Kingdom, or shortly thereafter. Thus you would avoid any possibility of delay in obtaining registration which might occur if you were to leave your application until you arrive here. In support of your application you must send to the GMC:-

- The form of application completed by you;
- Your original diploma attesting your primary medical qualification (or *in lieu* an original certificate from your University attesting that qualification);
- Your certificate of full registration issued by the country in which you qualified;
- A Certificate of Good Standing from every country in which you have practised medicine in the last 2 years. (These certificates must have been issued to you within 3 months of the date on which you make your application);
- The prescribed fee payable to the Council in sterling, and not in some other currency.

When preparing your application, do remember that the GMC will not accept copied documents of any kind, so send only original documents with your application, preferably by registered airmail post. Any document not in English must be accompanied by an official translation.

Full registration will enable you to engage in any form of medical practice in the United Kingdom. If you have not completed your pre-registration year overseas, you will be eligible on the basis of your primary medical qualification for provisional registration in this country which will enable you to acquire the professional experience needed for full registration.

If you graduated from the Universities of the Orange Free State or Pretoria or Stellenbosch, you will be required either to provide evidence of your competence in the English language or, *in lieu*, to pass a test of knowledge of English. If you graduated from the University of Malaya after 1st January 1988, you will also be required to pass the English test.

European Community Doctors

If you are a national of one of the member states of the European Community and hold a recognised primary medical qualification awarded in one of those states you may establish yourself in medical practice in the United Kingdom. But before doing so you must obtain full registration from the GMC. The address you should write to is *The General Medical Council, 44 Hallam Street, London W1N 6AE.* If you are eligible to apply for full registration, the GMC will send you the appropriate form and the accompanying explanatory note. You should complete the form and return it to the GMC together with the prescribed fee payable in sterling in the United Kingdom, your passport which is required as proof of your nationality, and the following documents:-

- Your original diploma attesting your primary medical qualification. If you qualified in Denmark, Germany, Greece, Luxembourg or Portugal, the GMC will require you to forward additionally an original certificate of practical training;
- An original certificate issued to you within the last 3 months by the medical authorities of the member state in which you were last established in medical practice. This certificate must confirm that you are legally entitled to practise and that you have not been disqualified or prohibited from practising as a doctor.

Either;-

- An original certificate issued by the medical authorities of the member state in which you qualified confirming that your primary medical qualification complies with the training standards laid down in Article 1 of the Second Medical Directive 75/363/EEC of the Council of the European Communities;

Or;-

- A certificate issued to you by the medical authorities of the member state in which you last practised confirming that you have been effectively and lawfully engaged in medical practice for at least 3 consecutive years during the last 5 years.

Any of the documents you send to the GMC to support your application for full registration which are not written in English should be accompanied by a translation into English, certified as correct by a government authority or official translator.

Before you commence work as a medical practitioner in the United Kingdom, you will be required to satisfy your employing authority that your proficiency in written and spoken English is sufficient for the appointment you are to undertake. In certain circumstances, you may be asked by those authorities to take the test of knowledge of English conducted by the Professional and Linguistic Assessments Board.

THE PLAB TEST AND LIMITED REGISTRATION

Qualification

In contrast with the position relating to full and provisional registration, there are upwards of 800 qualifications awarded throughout the world which the GMC accept for limited registration. In some cases, however, there are dates beyond which, or before which, a qualification is not so accepted. Do ascertain from the GMC the exact position about your own qualification before you make firm plans to come to this country. It would be most unwise to leave everything to chance only to find when you arrive here that your qualification is not one of those accepted by the GMC and that limited registration and thereby the opportunity to engage in employment as a medical practitioner in this country is not available to you.

The 'PLAB' test

The Professional and Linguistic Assessments Board conducts, on behalf of the GMC, a separate test of professional knowledge and proficiency in the English language (the PLAB test). A pass in this test is a prerequisite for the grant of limited registration, unless you are able to convince the GMC that you can properly be exempted from this requirement. For entry to the test, you must have completed, overseas, a 12 month internship or other professional experience which the GMC regards as equivalent. The GMC will not permit you to take the test unless you have acquired professional experience of this kind after (not before) you qualified, nor will they permit you to undertake house jobs in this country.

The PLAB test is divided into 2 components, one professional and the other linguistic. There are 3 written papers in the medical component and 2 in the language component. There is also an oral examination designed to assess a candidate's medical knowledge and his facility in the use of English. The standard required to pass the test is related to the standard to be expected of a senior house officer working in a British hospital. The tests are held at intervals of approximately one month at various centres in London, Edinburgh, or Glasgow. The written papers are taken on the first day and the morning of the second day and the orals are held during the remainder of the second day or on the third day. In the normal course, you should set aside 3 days to sit the test. It is very important that you should prepare yourself adequately for it. The test is not easy: on average only 25% of candidates at each test are successful. Contrary to popular belief, failure in the test is not in general attributable to inability in the use of English. It is lack of medical knowledge and an inability to apply that knowledge to clinical situations that is revealed by the tests. Careful preparation is essential before you take the test.

If you are eligible to take the test, and the GMC require you to pass it before granting you limited registration, they will send you a form of application and an explanatory note. You should complete the form and return it to the Council, together with original documentary evidence of your qualification and the prescribed fee payable to the Council in sterling. When the GMC has allocated you a place in a specific test, you will be notified by them and they will send you at that time a pamphlet entitled *Advice to Candidates*. This pamphlet, issued by the Board, gives comprehensive details, with examples, of each of the 5 written papers and also of the nature of the oral examination. There are a number of organisations in the United Kingdom which conduct courses of instruction aimed to prepare candidates for the test; some of these advertise in medical publications such as The British Medical Journal.

Restricted and General Exemption from PLAB test

If you have already made progress in your post-graduate training in a particular specialty, you may be eligible for restricted exemption from the PLAB test. For this you will need not only to have completed a 12 month internship or equivalent experience overseas, after you qualified, but you will also need to have completed 2 further years of clinical training, also overseas one of which must have been in the specialty in which you wish to obtain post-graduate training in the United Kingdom.

Additionally, you will need sponsorship. The British Council, the Association of Commonwealth Universities and the Department of Health and Social Security (acting on behalf of the World Health Organisation) arrange a small number of sponsorship schemes for approved post-graduate training but the majority of doctors who gain restricted exemption from the PLAB test do so by what is known as 'double-ended sponsorship'. In essence this means that a consultant in the doctor's country of origin, or in the country in which he is practising, is prepared to vouch for his suitability for post-graduate training in the United Kingdom and his competence in the English language, and is known to a United Kingdom consultant who is prepared to accept the doctor and be responsible

for his post-graduate training. Restricted exemption in this context means that if a doctor wishes to undertake employment outside the scope of the training programme arranged for him by his sponsoring consultant, he will then lose his entitlement to exemption and will have to pass the PLAB test before he can take up any alternative employment.

General exemption from the PLAB test (as distinct from restricted exemption) will be open to you if you have either:-

- Passed the former TRAB test (similar to the PLAB test and conducted by the former Temporary Registration Assessment Board between June, 1975 and February, 1979); or,
- Qualified from one of a number of universities in Australia, Canada, Hong Kong, New Zealand, Singapore, South Africa, the USA or the West Indies, or in the Republic of Ireland after 5 years' undergraduate study in that country, or at the University of Malaya on or before 31 December 1987; or,
- Hold in addition to an acceptable primary qualification granted overseas, a primary medical qualification granted in the United Kingdom or a higher qualification granted in the United Kingdom, the Republic of Ireland or Australia, which is registrable with the GMC.

General exemption will enable you to take up employment in educationally-approved posts in the training grades under limited registration.

Application for Limited Registration

On passing the PLAB test, or gaining restricted or general exemption from it, you will be eligible to apply to the GMC for limited registration. For this purpose you should study carefully the appropriate form of application and the accompanying note of explanation which the GMC will send to you. You should forward the completed form of application to the GMC together with the prescribed fee and, if you have not already done so, original documents attesting your qualifications and official translations of any documents not in English.

Scope of Limited Registration

The GMC will grant you limited registration for not more than 12 months in the first instance. This may be for a specific post or for a range of employment. You should take good note of the terms of your limited registration which are printed on the Certificate sent to you by the GMC. **You should be most careful not to undertake any employment which does not fall within the terms of your limited registration.** The GMC regards with concern instances of doctors who practise while unregistered and, in some cases, they will hold an oral hearing before a Committee into the circumstances in which a doctor is alleged to have practised either without limited registration or outside the terms of his limited registration. In order to be quite sure that you are practising legally at all times, you can always consult the personnel department of the hospital at which you are employed or the GMC

Renewal of Limited Registration

Do always make sure that your Limited Registration is renewed in good time. This is primarily your responsibility not someone else's. The date on which your limited registration is due to end is printed on your Certificate. Well before that date you should make further application to the GMC for a renewal or extension of your limited registration if, in fact, you are to be employed as a medical practitioner beyond that date. Although the GMC may by law grant Limited Registration, at their discretion, for an aggregate period of up to 5 years, in practice the Immigration Rules mentioned earlier in this article now make it impossible for overseas-qualified doctors to work in training grade posts for more than 4 years. It is therefore important that you should make the best possible use of these 4 years in the United Kingdom and plan your post-graduate training accordingly. Your consultant should be able to offer you advice on this and you may find it helpful to consult the Post-Graduate Dean of the region in which you are employed.

MEDICAL CASE REPORTS

Missed meningitis 1

A single-handed general practitioner had scant memory of the events and no contemporaneous records in relation to a claim recently settled for £530,000.

When in 1980 he received a solicitor's letter, he was able to recall the family and the infant patient but nothing of the illness which it was alleged caused the child to be severely brain damaged. Piecing together the events some 8 years after the events (which took place in 1972), it appeared that the then 5-month-old baby had been seen at home by the general practitioner. An upper respiratory infection was diagnosed and ampicillin prescribed. No note was made of the visit.

Two days later the baby was taken by his parents to the casualty department of the local hospital. There (the records show) he was seen shortly after midnight. The examining doctor noted that he had had a cold and that he had been vomiting. The record specifically states that there was no neck stiffness and no dehydration. A doctor advised that the ampicillin be continued and that the patient should be seen again by the general practitioner. The family alleged that the child was visited by him later that morning but, once again, he had no recollection of this second consultation and no note of it. The statement of claim alleged that he had examined the patient and prescribed 'medicines'.

Within 18 hours and in the early hours of the following morning, the parents once again took their baby to the local casualty department. There being no beds available in the local district hospital, the patient was admitted to a nearby major centre for paediatrics where, shortly after arrival, he suffered convulsions. His serum sodium on admission was 174 m.eq/litre. Brain damage had occurred due to the dehydration and hypernatraemia.

The Society investigated the case carefully and thoroughly but was advised that it was indefensible. Issues of causation as well as liability were considered in detail.

When asked whether he would normally have made notes of such consultations the practitioner said he would only have done so "if it had been important"! One cannot say that if the practitioner in this case had kept a record that it would have necessarily meant a successful defence could have been mounted, but that must have been more than a possibility.

The agreed damages, arrived at after detailed assessment of the needs of the patient, were approved in court by the judge, as is the case with all infant settlements.

Missed meningitis 2

In 1984 a 56-year-old woman called her general practitioner and was visited by a doctor from a deputising service. The patient complained of frontal headache and was pyrexial. The locum doctor diagnosed sinusitis but specifically advised that if the headache became worse or if vomiting ensued she should be seen again. The doctor mentioned to the patient's daughter that in giving this advice he was considering the possibility of meningitis.

Four hours later a further visit was requested but a different doctor attended. He later stated that although the patient was complaining of feeling sick and although it was suggested to him the patient was drowsy he found no specific abnormality. He diagnosed viral gastritis.

The patient's condition deteriorated further and, six hours later, the family called a private general practitioner who, following a brief examination, arranged for her to be taken as an emergency to hospital. There, on arrival, she suffered a cardio-respiratory arrest and died. The cause of death was meningitis. An inquest was held and the Coroner stated that although the patient had died of a natural disease, steps to treat it had not been taken and he consequently concluded that death was by misadventure.

The circumstances of the case were the subject of a complaint to the Family Practitioner Committee against the doctor in whose name the patient was registered. He was found to have been in breach of his Terms of Service. A claim for compensation followed and the expert advice received from the Society's General Practice Advisory Board was that the circumstances made the claim indefensible. A settlement was negotiated for £8,700.

MEDICAL CASE REPORTS

Blindness from failure to diagnose malignant hypertension

An 18-year-old student attended his general practitioner complaining of tiredness and haemospermia. He was referred to a consultant surgeon. Blood tests performed were normal but the blood pressure was not recorded. The student subsequently saw an optician who, following the examination, wrote to the general practitioner as follows:

"He has a raised disc in each eye with some tortuosity of the surrounding blood vessels. This may be normal but I feel it would be better confirmed".

No action was taken by the general practitioner on receipt of this letter.

Six months later the student presented again to his general practitioner with a complaint of headaches. A diagnosis of tension headaches was made due to the student's forthcoming examinations. Twelve months later the student was referred by his general practitioner to an ophthalmologist because of deteriorating vision. In the meantime, the student was seen by his optician who noted papilloedema and the student was admitted to hospital where his blood pressure was noted to be 250/150. Despite vigorous in-patient treatment the patient became totally blind through bilateral optic atrophy.

A settlement was explored here because of the several negligent failures of the general practitioner to examine the student's eyes or record his blood pressure.

Compensation of £375,000 was paid.

Pituitary tumour missed

A nine year-old girl was registered with a family doctor, a member of the Society, in 1972. Although she was seen on numerous occasions, her National Health Service record card contained few entries. The practice policy was for patients to retain a card recording treatment received but this girl's treatment card showed only two entries.

Thus the Society was posed a difficult task when a member sought help after being sued for failing to diagnose a pituitary tumour which, although eventually removed, had left the girl with brain damage.

Analysis of the few pieces of contemporary documentation allowed the following history to be reconstructed. The patient had been treated in hospital for obesity in 1972 and 1973 and had lost weight on a strict diet. A hospital letter showed that in 1981 the member had referred her to a dermatologist because of facial hirsutism and acne. He believed that amenorrhoea was also a complaint but did not investigate it. There was one record for 1981 when a cough was treated and a month later she attended surgery with a persistent unilateral headache and the member became concerned. There was no history of vomiting or incontinence but there was visual disturbance. He provisionally diagnosed migraine but noted that she was to be referred to hospital urgently. Unfortunately his plan was not executed.

About three weeks later the member's partner was asked to visit the patient at her home because of 'flu-like symptoms' but nothing significant was found or done. Only on a second home visit a short while later, this time by the member, did the 'alarm bells ring' and a domiciliary consultation was arranged urgently. This led to the diagnosis of a pituitary adenoma being made. The patient underwent two operations and radiotherapy but was left with mental impairment, epilepsy and urinary incontinence and in need of constant supervision.

It was alleged on her behalf that during 1981 no fewer than eighteen consultations occurred culminating in the true diagnosis being made by a consultant. The complaints over that year were said to have been: headaches, weight gain, amenorrhoea, vomiting, lethargy, stupor and intellectual impairment. The member could not remember most of the consultations or complaints and had no proper records to help recall the problems.

Because of this, the lack of evidence of any neurological examination and the admitted failure to refer, the Society had no alternative to exploring settlement. Agreement could not be reached on the appropriate amount of damages so this was assessed by a Judge as £266,914. Those indemnifying the member's partner contributed one-fifth of the damages.

For both professional and legal reasons the importance of good clinical records cannot be over emphasised. Accurate, legible and sufficiently detailed notes will enhance clinical management and facilitate continuity of care. When cases come under legal scrutiny the records become all-important. Good records suggest good clinical care and will always stand the doctor, as well as the patient, in good stead.

MEDICAL CASE REPORTS

Rubella immunisation problems

Pregnancy soon after rubella immunisation can lead to termination and litigation as the following case shows.

A general practitioner member saw a young woman who had read of the risks to the fetus of rubella in ear'y pregnancy and was most anxious to be immunised at once. The doctor did not know her immunity status though it later emerged from hospital records that she already possessed antibodies. He advised testing but at her insistence proceeded straight to vaccination. He thought he had warned her to avoid pregnancy for the following three months but only a month later she underwent termination of pregnancy because of possible risk to the fetus. She then sued him alleging that he had immunised her unnecessarily and had failed to warn her to avoid becoming pregnant for the next three months. At first the doctor's position seemed defensible but detailed investigation showed that his recollection and records of the events were so confused as to preclude success in court. Settlement was effected for several thousand pounds.

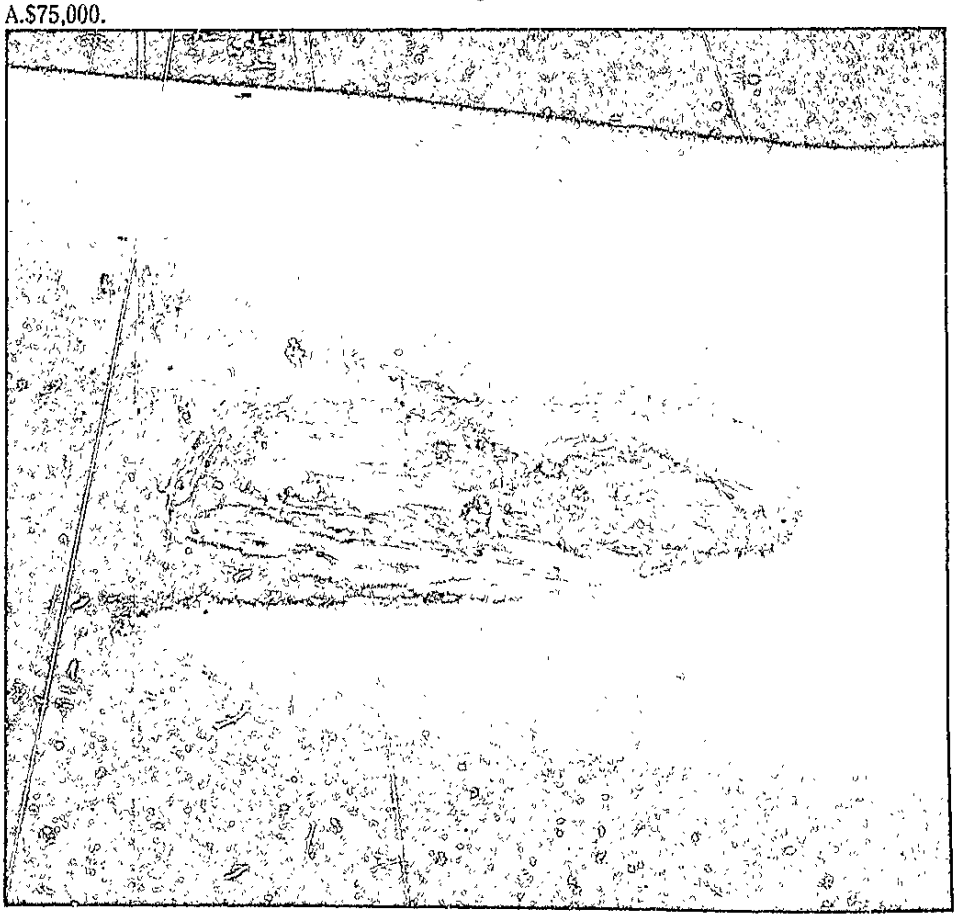
Another source of error is a failure of communication between doctor and nurse so that the latter vaccinates when the doctor's intention was that blood should be taken for antibody assay.

A costly injection error

In 1978 a family doctor anaesthetising a man for dental extractions induced anaesthesia by injecting thiopentone 2.5% through a Gordh needle in a vein on the back of the hand. By the time the patient complained of pain at the injection site, 8 or 9 ml had been injected and the doctor saw no sign of extravasation. Later in the operation he injected another 3 ml of thiopentone. At the end of the procedure the man's hand was very swollen but the doctor merely advised its elevation.

The patient's hand became permanently disabled, he lost his job as a driver and in 1979 he sued the doctor, a member of the Society. The doctor admitted that he had not checked the position of the needle sufficiently carefully and had not taken adequate steps on the first or later complaint of pain in the hand. Liability was conceded, therefore, but financial agreement could not be reached so the claim went to trial on the issue of damages alone. The claim was eventually settled for A.$75,000.

Sequelae at the wrist of extravasation of intravenous injection



MEDICAL CASE REPORTS

Torsion of the testis

A four-year old boy was brought to a general practitioner's surgery with a history of having been sick and complaining of stomach-ache. The father had seen that the boy's left testicle was slightly swollen and inflamed. The general practitioner examined the patient's scrotum, diagnosed *'an inflamed testicle'* and prescribed penicillin. Two days later the left testicle became more swollen. Another general practitioner was consulted who arranged immediate admission to hospital where, that same night, an operation was carried out to remove an infarcted left testicle.

The circumstances were the subject first of a Service Committee complaint and then a civil claim. A failure by the doctor to consider torsion as the presumptive diagnosis was viewed as indefensible. A payment into court of £6,500 was accepted.

Missed tendon injury

The Society's member, a general practitioner, also acted as occupational physician to a food factory. In this capacity he saw an employee of the factory who had been involved in an accident during the course of his occupation. The patient's left little finger had become caught in a piece of machinery resulting in a laceration. The incident occured in 1983 and, following an examination of the patient, the doctor treated the injury conservatively. Three months later the injury appeared not to be healing. The patient was referred to a consultant surgeon at the local hospital who obtained the history that the patient had been unable to flex his finger since the date of the accident. Examination revealed a residual scar from the laceration over the flexor surface of the left little finger at the middle crease. The surgeon concluded that the patient had divided the flexor tendon to the left little finger in the original accident. He was referred to a consultant plastic surgeon at another hospital. Suturing of the tendon was performed but, because of the delay, the result was poor.

At the time of notification of the claim the member had retired. He had destroyed all old records when he moved house and he had no clear recollection of the particular incident. In the absence of any clinical records or a clear recollection of the case, there was no possibility of successfully defending the claim. The claim was settled for £15,000 of which sum the Society contributed £5,000 on behalf of the member.

Red faces all round

A general practitioner member was accused of negligence after prescribing 0.5% instead of 0.1% Dithrocream for psoriasis. The patient concerned had to undergo several weeks of treatment for a burned and swollen face as a result of using it. She claimed compensation on the grounds that Dithrocream is contraindicated for facial application and that the doctor had not explained its use properly. Understandably, she was upset at the severe facial reaction and mahogany colouration which occurred.

The doctor's notes were poor and he could not remember where the psoriatic lesions were or whether he had warned against using the cream on the face. The claim against him was settled by the Society for £2,500 plus costs.

Faint following injection

An Australian general practitioner gave his 18-year-old patient, suffering from a throat infection, an intramuscular injection of penicillin. The patient complained that immediately after the injection he was shown out of the consulting room only to faint in the corridor. As a result of the fall he suffered facial injuries and a fractured skull. Fortunately he made a rapid and complete recovery.

It was not thought advisable to defend the claim. Doctors have a duty to take proper precautions when giving injections and this would certainly include anticipating that some patients faint at even the sight of a needle. Settlement was achieved for A$2,750.

Disastrous delivery

In December 1970, soon after starting his first appointment as an obstetric registrar, a member was called to see a woman in labour. She was 26 years old and had been admitted for induction of labour as she was believed to be 12 days past term. The baby was presenting by the breech and the mother's pelvic outlet was known to be contracted. The consultant in charge was on leave but the member believed that he had discussed management with the senior registrar.

The first stage of labour lasted for 28 hours and fresh meconium was seen. The second stage lasted for 1 hour 45 minutes and the doctor had difficulty in delivering with forceps the large aftercoming head. The baby weighed 8 pounds, was hypotonic and made no respiratory effort. The Apgar score at one minute was 2 and at 55 minutes it was 7. He was resuscitated and cared for in the special unit.

The paediatric registrar later wrote to the GP *"...it is probable that this child suffered cerebral damage as a result of anoxia at birth and this has been explained to the parents. We have also said that he may be retarded..."*

MEDICAL CASE REPORTS

In 1973 the mother delivered normally a baby weighing 8lb 4oz.

In August, 1984 the parents brought proceedings alleging negligent mismanagement of the labour and delivery in 1970.

The Society received expert advice that both the medical supervision of the case and the labour records were unsatisfactory. It may have been reasonable in 1970 to allow a trial of labour. However, Caesarean section was not considered even in the presence of the slow progress, meconium, and the reduced pelvic outlet. By the standards of 1970 obstetric practice, the management of this breech presentation was judged to have been inadequate and to have caused severe brain damage. The Society resolved to settle the claim.

In January 1987 examination of the plaintiff revealed him to be severely and permanently disabled but with unimpaired intelligence. Damages were agreed at £775,000 and when approving that sum, a High Court Judge said *"it was not a penny too much in compensating him for what he has to go through for the rest of his life."*

Glaucoma, not migraine

A 40-year-old housewife developed headaches following a road accident. She was seen by a neurologist who diagnosed migraine. She was seen on 7 occasions during the next 12 months by her general practitioner and on two occasions complained of severe headaches and also remarked that she had noticed rings around lights.

Her symptoms were ascribed to an exacerbation of migraine. She then developed acute bilateral loss of vision accompanied with severe headaches and vomiting. The general practitioner diagnosed a cerebral vascular accident. The following morning she was seen at an eye unit and a diagnosis of bilateral acute glaucoma made.

The patient now has no perception of light in the right eye and tunnel vision in the left eye.

A settlement was explored because of the failure of the general practitioner to consider a differential diagnosis for the persistent headaches. Damages of £85,000 have been paid.

Topical steroids — missed glaucoma

A 10-year-old schoolboy was seen in an eye department with vernal conjunctivitis. He was initially treated with Opticrom drops but, as there was a poor response, topical steroids were prescribed. During a period of 22 months' topical steroid treatment, he attended the eye clinic 14 times. The intraocular pressure was checked on 5 occasions and found to be within normal limits.

Two years after commencement of treatment his vision was checked at a school eye clinic. The right visual acuity was noted to have fallen from 6/9 to 6/36 and he was reviewed by the consultant ophthalmologist. He confirmed the deterioration in vision and noted *'a very big right optic disc'*. Topical steroids were continued. Two months later the vision in the right eye dropped to hand movements and the patient was seen at another hospital. He was noted to have visual acuity of count fingers right eye, 6/12 left eye. The right disc had a cup/disc ratio of 0.9 the left a cup/disc ratio of 0.7. Visual fields confirmed a diagnosis of glaucoma.

A settlement was explored because of the failure of the consultant ophthalmologist to consider a diagnosis of glaucoma and to check visual fields.

Failed vasectomy — school fees

In calculating the quantum of damages, it has long been the rule that, in relation to medical expenses, there is no requirement that a patient who has been harmed by medical negligence must receive necessary treatment from a state health service. The expense of medical and nursing care obtained through the private sector is recoverable, may be considerable, and is one of the reasons for the escalation of claims settlement costs. A recent failed vasectomy claim has confirmed that fees for private education may be recoverable as a reasonably foreseeable consequence of a failed sterilisation operation.

A 34-year-old man underwent a vasectomy. The operation was performed by a locum consultant surgeon. During the operation one vas was normally divided and ligated, but the other was released from the clamp and had to be relocated before ligation. The patient seemed to make a satisfactory recovery and was advised to undergo two sperm counts before discontinuing contraception.

There were difficulties relating to the sperm counts which were in part due to a failure of the follow-up system. Suffice it to say that some nine months after surgery and after two positive counts, a letter was sent to the patient requesting a third specimen. This result again was positive. Even a fourth specimen of semen was examined (on this occasion, at the request of the patient's general practitioner). Once more the test was positive. The problem was that these positive results may not have been clearly passed on to the patient!

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MEDICAL CASE REPORTS

Two years after the operation the patient's wife became pregnant. A writ was issued alleging negligence. The Society was advised that it would be impossible to defend the claim with any prospect of success and accordingly resolved that a settlement should be explored.

It proved impossible to agree settlement terms because the patient and his wife claimed not only the usual heads of damage but also claimed a sum of money for the cost of private education for the unwanted child. The parents were able to establish to the satisfaction of the High Court Judge that their other children had attended private [illegible] damages of almost £62,000 of which almost £20,000 represented the costs of private education, the judge said: *"I think it is clear that at the date (of conception) the family had decided their children would be privately educated..."*

Failed vasectomy defended

In 1982 a consultant surgeon performed bilateral vasectomy on a 37-year-old man. He divided both vasa, excised about 3 cm from each, ligated the upper ends and doubled back and ligated the lower ends. It was not his practice at the time to warn of the small risk of failure of sterilisation. There were two negative sperm counts and the patient was so advised. Nearly three years later the man's wife became pregnant and had a miscarriage at about 26 weeks. Subsequent sperm counts confirmed that recanalisation must have occurred.

The Society received expert advice that the claim which followed should be strongly resisted. The member had followed a reputable school of surgical practice even though subsequent litigation experience had produced a change of practice so that now most surgeons do warn of the small risk of regaining fertility. The form of consent recommended by the Society is illustrated. The member's defence was prepared but on the day before the trial the patient discontinued his action, presumably on advice that he could not succeed.

The Society adheres to the policy of defending members when the clinical facts permit even though, as in this case, it would often be cheaper to settle.

Recommended consent form for sterilisation procedures

STERILISATION
CONSENT OF PATIENT

I, _____ of _____
(name and address of patient)

_____

hereby consent to undergo the operation of _____

_____

the nature and purpose of which have been explained to me by

Dr Mr _____

I have been told that the intention of the operation is to render me sterile and incapable of further parenthood. I understand that there is a possibility that I may not become or remain sterile.

I also consent to the administration of a general, local or other anaesthetic.

No assurance has been given to me that the operation will be performed by any particular surgeon.

Date _____ Signature _____
Patient

I confirm that I have explained to the patient the nature and purpose of this operation.

Date _____ Signature _____
Medical Practitioner

MEDICAL CASE REPORTS

Principle, not expediency

The Society is sometimes accused of settling cases too readily instead of contesting them. Such criticism may arise through an incomplete understanding of the forensic process and, in particular, of the burden of proof in civil cases, which is on the balance of probabilities. The Society has often reported cases in which a stand is taken on principle, despite the expense. Expediency settlements are made only rarely and with great reluctance by the Society. A case will be fought as an issue of principle especially in circumstances where great care is taken in the treatment of an acutely-ill patient but a regrettable though unavoidable complication arises — such as skin necrosis from an intravenous infusion which leaks into surrounding tissues. Two such cases, concluded recently, are reported here.

1 The first case arose in England in 1982. A 900 gram baby survived in good general condition despite prolonged cardiovascular and respiratory difficulties in addition to the complication of necrotising enterocolitis. Some extravasation from one of the many intravenous lines caused tissue damage to the right foot. A writ and statement of claim were served on the health authority alleging negligence in failing to *"have sufficient regard to the known risks and to supervise the drip sufficiently..."*

An expert consulted by the Society was suitably positive in his attitude to the claim. He wrote *"it is a tribute to the staff that she survived and is apparently progressing so normally without many of the more serious complications of pre-term birth and neonatal care. There is no evidence whatsoever that the negligence of any individual caused the damage, the unfortunate but well-recognised problem of extravasion in these small infants. To seek a low-cost settlement on the grounds of expediency is not an acceptable alternative".*

2 The second case arose in Northern Ireland in 1983. The baby was not so premature but his many problems included hypocalcaemia. At three separate infusion sites some extravasation of the necessary calcium-containing infusion occurred, causing tissue damage to the scalp and one wrist and ankle. In essence the statement of claim alleged negligence on the part of the health board in failing to provide trained staff and failing to ensure that drips did not leak. The defence expert was even more forthright than in the first case, commenting that the management was truly excellent and that the parents should be ashamed of themselves for making a claim.

The first of the two claims was discontinued but as is invariably the case the defence costs could not be recovered as the plaintiff was legally-aided with a nil contribution. The second case was fought and won. Both demonstrate that the Society will not readily compromise a principle.

Paediatric overdose of digoxin

A five-week-old baby was admitted in cardiac failure due to a patent ductus arteriosus. The paediatric registrar, a member, prescribed digoxin 0.06 mg which he incorrectly converted to 600 micrograms so that the baby received ten times the intended dose. Bradycardia and dropped beats (the baby's, not the doctor's) responded to atropine and later the patient underwent successful surgery.

The parents sought compensation because of the shock which they had suffered and the Society's legal agents advised that this was a lawful claim in that jurisdiction. It was valued at the equivalent of some $250 and settled on the member's behalf. It is so easy to miscalculate the dose of a drug and in the Society's experience errors commonly occur with paediatric digoxin, cytotoxic drugs, insulin and intrathecal penicillin. This list should not, as official documents so often warn, be regarded as exhaustive. The only answer is to check and double check and if in any doubt ask a colleague to help.

Drug interaction led to unwanted pregnancy

The oestrogen/progestogen oral contraceptive pills are not reliable during concurrent treatment with phenytoin, primidone, barbiturates or possibly carbamazepine. Break-through bleeding and spotting may take place and pregnancies may occur. Epileptic seizure control may also be disturbed.

A young woman sued her consultant neurologist and general practitioner alleging negligence in the concurrent prescription of phenytoin and oestrogen/progestogen oral contraceptive. She alleged that this had caused contraceptive failure resulting in an unwanted preganancy.

In 1982 the neurologist had prescribed phenytoin for epilepsy without, according to the Statement of Claim, warning her that this drug could reduce the efficacy of the oral contraceptive she was taking. She became pregnant, had the baby and sued for damages for the unwanted pregnancy. In particular she claimed for loss of earnings and overtime, for removal expenses to a larger house, its extra running costs and layette expenses. The Plaintiff was aged 30 when the child, her first, was born and since she and her husband had intended to have a family in a few years anyway appropriate damages were $6,000 plus costs.

MEDICAL CASE REPORTS

The Society contributed half on behalf of the general practitioner member who had not prescribed the phenytoin but had been told about it in a hospital letter. He knew the patient was taking an oral contraceptive as well and had several opportunities to warn of the possibility of drug interaction. The safety net which he might have provided did not work first because he relied on the hospital doctors to get it right and secondly because he was unaware of the possibility of interaction between phenytoin and oral contraceptive drugs.

Both the British National Formulary and the Data Sheet Compendium were warning of this interaction at the time so there was no question of defending the claim. The first report of contraceptive failure in such circumstances was in 1972 and the Committee on the Safety of Medicines received reports of 49 such cases in the period 1972 to 1980.

Chemotherapy overdose

A 29-year-old woman was admitted for investigation of 5 weeks' irregular intermenstrual bleeding. At examination under anaesthetic the gynaecologist discovered a poorly-differentiated cervical carcinoma. Three months later, after radiotherapy, he performed a radical hysterectomy with conservation of the ovaries.

At review eight months later there was evidence of widespread pelvis metastases and a recto-vaginal fistula had developed. During this admission a member of the Society, a senior house officer in radiotherapy, gave a course of Ifosamide, cisplatinum and mesna. A week later the patient's condition deteriorated and she went back into hospital, having developed septicaemic shock and acute renal failure. The consultant radiotherapist reviewing the notes of the previous admission realised that his SHO had made a mistake in calculating the Ifosamide dosage. She had given double the correct dose. The patient died a few days later.

A claim for compensation was made by solicitors acting for the patient's dependants. There had been an error in dosage in a calculation which the SHO had made for other patients before without difficulty. The patient's prognosis was poor but the overdose of chemotherapy had probably shortened her life. The Society settled this indefensible claim for £4,000. Additionally, plaintiff's solicitors' costs amounted to £1,531. Members are reminded of the need for care in calculating doses of therapeutically-active substances.

Failure to check ESR in patient with sudden loss of vision

A 77-year-old lady presented to an eye clinic with a 5-day history of sudden loss of vision in the left eye not associated with headache or pain. On examination, visual acuity, right: 6/6 > left: count fingers. The fundus showed a central retinal artery occlusion in the left eye. No treatment was given.

Two months later the patient presented at another hospital with sudden deterioration of vision in the right eye down to count fingers. An ESR was taken and the result was 54 mms per hour. Prednisolone 60 mgs daily was commenced. Her acuity improved to 6/12 in that eye, but she was left with tunnel vision.

On review of the case following a claim for compensation the Society's expert commented that it is well-known that a significant proportion of patients who suffer the ischaemic consequences of temporal arteritis do not present with the classical history of pain, headache or tenderness. The only safe rule is that any patient who presents with arterial occlusive disease must be assumed to have temporal arteritis until proved otherwise.

The claim, considered to be indefensible, was settled for £25,000.

Missed intra-ocular foreign body

A 30-year-old fitter attended a casualty department following an injury to his right eye at work. Vision was recorded as 6/12 right eye, 6/6 left eye. He was seen by a nurse who noted a conjunctival laceration of the right eye. Subsequently the doctor noted a large sub-conjunctival haemorrhage. The retina was ticked as normal. Chloramphenicol drops were prescribed and no follow-up appointment was arranged.

Two years later the fitter had flashes and floaters in his right eye. A fundal examination at that time noted an intra-ocular foreign body and an extensive retinal detachment. ERG studies suggested early siderosis.

The intra-ocular foreign body was removed and retinal detachment surgery carried out. This was not successful and the right eye is now blind.

A settlement was effected for £10,000 for failure to take a history adequately and failure to request a radiograph on the first consultation.

MEDICAL CASE REPORTS

The chest pain trap

A man aged 63 years was taken to hospital by ambulance and seen by a senior house officer in the accident and emergency department. The patient had been taking medication for hypertension for some time but the recent history was of three episodes of left-sided chest pain which radiated to both arms and was accompanied by breathlessness and sweating. These symptoms had abated by the time of examination and the doctor judged the problem to be worsening, rather than crescendo, angina or infarct. He prescribed isosorbide dinitrate and discharged the patient. Twenty four hours later the man was again brought to hospital by ambulance, but this time he was dead. Autopsy showed myocardial infarction.

The relatives pursued a negligence claim and the consultant physician advising their solicitors was certain that the patient should have been admitted to the intensive therapy unit on the first occasion. The Society, representing the doctor, received similar expert advice and settled the claim.

This is not to say that every patient with chest pain could or should be admitted to hospital but great care must be exercised in the assessment of such patients. If there is doubt about correct management of a particular case, a more experienced medical opinion should be obtained before sending the patient home. Errors of clinical judgement may or may not be negligent: it all depends on the facts of the particular case and whether or not the practitioner exercised reasonable skill and care in all the circumstances.

No films — no defence

After a row with his girl friend a young man threw himself at a passing car. In hospital he was seen by a registrar in the accident department, treated for minor injuries and sent home. The patient returned the next day because he was limping and X-ray films were taken which showed fractures of the left pubic ramus and iliac crest. Inevitably the Society had to pay, on the registrar's behalf, for the short period of avoidable pain and suffering.

Even in these litigious days, there is no question of investigating radiographically *every* injured patient; doctors have to exercise careful clinical judgement in selecting patients for radiography. But when injuries are missed because no films were taken, the doctors concerned need strong arguments to support their decisions in court.

And again...

An experienced surgical registrar saw in the casualty department a young woman who had fallen downstairs and injured her right forearm. His brief record of examination read *'some bruising of the right forearm'* but gave no indication of the site of the bruising or that of the greatest tenderness or of the range of movements which elicited pain. Since the patient had in fact sustained a fractured head of radius, a thorough clinical examination would almost certainly have led to radiographic examination and the true diagnosis. It was insufficient to send her away with her arm in a sling with no recorded follow-up arrangements even though the doctor said he probably advised her to return if she had problems. The patient later underwent excision of the radial head for a displaced fracture and claimed compensation for the consequences of the delayed diagnosis. Her claim had to be settled by the Society because the scanty notes gave no support to the incorrect decision not to request radiographs.

Missed depressed malar fracture

A 20-year-old student was admitted to hospital following a road traffic accident. He was seen by the consultant who made a clinical diagnosis of a fractured right malar bone. Skull X-rays were requested by a house officer and the clinical information put on the form was *"head injury: ? fractured right zygoma"*. The films were reported as showing an opacity of the right maxillary antrum. The patient was then discharged by the house officer because the report had not confirmed a fracture.

Six weeks later the patient was seen in a follow-up clinic and noted to have diplopia and slight enophthalmos. Facial views were requested and showed a severely-displaced fracture of the right zygomatic-maxillary complex together with a fracture of the nasal bones.

A settlement was explored because of the failure of the medical team to request appropriate special views or to document adequate information on an X-ray request form.

MEDICAL CASE REPORTS

Lost films — lost cause

A 75-year-old man fell while shopping and complained of a painful left hip. He was examined in the accident department by a senior house officer who made good notes and requested X-ray examination. She saw no fracture on the films and said she would have sought a senior opinion had she been in doubt. She discharged the patient but a month later he returned with an obvious fractured neck of femur which was impacted. This was successfully treated by the insertion of an Austin Moore prosthesis.

The patient brought a claim saying that the delay in diagnosis of his fracture had caused him unnecessary pain and suffering. He also alleged that with immediate diagnosis he might have had a lesser operation and a better prognosis.

The hospital had lost the films which had never been reported upon and so there was no question of resisting the claim. The health authority paid half of the damages because of this, the Society contributing the other half for the doctor.

Complications, cosmetic procedure

A 30-year-old housewife was seen by a consultant ophthalmologist with bilateral extensive xanthelasmata which were unsightly. Simple excision of xanthelasmata was carried out bilaterally. Postoperatively the patient developed watering of both eyes as a result of bilateral ectropion. She was referred to a plastic surgeon who inserted a skin graft to both lower lids to correct the deformity.

A claim for compensation was made by the patient who stated that an excess of skin had been excised from both lower lids in what had been cosmetic operations. It was alleged that the need for skin grafting was apparent pre-operatively. Experts consulted by the Society were unable to dissent from this view and a settlement was explored for £8,000.

Not altogether in the pink

Based upon amniotic fluid examination, a partnership of pathologists wrongly advised a pregnant woman that she was carrying a girl. Later her solicitor claimed compensation because *"my client and her husband decorated the baby's room, bought clothes, nappies etc. all in pink and now have to start again"*. He added a token sum for their *"surprise and disappointment"*.

The modest claim was settled for A.$600. The colour of the faces in the laboratory was not described.

Pathologists not negligent — official!

Three members of the Society practising in partnership as pathologists were sued by a young woman who developed an abscess at the site of a venepuncture.

A blood sample had been taken from the right antecubital fossa by a trained nurse employed by the doctors. She had cleansed the skin with a sterile disposable alcohol swab and had used an aseptic technique and sterile equipment. Nonetheless, four days later the patient attended a physician complaining of fatigue, nausea and shivering. She soon developed an abscess at the venepuncture site and pus from it grew *E. coli*, various streptococci and bacteroides. After antibiotic treatment and surgical drainage she recovered but needed skin grafting and undoubtedly had had a most unpleasant and unusual complication of a simple blood test.

It is easy to see that she felt the nurse and the practice were to blame but in fact there was no evidence of negligence and, when her claim was defended in court, the Judge agreed.

A suitable case for no-fault compensation you might think, but it illustrates one of the dilemmas thrown up by that system — was it a medical accident or an unavoidable complication of treatment?

No lung scan — death from pulmonary embolus

Five weeks after sustaining a comminuted fracture of his right tibia a young man was admitted to hospital with left-sided chest pain. The medical registrar, a member, diagnosed pneumonia and prescribed antibiotics. Despite finding no signs of deep venous thrombosis he also suspected pulmonary embolism and prescribed intravenous heparin. The patient was anxious to leave hospital to attend a funeral and as he appeared well he was allowed home on subcutaneous heparin 5000 units twice daily. He was given a request form for a lung scan but this form was returned by the department to the house officer who had signed it with a message that since the patient had been discharged the scan would not be done. The returned form lay unopened while the house officer was on holiday.

The registrar next saw the man in outpatients ten days later when he appeared well but nonetheless a lung scan was requested, urgently. The result — *'lesion compatible with pulmonary embolism'* — was telephoned to the registrar who at once contacted the patient to ask him to return to hospital but he refused. He later died of pulmonary embolism.

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In their claim, his family alleged the following negligence;

"a) Failed to perform an immediate lung scan and to ensure a drug régime appropriate to the diagnosis.
b) Discharged the deceased from hospital without confirmation of the diagnosis.
c) Failed to institute standard treatment for DVT and or pulmonary embolism sufficient to prevent the fatal pulmonary embolism.
d) Administered Minihep and continued to do so after the diagnosis of DVT and pulmonary embolism had been confirmed when same is not a recognised treatment for established DVT.
e) Failed to provide the Plaintiff with any or any sufficient treatment and/or advice and/or to take any or any sufficient steps to reduce the risk of further pulmonary embolism."

The Society considered that the claim should be settled and the health authority agreed to contribute because of its imperfect services which had played a part in the story. On counsel's advice, damages of $65,000 were offered and accepted.

Spirit + cautery = fire + scars

The dangers of using alcoholic solutions concurrently with cautery or diathermy has been stressed many times. We make no apology for reporting another case where a settlement had to be made following an avoidable error.

A girl aged 4½ years was admitted for an excision biopsy of a lump in her neck. Her skin was prepared with a 1 in 10 solution of chlorhexidine in 70% alcohol. Because the child had long hair which crept on to the operation field, two pieces of gauze moistened with chlorhexidine in spirit were used to surround and to isolate the operation field and to keep it free from hair. Following the skin incision, electro-coagulation was used to deal with a bleeding vessel. Flames were noticed and these were promptly extinguished. The right side of the child's shoulder, neck and ear were burned (See photograph, below).

The burned area was estimated to be about 5%. The inevitable claim for compensation was settled for HK $160,000.

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Speculum burn

Doctors are warned again of the need to use with great care instruments which have been subject to heat sterilisation. In an Australian case a gynaecologist was handed a Sim's speculum by the theatre sister who warned that the instrument might still be too warm to use and asked whether the doctor required a bowl of cold water in which to cool it. The gynaecologist picked up the speculum, felt it through her *gloved* hand and considered the instrument cool enough to use and inserted it into the vagina.

In a later-prepared report the member wrote *"at the end I was surprised to see the patient appeared to be burned in the area where the speculum had been placed".*

The obviously indefensible claim was settled for A$6,500. The Society reminds members that the heat of an instrument cannot quickly and accurately be assessed through the thickness of a rubber glove and that some instruments can cause quite serious burns.

Diathermy hurts

The Society is often called upon to deal with, which usually means settle, claims arising from accidental diathermy burns. The precise cause is not always ascertainable but the damage is usually only too obvious and painful — as in this case.

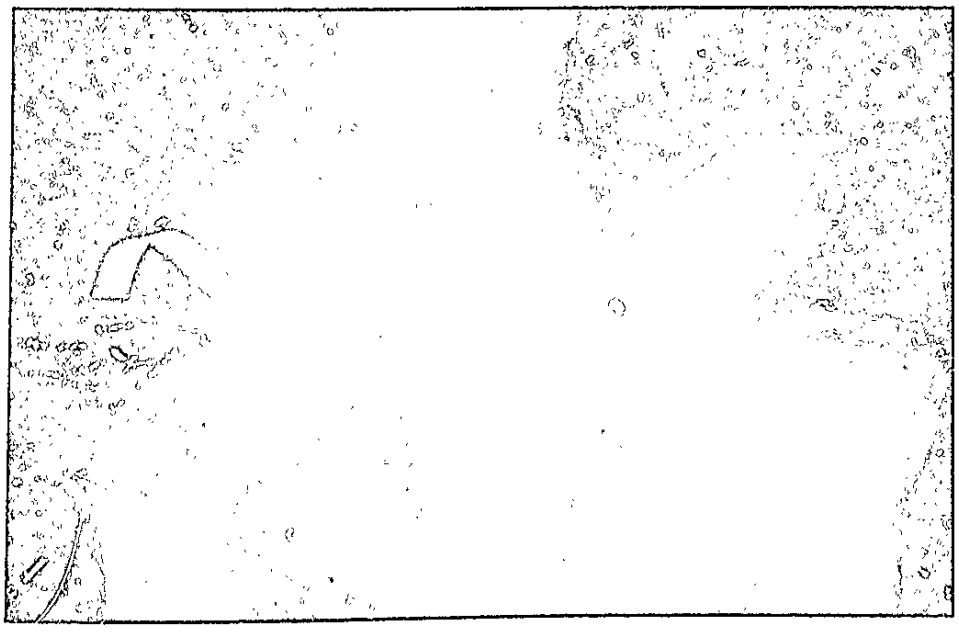
A young man sustained a burn to his penis during an operation for pilonidal sinus. A diathermy pad had been applied to his right thigh and the probable mechanism of the injury was contact between his penis and the diathermy pad. There may also have been some electrical fault but, as so often happens, the equipment was checked after the accident and reported as being in perfect working order. The patient had genuine cause for complaint for several weeks but had no long term problems. His claim was met in the sum of £2,750 plus costs. The society paid half this sum on behalf of the member, the surgeon, while the health authority paid the other half.

Members who use diathermy may care to refer to the section upon it which appears in the Society's publication, *"Pitfalls of Practice".*

Retained swab

Despite repeated warnings and preventative advice by the defence bodies and others, (refer to *"Theatre Safeguards," see p.64*) swabs are still accidentally left inside patients leading to unnecessary suffering and indefensible claims.

For several weeks after a Caesarean section a patient was pyrexial, vomited and had diarrhoea. Finally a retained swab was seen on an X-ray film and removed at laparotomy. The Society, for the doctor, and the Health Authority, for the scrub nurse, followed the usual policy in such cases and settled the claim in equal shares. The total damages and costs were £6,500.



Abdominal radiograph showing marker of retained swab

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Double jeopardy

When surgical instruments are accidentally left inside patients, civil claims often follow but in some jurisdictions the surgeon may face criminal charges as well.

A surgeon in Africa operated, apparently successfully, on a young man with a duodenal ulcer. A year later he received a letter from the patient's solicitors which caused him to seek the Society's help. A surgical needle had been found and removed from the patient's upper abdomen and compensation was demanded. Before the claim could be resolved, the member was arrested and charged under the penal code with having committed "a reckless and negligent act". The Society's lawyers in the country secured his release on bail and more than a year later he was acquitted. The civil claim was settled.

Wrong operation

An ENT surgeon was responsible for the administrative error which led him to perform a submucous resection of a young man's nasal septum instead of removing grommets.

Wrong operations are indefensible; all the surgeon can do is apologise and all the Society can do on the member's behalf is to pay the appropriate damages promptly. Such errors can be avoided if the recommendations contained in the booklet *"Theatre Safeguards"* are followed.

The Society compensated the patient for several weeks of pain and discomfort following this unnecessary operation.

A fatal surgical mistake

A young woman who was 33 weeks pregnant had to be admitted for the control of persistent epistaxis. Packing and cautery having failed to arrest the haemorrhage, the consultant ENT surgeon decided to ligate the external carotid artery. A few hours postoperatively she became dyspnoeic and cyanosed and it was thought she may have inhaled blood. When fetal distress occurred the baby was delivered by Caesarean section and progressed well. The mother never regained consciousness and was thought to have suffered a stroke. Brain stem death was confirmed and the ventilator was disconnected.

Post-mortem examination revealed that the common carotid artery, rather than the external carotid artery, had been ligated and the Inquest verdict was death by misadventure.

Not surprisingly, a claim followed against the hospital and the surgeon. The Society's expert adviser sympathised with the difficult clinical problem which the member had faced but recommended prompt settlement of the claim. He felt that arterial embolisation should have been tried with, if necessary, the patient being referred to another hospital and he did not believe the serious surgical error could be defended.

The claim was settled for £40,000 plus costs.

Cure worse than disease

In an Australian state a 27-year-old man suffered a work-related back injury in 1981. A specialist orthopaedic surgeon who saw him after the event considered there was much in the way of functional overlay and considered surgery to be contra-indicated in the absence of any neurological signs.

In 1982 the patient was referred to another orthopaedic specialist who diagnosed classical sciatica due to a ruptured intervertebral disc and proceeded to perform a laminectomy and an L5/S1 fusion.

The patient did not do well. He continued to complain and the specialist decided after some further investigations to re-operate. His records relate that he found considerable fibrous tissue around the right S1 nerve root which he 'cleared' without the benefit of a microscope. The specialist advised the patient's general practitioner that an anterior fusion might be needed in the future.

The patient's condition became worse. A myelogram showed severe narrowing at the L5/S1 level. The patient suffered a much greater disability than was present prior to surgery and this in turn led to a claim for compensation inflated to a very substantial degree by the special damages element which, members will know, includes loss of past and future earnings.

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No expert support could be gathered which would have enabled a defence to the allegations to have had any realistic chance of success. A settlement was negotiated for a sum totalling over A$ 500,000 to which the Society contributed 85%, the remainder being paid by the plaintiff's employer.

A thorny problem

A farmworker attended an accident department after injuring his right knee in a fall at work. The senior house officer wrote *"Inj (R) Knee at 2.00p.m. Able to bear weight for 1 - 2 hours but now unable to walk"* but recalled no history to suggest entry of a foreign body. She found the knee to be swollen and tender over the lateral ligament but made no record of any cut or puncture wound. A radiograph showed no abnormality and a Robert Jones' bandage and crutches were provided.

On review two days later, the doctor recorded that the knee was improved and stable and a week later discharged the patient because all appeared well. Two months later the man returned with the knee swollen but the doctor, finding nothing untoward apart from slight swelling, again discharged him.

The man's general practitioner soon referred the patient to casualty saying *"You saw this chap in casualty about 2/52 ago with an effusion on his right knee possibly following a FB in March. Yesterday it was unchanged. This morning the effusion is greater..."*

Another senior house officer, also a member of the Society, saw the patient and noted *"...he removed a blackthorn from his knee one week ago..."* and prescribed an antibiotic. An orthopaedic surgeon later explored the knee and found extensive synovitis, pus, a large piece of blackthorn and numerous small fragments.

The patient made a good recovery but complained of residual pain and stiffness and sued for damages. With the benefit of hindsight, his solicitors confidently asserted that the diagnosis should have been obvious from the start. They claimed their client had raised the possibility of a thorn in the knee but said this had been dismissed by the doctor. An alternative interpretation of the sequence of events was that only when the piece of blackthorn was extruded did the patient and then his doctors appreciate the true cause of the symptoms. Certainly the first doctor could not recall any mention of a thorn.

In the course of litigation the defendants may have the plaintiff medically examined and in this case it emerged that though the disability seemed small, the man insisted that he had mentioned the possibility of a thorn at his first attendance. The Society felt that, although hindsight had played a large part in the evolution of the claim, because of the delayed diagnosis and the conflict of evidence over the history of the accident, it would be difficult to defend successfully. Settlement was agreed but proved costly at £45,000 because of compensation for loss of past and future earnings.

Beware os scaphoid

Another perennial mishap is failure to diagnose a fractured os scaphoid. Accident officers, radiologists and general practitioners are most at risk of falling into this trap.

A young plumber went to an accident department with a history of a blow to his right wrist at football. The senior house officer considered the possibility of a scaphoid fracture, but still missed the diagnosis. The physical signs did not include tenderness in the anatomical snuff box and although the doctor did not specifically request 'scaphoid views' the radiographer skilfully took some. The doctor could see no fracture but did re-examine the wrist and even noted that there was no tenderness over the scaphoid. He asked the man to return in two days when the formal report on the radiographs would be available.

The Society's member in this case was the registrar in radiology who reported the films, incorrectly, as showing no fracture. When the patient returned for review, the combination of him saying that his wrist felt better and the radiologist's unequivocally negative report caused the casualty officer to discharge him.

Fifteen months after the injury, the true diagnosis of a fractured scaphoid was made and, with bone grafting, a good result was obtained. This was one reason the man's claim was settled for a modest £15,000. The Society paid three quarters of this sum on behalf of the radiologist.

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A tight bandage

In 1984 a male patient underwent a ligation and stripping of his varicose veins. Bandages were applied by the surgeon and, 48 hours later, these were changed on the ward by his registrar. The day after that a circumferential ring of blisters was found at the top of the bandaged leg.

The bandages used were of an elasticated "Tubigrip" variety and the lesions could only have been caused by constriction. There was no way of knowing for certain whether the over-tight bandages had been applied in theatre or on the ward. In assessing the responsibility for the event it was relevant to consider the patient's allegation that he had complained of pain but that the nursing staff had paid him no attention. He has been left with some scarring.

In considering the patient's claim for compensation, the health authority's solicitors and the Society agreed to share a settlement equally. The patient received £3,000.

A difficult decision

A consultant gynaecologist saw a 22-year-old woman with abdominal pain and swelling and advised laparotomy. At operation he was assisted by a consultant surgeon and, as anticipated, a pelvic mass was found. Adherent bowel and disorganised anatomy suggested malignancy and the member performed sub-total hysterectomy with bilateral salpingo-oophorectomy. The patient recovered well but the histological examination of the excised tissue showed no malignancy, only chronic inflammation.

The patient sued and after thorough investigation and discussion, the Society resolved to settle. Hysterectomy in such a young patient presenting as she did and with no prior evidence of malignancy could hardly be successfully defended in court. The claim was settled for £25,000.

Hazard in the posterior triangle

An experienced surgeon removed a swollen gland from a young man's neck. On recovery, the patient complained of a weak, numb shoulder and reduced power in his arm. The surgeon had taken a biopsy from a large fibrotic mass in the posterior triangle and the histology report on the frozen section showed tuberculosis. He had then dissected out the whole mass and damaged the accessory nerve in so doing.

The man claimed compensation on the basis that because of risk to the accessory nerve, only a limited biopsy should have been taken. This argument carried weight and in addition the surgeon could have chosen to take a biopsy from a node in a less hazardous site.

The Society decided to explore settlement and since the patient had successfully had reparative surgery, only a small sum was required to dispose of the claim.

Valgus osteotomy successfully defended

A 52-year-old lady had a long history of problems with her right knee including osteoarthritis and had a varus deformity of 20 degrees. She was admitted to hospital for a valgus osteotomy of the right upper tibia.

The operation was performed by the consultant, a member, and post-operatively a good valgus position was obtained. Two weeks later check radiographs were satisfactory but two months post-operatively the consultant noted an increasing valgus deformity with some angulation. Despite wearing a full leg brace with hinges the valgus deformity increased and the patient declined further surgical intervention. Review of the radiographs shows the immediate post-operative position to be entirely satisfactory but subsequent films show progressive union with a considerable degree of valgus at the osteotomy site.

Having explored the matter fully, the Society denied liability on behalf of the consultant who performed the operation and the matter proceeded to trial. Following a two-day hearing, the Judge found in favour of the defendants. There was no evidence of any negligence at operation and the Judge accepted the views of the medical experts for the defendants.

Bile duct damage

A 70-year-old lady was referred to a general surgeon by her general practitioner with a history of persisting pain at the right costal margin and some tenderness in the right flank. The consultant surgeon made a diagnosis of gall stones and placed the patient's name on the waiting list for a cholecystectomy.

One month later the patient developed acute pain for which she was admitted to hospital as an emergency. The consultant was on holiday and his locum delegated the case to the registrar, a member of the Society. The registrar was well experienced and held the FRCS.

At operation the registrar delegated the cholecystectomy to the senior house officer, a member of a sister defence organisation. The registrar was scrubbed and guided the senior house officer through the operation.A per-operative cholangiogram was performed but the registrar allowed the senior house officer to proceed to mobilise and to remove the gall bladder before waiting for the x-ray films to arrive in the operation theatre. As soon as the films were reviewed it became apparent

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that there was filling of the common bile duct distally but no filling of the proximal portion nor filling of the common hepatic duct. The registrar then took over the operation and called in the locum consultant. He found only short ends of both hepatic ducts. The distal end of the common bile duct was ligated and he brought up a loop of jejunum and performed a mucosal graft portohepaticojejunostomy followed by a side-to-side jejunostomy.

The patient was then referred to a post-graduate institution for further treatment where a hepaticojejunostomy was performed. Due to extensive inflammatory changes it was impossible to lower the hilar plate properly. A few months later a percutaneous transhepatic cholangiogram was performed and it was concluded that there was complete obstruction of the right main hepatic duct which was drained percutaneously. It was subsequently found that there was a severe stenosis of the anastomosis to the left main hepatic duct.

Some months later the patient underwent percutaneous radiological dilatation of the right-sided stricture and her general condition improved.

A claim for compensation was made. The Society obtained expert opinion and was advised that the matter was indefensible. The operative cholangiogram was pathognomonic of having the tie around the common duct rather than around the cystic duct. The operators failed to wait for the x-ray films before proceeding with the cholecystomy. This was considered to be a serious error and the Society, in conjunction with a sister organisation, agreed that the claim should be settled. The patient was examined and subsequently settlement was reached for £20,000 of which the Society bore 80% on behalf of the registrar.

Lumbar disc surgery — cauda equina damage

A woman with chronic backache was referred by her general practitioner to a specialist orthopaedic surgeon, a member of the Society, following a recent back injury. A myelogram revealed a disc lesion at L5/S1. Hysterectomy for menorrhagia failed to bring any relief to the back symptoms and thus an operation on the disc lesion was recommended. The operation was undertaken by the orthopaedic surgeon assisted by a neurosurgical colleague, also a member of the Society. Following laminectomy, the neurosurgeon dissected out what was thought to be a perineural cyst and carried out a microsurgical lysis of "matted nerve roots".

Immediately post-operatively the patient noted sensation loss in both legs with bladder dysfunction. She suffered locomotive dysfunction and required a suprapubic catheter for bladder drainage. She suffered complete vaginal anaesthesia and required daily manual evacuation of faeces. Her marriage was dissolved.

The patient sued the neurosurgeon and was strongly supported in her claim by local expert opinion. A review of the myelogram showed arachnoiditis but no disc lesion and the histological report on the presumed cyst revealed arachnoid tissue. Despite the wishes of the member to defend the action, it proved impossible to find adequate expert opinion in support of a defence. Accordingly the claim was settled and the Society paid damages in the local currency equivalent of almost £300,000.

Circumcision — ventral fistula

A general medical practitioner, a member of the Society, performed a circumcision on a four-year-old boy. The operation was performed in the doctor's surgery. The doctor made no notes about the operation. Approximately one week after the operation the parents brought the boy back to see the member. They said they complained that the child was having difficulty in passing urine. The doctor made no notes but is alleged not to have removed the bandage and to have taken no further action.

Within three months the parents noted that the boy was urinating from the ventral surface of the penis. Two months later the child was referred to a paediatric surgeon who subsequently performed an operation to close a fistula on the ventral surface of the penis.

A claim for compensation was made against the member. The case was considered by the Society's General Practice Advisory Board and by the Cases Committee. It was not thought possible to defend the case, not least because of the absence of any contemporaneous notes or clear recollection by the member. The claim was settled for a total of £6,530. Members are reminded of the advice on page 11 and of the need always to make and keep accurate medical notes.

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Incomplete prescription

A mother consulted her general practitioner, a member of the Society, about her infant daughter who was suffering from colic. After examining the infant, the member prescribed half-strength Merbentyl syrup 2.5 mls. Some 2 weeks later the mother visited the member's surgery again, this time without her daughter, and asked the practice receptionist for a repeat prescription. Following the mother's first visit to the surgery, the member had been made aware that caution should be exercised when prescribing Merbentyl for infants. Accordingly, he advised the practice receptionist to prepare a prescription for Gaviscon and she wrote *"Gaviscon sachet 10 x 10 OP"* and entered in the appropriate place on the prescription the infant's age as *"11/52"*. The member signed the prescription although the word 'Infant' or 'Paediatric' was omitted from it. The pharmacist to whom the prescription was presented dispensed *adult* Gaviscon.

The mother subsequently complained to the Family Practitioner Committee. Following an oral hearing before a Joint Service Committee (which the mother did not attend) the member was found to be in breach of paragraph 13 of his Terms of Service in that he had not correctly prescribed medication for the infant. A recommendation was made that £100 should be withheld from his remuneration.

The member felt that the finding was unfair in that the infant's age had been entered on the prescription form. The Society assisted him with legal representation for an appeal to the Secretary of State where it was argued on his behalf that the prescription in question showed quite clearly not only the age of the infant, but also the instruction to dispense Gaviscon in sachet form. The preparation of this drug designed for infant use is manufactured only in that form.

Although the Secretary of State did not accept the recommendation to withhold £100 from the member's remuneration, the decision on the appeal was that the member *"was in breach of paragraph 13 of his Terms of Service because he failed to indicate on the prescription form that Infant Gaviscon should be dispensed"*. In reaching this decision the Secretary of State adopted the view that:

"The only sure and unequivocal way in which to ensure that Infant Gaviscon Sachets are dispensed is to prescribe as described in the section Prescription Writing in the British National Formulary. Misinterpretation could have been avoided had Infant Gaviscon been prescribed; it was not sufficient merely to write Gaviscon Sachets and rely on the date of birth of the patient to guide the pharmacist to prescribe Infant Gaviscon."

The member subsequently expressed his dissatisfaction with the Secretary of State's decision, but was advised by the Society that the Regulations (made by Parliament) allowed of no further appeal and that the circumstances of the case, which appeared to have included some irregularities by the Family Practitioner Committee in the administration of the complaint, did not lend themselves to an application for Judicial Review.

The British National Formulary includes the following advice under the section entitled "Prescription Writing":—

Prescription Writing

The following recommendations are acceptable for prescription-only medicines (POM). For items marked CD see Controlled Drugs and Drug Dependence. It should be noted that internationally recognised units and symbols are used in the BNF wherever possible.

Prescriptions should be written legibly in ink or typewritten, dated and signed by the prescriber, and the full name and address of the individual patient added. The age of the patient should preferably be stated, and is a legal requirement in the case of prescription-only medicines for children. In general practice the following should be noted:

(a) For solids, quantities of 1 gram or more should be written as 1 g etc.

Quantities less than 1 gram should be written in milligrams, e.g. 500 mg, not 0.5 g.

Quantities less than 1 mg should be written in micrograms, e.g. 100 micrograms, not 0.1 mg.

When decimals are unavoidable a zero should be written in front of the decimal point where there is no other figure, e.g. 0.5 ml, not .5 ml.

Use of the decimal point is acceptable to express a range, e.g. 0.5 to 1 g.

(b) 'Micrograms' and 'nanograms' should not be abbreviated. Similarly 'units' should not be abbreviated.

(c) The term 'millilitre' (ml) is used in medicine and pharmacy, and cubic centimetre, c.c., or cm^3 should not be used.

(d) Dose and dose frequency should be stated.

For oral liquid preparations of the linctus or elixir type and for preparations for children, doses should preferably be stated in terms of 5-ml spoonfuls.

For mixtures for adults, doses should preferably be stated in 10-ml quantities; unless the prescription states otherwise, the patient will be directed to take the dose with water.

When doses other than 5 or 10 ml are prescribed the dose-volume will be diluted to 5 or 10 ml or a multiple thereof (except for preparations intended to be measured with a pipette).

The volume of liquid preparations should normally be 50, 100, 150, 200, 300, or 500 ml. Suitable quantities of liquid preparations:

Elixirs, Linctuses, and Paediatric Mixtures (5-ml dose), 50, 100, or 150 ml
Adult Mixtures (10-ml dose), 200 or 300 ml
Ear Drops, Eye-drops, and Nasal Drops, 10 ml (or the manufacturer's pack)
Eye Lotions, Gargles, and Mouth-washes, 200 ml
Liniments, 100 ml

(e) Quantities of solids prescribed should normally be 15, 25, 50, 100, 200, 300, or 500 grams (or the manufacturer's appropriate pack).

For suitable quantities of dermatological preparations, see section 13.1.

(f) The names of drugs and preparations should be written clearly and not abbreviated.

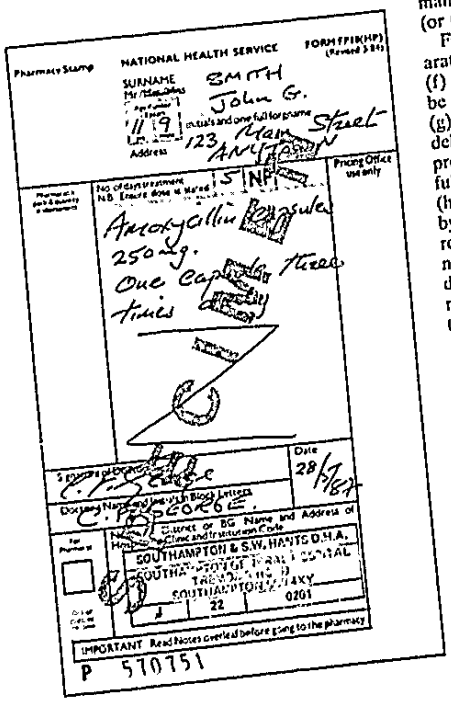
(g) The symbol 'NP' on NHS forms should be deleted if it is required that the name of the preparation should not appear on the label. For full details see under General Guidance.

(h) The quantity to be supplied may be stated by indicating the number of days of treatment required in the box provided on NHS forms. In most cases the exact amount will be supplied. This does not apply to items directed to be used as required; if the dose and frequency are not given the quantity to be supplied should be stated.

When several items are ordered on one form the box can be marked with the number of days of treatment providing the quantity is added for any item for which the amount cannot be calculated.

(i) Directions should preferably be in English without abbreviation, e.g. one at night, not i.o.n.

(j) A prescription for a preparation that has been withdrawn or needs to be specially imported for a named patient should be handwritten. The name of the preparation should be endorsed with the prescriber's signature and the letters 'WD' (withdrawn or specially-imported drug); this will be a valuable indication to the pharmacist of the prescriber's intentions. There may be considerable delay in obtaining a withdrawn medicine.



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Vocational Training Regulations

A 20-month-old patient attended surgery and was seen by one of the partners. Gastro-enteritis was diagnosed and Maxolon was prescribed. The following day a trainee general practitioner, a member of the Society, made a home visit. He diagnosed diarrhoea with mild dehydration and prescribed Dioralyte. Five hours later the patient's condition deteriorated and he died. The stated cause of death was interstitial pneumonia.

The patient's mother claimed compensation against the member and the member's Trainer. The Society considered the claim should be settled. Compensation of £2,600 was paid.

The patient's mother also complained to the Family Practioner Committee. The member's principal, on behalf of his trainee, was found to be in breach of the terms of service. The Medical Service Committee found that the member had not made a full clinical examination, especially of the child's chest. Had he done so, he might have arranged an immediate admission to hospital. An appeal by the member's principal to the Secretary of State was dismissed.

When the member had finished his training, his principal was reluctant to sign a Statement of Satisfactory Completion of the member's period of training. The principal considered the member not to have achieved a satisfactory level of *competence*. The Statement of Satisfactory Completion was required for the purpose of obtaining from the Joint Committee on Post Graduate Training for General Practice a Certificate of Prescribed Experience, without which the member would be ineligible to become a principal in the National Health Service.

The member sought the Society's advice and assistance in securing a signed form VTR1 from his Trainer. The Society was advised that the member's principal was by law required to certify only about the member's *experience* and not about the member's *competence*. Subsequently, the member and his principal reached a compromise. A Statement of Satisfactory Completion was signed in a qualified form: the principal certified that the member had completed satisfactorily as to experience, but not necessarily as to competence, his period of training.

The member applied to the Joint Committee for a Certificate of Prescribed Experience. The Joint Committee at first indicated that they would take account of the member's *competence*. The Society was advised that the Joint Committee could not take account of competence when considering whether or not to issue a Certificate of Prescribed Experience.The member's competence had been properly assessed by, for example, University examinations. After some delay, the Joint Committee issued a Certificate of Equivalent Experience. The Society was advised that a Certificate of Equivalent Experience would allow to the member the same benefits as a Certificate of Prescribed Experience, so that the member would not be prejudiced. The member therefore accepted the Certificate of Equivalent Experience.

It should be noted that in the United Kingdom general practitioner training (for admission to the medical list as a National Health Service practice principal) is controlled by statute. No other specialist training in the United Kingdom is subject to detailed control by Parliamentary regulations. Where regulations are found to pose difficulties in interpretation the position can only be resolved by an amendment to the regulations, a complex and time consuming business.

COMPLAINTS AGAINST GENERAL PRACITIONERS

One day a patient will complain about you. You will be surprised, angry and, above all, hurt. In the 1987 Annual Report ("General Practice Complaints — A look at both sides" page 36) we explained the common reasons why patients complain and looked at how to reply to a complaint. What action can the Family Practitioner Committee take after investigating a complaint? The following five cases illustrate what can happen.

Complaints Against GPs: What Can Happen?
by C.A.Owen BSc MPhil MBBS MRCGP
Member of Secretariat, Medical Protection Society

1 Patient withdraws complaint

At 9.30am a woman telephoned her mother and learned that she had collapsed in the toilet during the night and now had a lack of feeling in her legs, hands and arms. The daughter telephoned surgery to speak to one of the doctors. A receptionist said that they were busy and suggested phoning back later. When the woman did this the doctors were still busy in surgery so she explained about her mother to the receptionist. The receptionist said she would put the lady on the visiting list for that morning. But the daughter said she would still like to speak to the doctor before he visited and the receptionist agreed to pass on this message.

The daughter spoke to one of the doctors around midday explaining that her mother's condition had now deteriorated during the morning. She asked for an urgent visit. By 2.00pm the doctor had not called and the daugher asked again for an urgent visit. A different receptionist said that she had been told that the visit had already been made. The woman pointed out that no doctor had called to see her mother and added that she was now very anxious that a doctor should come quickly. A doctor arrived at 3.30pm and the patient died five minutes later. The cause of death was given as myocardial infarction.

The deceased's daugher complained to the Family Practitioner Committee. She criticised the practice for its organisation which resulted in her requests for an urgent visit not being attended to promptly. The complainant realised that an earlier visit might not have saved her mother's life but she was concerned that other patients might suffer similarly as a result of what she considered to be poor communication in this practice.

With the advice of the Society the general practitioner included in his reply to the complainant a description of the investigation which had taken place within the practice. All the receptionists had been interviewed and the partners had discussed the matter fully. They had produced a set of guidelines for the handling of urgent visit requests. On reading this the woman withdrew her complaint and the matter progressed no further.

2 Family Practitioner Committee dismisses complaint without a hearing

A general practitioner admitted a blind, disabled lady to hospital because of a chest infection. While the patient was in hospital her son telephoned the general practioner, a member of the Society, and asked if arrangements could be made for his mother to placed in warden-controlled accommodation. The general practitioner said that, as the patient was in hospital, it was up to the hospital to make these arrangements. The hospital did so and the woman was accommodated.

The son complained to the Family Practitioner Committee saying that the general practitioner had refused to help. The general practitioner explained that he knew the elderly lady well, having visited her twelve times that year already. He said that he had been telephoned by one of the hospital doctors to discuss the need for warden-controlled accommodation. He agreed that this was appropriate and the hospital doctor had said that he would make the arrangements with Social Services. The Chairman of the Medical Services Committee considered that an oral hearing of this complaint was unnecessary. He dismissed the complaint on the basis of the correspondence.

3 Family Practitioner Committee dismisses complaint after Service Committee hearing

A woman consulted her general practitioner thinking she was pregnant. Her last menstrual period had begun 13 weeks before the consultation and the doctor's assessment, based on abdominal examination, was of a 14-16 week gestation.

The patient wanted a termination of pregnancy. The general practitioner agreed to this, pointing out that time was short because of her advanced pregnancy. He sent a handwritten letter to the consultant gynaecologist that day and told the patient to contact the surgery if she did not receive an appointment.

Ten days later the patient phoned the surgery saying she had not heard from the hospital. A surgery receptionist established that the letter had not been received by the hospital and made an appointment that day by telephone for one week later. The receptionist informed the patient and gave her another letter.

The woman did not keep her appointment at the gynaecological clinic but instead made her own arrangement for a private termination. The discharge letter from the private clinic put her gestation at only nine weeks.

The patient complained to the Family Practitioner Committee. She said that when the first appointment went astray the general practitioner phoned her advising her to seek a private termination because the pregnancy was so advanced. The patient paid £330 for this operation. She considered that her general practitioner had been at fault in mistaking the maturity of her pregnancy and so advising her to seek a private termination. Because of this she wanted the general practitioner to reimburse the £330.

In his reply the general practitioner argued that he had put no pressure on the woman to seek a private termination. He had done all he could to arrange for a termination of pregnacy on the National Health Service. He defended his assessment of the gestation by pointing to his many years' experience of looking after pregnant patients. He had made a careful assessment and, knowing the woman's last menstrual period, he had reckoned the pregnancy to be around 14 weeks.

A Service Committee hearing found that the general practitioner was not in breach of his Terms of Service. No further action was taken. The patient appealed against this finding. The Secretary of State dismissed the patient's appeal without an oral hearing.

4 Family Practitioner Committee finds General Practitioner in breach of Terms of Service

The mother of a four month old baby telephoned her general practitioner around 5pm one day describing symptoms of fever, poor feeding, lethargy and increasing reluctance to be handled. The general practitioner, a member of the Society, reassured the mother over the telephone and advised that the baby be given fluids only. Shortly afterwards her husband telephoned again and asked for a visit. This was carried out around 7pm.

The general practitioner examined the baby's chest, inserted a finger in the mouth to assess the degree of hydration and found nothing abnormal in the abdomen. He did not examine the fontanelle although he pinched the skin, again to assess hydration. He made a diagnosis of viral infection and advised that Calpol and fluids should be given, reassuring the parents that there was nothing seriously wrong.

The child deteriorated through the night. During the morning convulsions began though the parents did not recontact the general practitioner until the afternoon after the baby had become unconscious. The general practitioner told them to take the child to the nearby Accident & Emergency unit. A diagnosis of pneumococcal meningitis was quickly established. The child was ventilated for three days, with intensive antibiotic treatment.

Despite anticonvulsant therapy an average of six convulsions a day was recorded. During the following two years there were 14 admissions to hospital.

In her complaint to the Family Practitioner Committee the child's mother wrote:—

> *"We do understand that in a situation such as ours you tend to look for someone to blame — it must be an easy way to relieve one's anger, but the facts stare you in the face. The doctor did not want to come out; his sarcastic manner; his failure to examine properly and suspect a serious illness, or even note that my baby's temperature was 104°F. He also gave us wrong advice on treating a temperature. We were told by doctors that a baby should never be left without medical supervision with such a high temperature or left to become delerious as it could become very dangerous. We are sure that you have had other complaints concerning this in the past, as we have since heard many bad reports, even via Health Visitors. We know, and have been told, that we have a valid case. We also realise it will be very costly, extremely hurtful and time-consuming but we are willing to risk everything. After all, we have lost a lot already — my job, loss of earnings, as my husband has had a great deal of time off work, loss of faith in doctors and the loss of our son's health and sight".*

The doctor and parents attended a Service Committee hearing. The Committee found the general practitioner in breach of his Terms of Service. Additionally, as can happen with a finding of breach, a withholding of £200 was made from his remuneration. In reaching this decision the Medical Service Committee concluded that the general practitioner had failed to examine the baby adequately and had failed to give appropriate advice to the parents. The Committee also considered that the general practitioner had failed to make adequate arrangements for the patient's admission to hospital.

The member appealed against the decision of the Service Committee to the Secretary of State. The Society provided legal representation for the member at the oral hearing of appeal. Not only did the Secretary of State dismiss the appeal but the withholding was increased to £500.

5 Referral to NHS Tribunal

The wife of a middle-aged man telephoned the surgery asking for a visit for her husband who had chest pain. The general practitioner, a member of the Society, visited and diagnosed angina, which was temporarily relieved by a glyceryl trinitrate tablet. The man's wife called the same general practitioner again on two more occasions shortly afterwards because of a recurrence of chest pain. The doctor did not visit and on the second occasion suggested that the woman should contact the ambulance service herself.

The complaint was investigated by a Service Committee hearing. The Committee found the doctor in breach of his Terms of Service and imposed a withholding of £2,000 for performing an inadequate examination and for failing to re-visit. The Committee recommended to the Family Practitioner Committee that the size of the general practitioner's list be reduced. The Family Practitioner Committee chose instead to adopt an unusual alternative: referral to the National Health Service Tribunal. The Tribunal examines whether the doctor is fit to continue to serve as an NHS principal and may direct that a doctor's name be removed from the Family Practitioner Committee list.

The Tribunal considered this complaint along with two other matters. First, a previous complaint arising out of a failure to visit and resulting in a finding of breach of the Terms of Service and an appearance before the General Medical Council. Second, an occasion on which the doctor had left his practice in the care of a locum but had failed to return to the practice to resume work at the agreed time. The Tribunal heard representations from the Society's solicitors on behalf of the general practitioner. The Tribunal was concerned about the doctor's organisation of his practice and about his handling of visit requests. The Tribunal concluded that *"the continued inclusion of this doctor in the medical list would be prejudical to the efficiency of general medical services"* and ordered that the doctor should not be incuded as a principal on any Family Practitioner Committee list in England and Wales. An appeal to the Secretary of State was unsuccessful.

Subsequently the doctor was summoned by the G.M.C. because of the Tribunal findings. The Council found him guilty of serious professional misconduct and directed that his name be erased from the Register.

THE DIAGNOSIS AND TREATMENT OF OCCLUSAL AND TEMPORO-MANDIBULAR JOINT PROBLEMS IN GENERAL DENTAL PRACTICE

Roy H Higson
BDS Manc

The increase, in recent years, of more advanced forms of restorative treatment coupled with patients' expectations of longevity for both natural and restored teeth has led to a much greater need for accuracy in diagnosis and treatment planning in general practice. A recognition of occlusal and temporo-mandibular joint (TMJ) problems and ability either to treat or refer them for treatment prior to starting any restorative therapy should be within the ability of all dentists in general practice, in exactly the same way that periodontal or orthodontic or surgical problems should be diagnosed and referred if necessary.

Although we cannot stop the body from ageing, the teeth and their supporting structures, the peridontium, bones, joints and muscles can be reasonably expected to last a lifetime. Breakdown of any of these structures, or the teeth themselves, only occurs when physiological limits are exceeded by:

1) Micro-organisms
2) Stress
3) Trauma
4) Neoplasm

The degree of breakdown is determined by the intensity of the causative factor and the patient's host resistance. To arrive at an accurate diagnosis it may be necessary to analyse factors affecting host resistance such as general health, nutrition and emotional stress.

The examination of all patients in need of advanced restorative therapy or suspected of having occlusal or TMJ problems should include:

1) General medical history
2) General dental history
3) Muscle palpation
4) Intra-oral examination
5) Radiographic examination
6) Study model analysis

1 General medical history

A patient's ability to respond to stress affects host resistance; it is therefore essential that a detailed medical and, if necessary, social history should be taken. A written questionnaire filled in by the patient and checked by the dentist and patient is probably the best way of ensuring a complete history. It is essential that details of traumatic incidents are included, to exclude the possibility of haematomata among other conditions causing headaches where a delay in treatment could have serious consequences.

A simple question such as *"do you think you are under stress?"* with a Yes/No answer box, may be enough to elicit if the patient wishes to enlarge on the subject.

A detailed history of the patient's headaches, neck aches and back pain is essential.

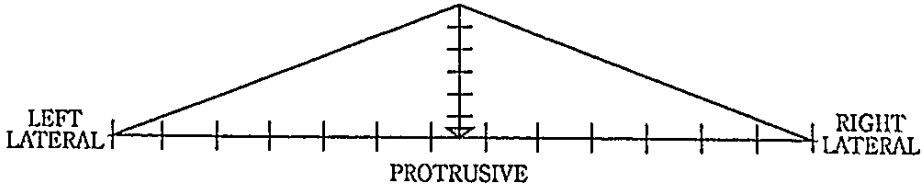
The headache questionnaire should be designed to ask:

a) How long has the patient suffered from headaches?
b) How often do they occur?
c) When during the day do they occur?
d) Where is the site of the pain?
e) What gives relief?
f) Who else has been consulted regarding treatment?
g) What other treatment has been received?

3 Muscle palpation

An awareness of the relationship between trigger points in muscles and the likely pain referral sites is helpful when examining muscles. Whenever possible, muscles should be palpated bilaterally so that the patient can assess relative tenderness. All areas of tenderness should be recorded in the following muscles:

Trapezius
Posterior cervicals
Sterno-mastoid
Digastric
Temporalis *(anterior, middle, posterior)*
Masseter *(superficial, deep)*
Medial & Lateral Pterygoids



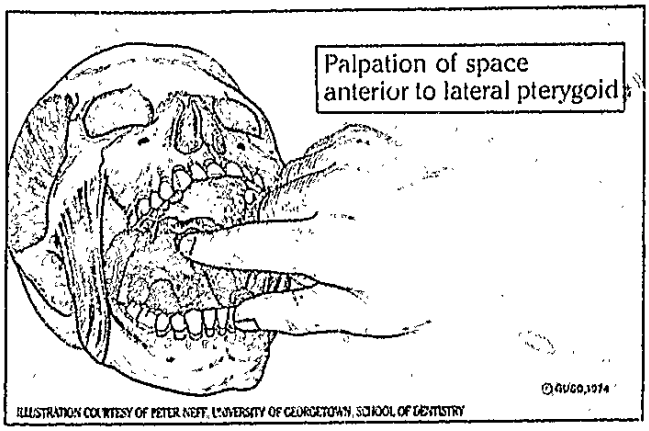
In addition the TMJ should be palpated via the external auditory meatus and laterally. The presence of any pain, clicking or deviation on opening should be recorded. Lateral excursions in both directions should be measured and recorded along with the amount of maximum opening, measured from incisal tip to incisal tip.

4 Intra-oral examination

The intra-oral muscles are palpated first (medial and lateral pterygoids). Then the soft tissues, peridontium, teeth and occlusion should be examined.

The soft tissues should be examined for signs of nature's own bite guard, that is a ridged or scalloped tongue or buccal mucosa.

The periodontal charting should follow the recognized procedure, particular care being taken in charting pocket depths and any mobility of teeth. To assess if mobility has changed at subsequent examinations it needs to be recorded and monitored. The usual recording system grades mobility on a scale of 1 to 3 with half increments marked as (+) as follows:



0 - Normal mobility less than 1mm
1 - Mobility approximately 1mm bucco lingually
2 - Mobility 2mm bucco lingually, no apical movement
3 - Mobility more than 2mm bucco lingually plus apical movement

The teeth should be examined for evidence of wear faceting, chipped or fractured cusps, broken restorations and enamel cracks. It is often useful to demonstrate to patients the way wear facets in opposing jaws fit perfectly in eccentric movements using a mirror. In particular evidence of occlusal breakdown in teeth involved in future restorations should signal the need for care in treatment planning.

5 Radiographic examination

Patients who have no signs or symptoms of TMJ disorders and present for restorative therapy only should have full mouth periapical films taken using a long cone technique, unless there are medical contra-indications. If there are any suspected TMJ problems, corrected trans-cranial radiographs of both condyles in the closed, relaxed and wide open positions should be taken.

The periapical radiographs should be examined for evidence of widening of periodontal ligaments, size of pulp chambers in worn teeth, bone sclerosis, hypercementosis, apical resorption or root fractures. The trans-cranial radiographs should be examined for evidence of normal movement, changes of shape of the head of the condyle (e.g. beaking) distallization of the condyle by the occlusion, osteoporosis and fracture.

6 Study model analysis

Unless an operator is highly skilled at examination and mandibular manipulation, the working relationship of the jaws can be examined far more satisfactorily using study models properly mounted in a semi-adjustable articulator. Study models, mounted in centric relation (retruded contact position) should always be prepared for patients exhibiting occlusally-related problems or requiring multiple crowns or bridges.

Accurate study models are needed for:

a) Diagnosis
b) Reference
c) Equilibration
d) Diagnostic waxing

a) Diagnosis

The presence of wear facets, fractured cusps, plunger cusps etc. can be seen on hand held models but their significance may be missed unless the models are correctly mounted. Interferences with an optimum occlusion can be diagnosed only with the use of an articulator.

b) Reference

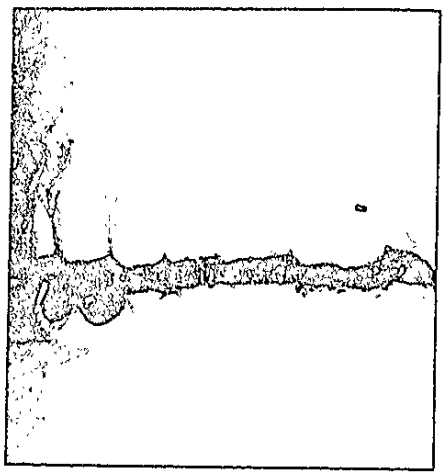
Duplication of the original set of study models should be carried out prior to any modification of treatment so that future referral to the original models will enable the operator to assess the stability of the existing occlusion or the restorative dentistry.

c) Equilibration

Equilibration is an irreversible procedure. Unless the operator is extremely experienced in the treatment of occlusal problems, a duplicate set of accurately mounted study models should be equilibrated first. The amount of tissue reduction necessary to achieve correct condylar position and occlusal harmony can be checked against the original models to see if equilibration alone will achieve the desired result. If it is necessary to grind through existing crowns or if the teeth may become sensitive the patient needs to be consulted first. The grinding of opposing teeth should be a pre-determined treatment, not the result of faulty planning and execution.

d) Diagnostic waxing

The likely success of therapy depends on many decisions that can often only be determined by waxing up a desired final result. Decisions on whether teeth need to be equilibrated, crowned (with or without endodontic therapy), orthodontically moved or extracted can often be made only by assessing this final result.



The need for accuracy both in the preparation and mounting of study models cannot be stressed enough. Care in taking an accurate impression and ensuring the impression material has not distorted, care in taking a face bow recording and care in taking an accurate centric relation record will all ensure valid recordings. Centric relation records in a non-distorting durable material such as Duralay should be preserved along with the original study models.

e) Treatment planning

Once an accurate diagnosis has been made the treatment phases should be as follows:—

[i] Emergency
[ii] Soft tissue
[iii] Splint therapy
[iv] Restorative

[i] Emergency treatment

For patients with acute TMJ or occlusal problems, for example severe headaches, an anterior jig to relocate the joint or keep the teeth apart will often give immediate relief. Failure to give relief indicates a possibility of more severe problems. The angulation of the anterior contacting plane is critical in these cases.

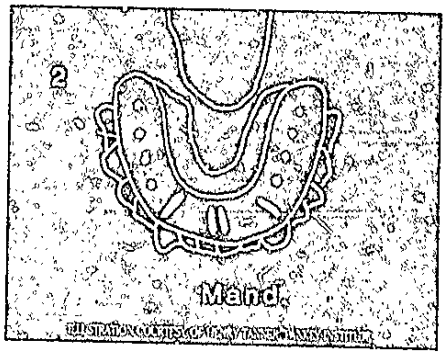
[ii] Soft tissue treatment

Periodontal problems should be dealt with before any further stages to assess the prognosis of involved teeth.

[iii] Splint therapy

Any form of prolonged splint therapy should only be undertaken with full coverage hard acrylic splints. Lack of full coverage can lead to depression of the teeth involved in the splint.

Splints for occlusal correction should be perfectly equilibrated with correct anterior guidance; splints for TMJ problems should have positive guidance to correct the problem.



[iv] Restorative treatment

Only when all the signs and symptoms discovered during the diagnosis have been successfully treated should the restorative phase be considered. On patients who have experienced severe problems the use of long term temporaries should be considered; these can be constructed either from the diagnostic wax up or by using the finalized splint.

Once the final restorations have been inserted it is necessary to check the occlusion regularly and make any small adjustments if necessary.

The difficulties of dealing with occlusal and TMJ problems and the possibility of future re occurrence makes it imperative that patients are fully informed of the problems and involved in decisions regarding treatment plans.

Written acceptance of treatment plans that explain these problems should always be obtained where extensive, lengthy and expensive dentistry is proposed. The acceptance should set out an explanation of possible problems.

N.B. No attempt has been made in this article to discuss specific condylar positions or occlusal schemes, or the means of achieving them. Whatever the desired final result, it should be based on an accurate diagnosis, proven techniques and be within the abilities of the operator.

OSSEOINTEGRATED IMPLANTS

by David S Harris FDSRCS LRCP MRCS

The availability of allogenic implants that can be placed within the jaw bone to provide long term support for tooth replacements has long been desired by the dental profession. Over the years various materials, often fabricated into ingenious designs, have been utilised by dentists in attempts to deal with the very real problems faced by patients who simply cannot cope with dentures. These earlier attempts were mostly based on anecdotal reports of success without any real background of research. Not surprisingly results were, at best, unpredictable and, at worst, a failure. Long term complications, sometimes occurring after a short period of clinical use, included further loss of remaining bone and scarring of soft tissues.

However well-meaning the intentions of those prescribing the treatments, in the absence of a solid scientific foundation on which these implants could be based, their clinical use amounted to human experimentation — often carried out without fully informed consent.

Such genuine concerns about the use of implants ensured that the vast majority of dentists would not advise their patients to undergo such treatment.

More recently, basic research has been carried out into those factors that govern the biological responses of bone and soft tissues to the method of insertion and long term presence of implantable biomaterials. Over many years this work has been brought to the stage of an acceptable clinical technique by a Swedish team led by Professor Per Ingvar Brånemark. Uniquely in the field of dental implants a large volume of basic science has been followed up by meticulous animal and clinical research and development to produce an implant that will withstand long term scientific scrutiny. The term "OSSEOINTEGRATION" was introduced to the literature by Brånemark to describe the biological events which take place at the interface between his implant and the surrounding bone. Not surprisingly perhaps the decription of osseointegration has been seized on by almost all manufacturers of dental implants. In many instances this is presumably intended to lend some credence to claims made for their successful use in the absence of any scientific validation.

The success of Brånemark's work has been recognised world wide and received a great deal of publicity in the lay press. As a result the general public are increasingly enquiring about implants from dentists. At the same time dentists themselves are being subjected to intensive marketing and launching of many different implant systems claiming to achieve success by osseointegration. This combination of demand and marketing, which is often misleading, poses special traps for the unwary. This is especially so when it is realised that there are no guidelines or controls established whatever with regards to standards or the suitability of an implant for clinical use. The manufacturers know and rely on the fact that the responsibility for the clinical use of any particular type of implant rests entirely with the dentist. Hence they can market a new implant design without any laboratory, animal or clinical research being carried out.

Any dentist who considers becoming involved in this exciting and attractive field must do so cautiously. All the ingredients are present for expensive failures and complications to occur which in turn may lead to settlements or costly and unpleasant court proceedings. The following are some guidelines which may be of help to those wishing to proceed responsibly when faced with high pressure salesmen and glossy literature.

Significance of Brånemark's Research

Brånemark's work started some 25 years ago by observing directly the cellular response to trauma in living bone using a technique called "vital microscopy". He subsequently found that some of the pure titanium observation chambers carefully placed within the bone marrow appeared to bond firmly over a period of months. In order to retrieve the chambers, blocks of bone had to be sectioned as they had become so adherent. He subsequently elucidated the factors that would allow him to produce this attachment in a predictable manner. Light microscopy showed that when this attachment took place the bone cells appeared to grow directly onto the surface of the titanium without any intervening fibrous tissue. He termed this phenomenon osseointegration. Further research showed that the cellular attachment had in fact only taken place where the surface oxide layer that had formed on the titanium was intact and uncontaminated. Following this work, implants of many different designs were placed in extensive animal studies. This eventually led to the development of a clinical procedure using a screw type implant, with specific surface characteristics and geometry, using a standardised atraumatic surgical protocol. Follow-ups, using computerised comparisons and measurements of post operative radiographs, over a period of 15 years, showed a success rate in excess of 98% in the mandible.

The success of the Brånemark implant occurs because of events that take place at a cellular level. Initial osseointegration is a function of the coating of the oxide surface with a protein layer in conditions which will allow subsequent repair and new bone formation. Long term function is a result of favourable stress distribution of the loaded implant, working within the physiological

limits of bone remodelling and resulting in continuing growth of the oxide layer and increased strength in the peri-implant bone trabeculae. It does not depend on mechanical retention by means of undercuts or bone growth through vents — osseointegration is entirely biological.

Can all implant systems achieve osseointegration?

It should be fully appreciated that Brånemark's work and reported success refer to the use of a commercially pure titanium implant of specific design and geometry, the surface of which was specially treated to ensure removal of any contaminants and the production of a favourable oxide layer. Furthermore a precise surgical protocol was used with a specially developed armamentarium that allowed atraumatic site preparation. The surgical placement was carried out under aseptic conditions in a manner that prevented any contamination of the oxide layer prior to the implant surface making contact with bone.

This is not to say that other implants cannot achieve equally good or even better results but it is quite wrong to assume that just because an implant bears a superficial resemblance to that used by Brånemark, it will perform in the same manner. It is positively misleading to use Brånemark's results and research in support of other implants on the basis of some supposed similarities in the absence of any scientific evidence as to how they will perform. Even very minor differences have been shown to affect cell adhesion. Before purchasing or using any implant system it is vitally important to demand to see satisfactory evidence of research, including animal studies, and a significant clinical trial that has been published in reputable journals and relates SPECIFICALLY to the implant being promoted. In the absence of such evidence the implant must be considered to be experimental and should only be used on the basis of "human experimentation with fully informed consent". A practitioner who does not obtain such consent is seriously departing from the principle of *primum non nocere.*

What criteria can be used to assess an implant system?

Clearly an implant must be constructed from a material that is non-toxic and biocompatible and animal studies must indicate that it has potential for successful human use. Clinical studies must include large numbers, stated criteria for selection and for judging success, long term follow up and a proper statistical analysis. The results must be accepted and published in journals that have a known scientific standing. Such journals will subject articles to careful independent scrutiny by a scientific advisory panel prior to acceptance for publication.

Albrektsson et al have proposed the following criteria for success:

1 *That an individual, unattached implant is immobile when tested clinically.*
2 *That a radiograph does not demonstrate any evidence of peri-implant radiolucency.*
3 *That vertical bone loss is less that 0.2mm annually following the implant's first year of service.*
4 *That individual implant performance is characterised by an absence of persistent and/or irreversible signs and symptoms such as pain, infections, neuropathies, paraesthesia, or violation of the mandibular canal.*
5 *That in the context of the above, a successful rate of 85% at the end of a five year observation period and 80% at the end of a ten year period is a minimum criterion for success.*

When judging published results it is highly desirable to discover if all implants inserted at the commencement of the study are subsequently accounted for and whether an independent replication study has been carried out with equally good results.

Who should carry out implant procedures?

Placing jaw implants requires substantial surgical skill. It also requires a demanding prosthodontic technique to construct a prosthesis that will satisfy the patient's expectations and maintain long term functioning of the implants. The extensive exposure of the jaws required when dealing with very resorbed, fully edentulous, cases is obviously best carried out by an appropriately trained oral surgeon. Even a partially edentulous case will require considerable surgical expertise to avoid possible complications such as nerve damage, haemorrhage, fracture, infection or loss of soft tissues. A practitioner must have a suitable training and background appropriate to the skills required in this demanding area prior to undertaking such treatment. It is most advisable to look carefully at the credentials of those offering courses and whether these courses are university based or not. Many such courses are of short duration and could not reasonably be expected to equip a practitioner with all the necessary skills to perform implant surgery in the absence of an extensive surgical background.

SHORT REPORTS — DENTAL CASES

Inhaled and ingested dental instruments

Since the dangers of failing to partition-off the pharynx are so well recognised, the Society could not defend any of the following cases and settlement was inevitable.

A post and core was inhaled by a patient in England and required removal by thoracotomy. The resulting claim was settled by the Society for £10,000. A second similar case was settled for £4,300. A bonded crown lodged in the trachea of a third patient and the Society settled for £2,000.

Two cases where orthodontic wires were swallowed and passed naturally cost the Society £500 each; two cases of swallowed endodontic reamers were settled each for £1,000, whereas an ingested giromatic file occasioned a settlement of £750.

A case of a swallowed dental bur in Northern Ireland was settled for £4,500.

Fracture of the mandible

During the removal of a partly-erupted lower third molar in an elderly [illegible] an edentulous mandible, the bone fractured. The danger of fracturing the mandible was apparent on the pre-operative radiograph but the patient had not been warned. Although the dental surgeon recognised that a fracture had occurred and took immediate steps to ensure the care of the patient the case was settled for the sum of £3,500. In a second case, where the fracture occurred in a dentate mandible, the Society had to accept liability since the patient was not informed of the accident by the dentist. Settlement was effected for £2,000.

Endodontic treatment

The past year produced more claims for avoidable harm resulting from the provision of endodontic treatment. The cost to the Society ranged from £250 for a merely unsatisfactory root treatment, through £2,000 for a fractured and retained paste filler to £3,000 and £5,000 for permanent damage to the inferior dental nerve as a result of endomethazone entering the nerve canal.

The Society continues to advise members that the greatest care must be exercised if endomethazone is to be employed in mandibular endodontic treatment.

Orthodontic treatment

A member in Australia used elastic bands round the necks of the two upper central incisor teeth to approximate these teeth. The bands were allowed to remain unsupervised in place with the result that the periodontal tissues were severely damaged and the future of the teeth imperilled. The resulting claim was settled for A$6,3000.

Three cases where the wrong teeth were extracted in error cost the Society respectively £500, £1,000 and £2,000.

Two cases in the West Indies where rapid-expansion techniques were employed on the maxillae of children were settled at $1,500 each when damage to the palate occurred.

Bridges

During the past year the Society received a large number of claims for the provision of unsatisfactory bridge work. This increase in the number of cases may well be due in part to public awareness and willingness to sue. Bridge work may be expensive. If the work undertaken is over-ambitious and fails, the patient may expect to recover compensation. It is important that patient expectations are not unrealistic and that full explanations of the proposed treatment are given by the dentist, including risks.

An unsatisfactory bridge of 7-units at the upper anterior teeth was settled for $5,000 and another case of a 6-unit bridge in the Republic of Ireland was settled for IR £5,000.

A 7-unit bridge provided in Australia proved to be unsatisfactory and the Society was obliged to settle in the sum of A$16,000.

A case in Canada involving 3 bridges, extensive endodontics and a dental implant did not provide the benefit expected by the patient, nor were there records of consent by the patient to the treatment. The Society settled the matter for $30,000.

SHORT REPORTS — DENTAL CASES

Soft tissue injury

Members should always bear in mind the dangers to circumoral tissues from the sharp or rapidly-rotating instruments which are used in everyday dentistry.

A member in Scotland who was using the dental drill during the removal of an impacted lower second pre-molar tooth inadvertently burnt the patient's lip. The Society settled the resulting claim on the basis of the patient's loss of earnings plus costs. A more severe injury to the cheek of a patient in England was settled for £3,500.

A cut on the lower lip by a rubber abrasive wheel was settled for £600 whilst more severe damage to the lip in another case cost the Society £2,500.

Dental implants

Reflecting the concern expressed in the article by Mr. D. S. Harris on implants within this issue, (see page 47) the Society has been called upon to settle a claim resulting from the unsatisfactory insertion of 3 endosseous blade implants in Australia. The cost to the Society was A$ 20,000.

Failure to diagnose and treat periodontal disease

A patient sued two practitioners who, she alleged, had failed properly to assess and treat her periodontal disease. In particular, the patient maintained that there was a failure to take regular radiographs, a failure carefully to probe and chart the areas around the teeth and gums to check for possible periodontal problems and failure to refer her for specialist treatment. The patient further claimed that she had been misinformed that there was nothing wrong with her gums.

On attending another practitioner she was referred to a specialist periodontologist who reported that there was a considerable degree of bone loss and that a full-mouth gingivoplasty was necessary.

Since the practitioners' notes were very inadequate and there was good evidence of insufficient supervision of the work of the hygienist, together with the incontrovertible evidence of bone loss and active periodontal disease, the case required settlement in the sum of £5,000.

Death under anaesthesia

A dental member set out to provide 7 fillings under general anaesthesia administered by a general medical practitioner colleague.

The anaesthetic was administered through a dental mask. Neither was an endotracheal tube passed nor was an adequate throat pack placed although the anaesthetic was to exceed 15 minutes. The patient was not questioned concerning the last time he had anything to eat or drink. He was rendered unconscious 4 hours after he had taken food and drink.

When the patient collapsed in the chair the methods of resuscitation used were inadequate and inappropriate. The patient died and autopsy showed evidence of regurgitation and inhalation of the stomach contents into the trachea and bronchi.

The provision of dental fillings under general anaesthesia is a relatively major and risky anaesthetic procedure. "There are minor operations, there are no minor general anaesthetics".

Ear and nerve damage at mandibular condylotomy

Condylotomy was performed through a standard pre-auricular approach for a female patient in her early sixties. Unfortunately, after the operation the patient suffered facial palsy, hearing loss, disturbance of facial sensation, sweating and dry eye. The facial nerve had suffered damage at the operation, and an opening had been made into the external auditory meatus with laceration of the tympanic membrane.

The case was settled in the sum of $9,000.

Misplaced local anaesthesia

An extraordinary claim arose in a case where a member provided a local anaesthetic in the lower jaw but extracted the first pre-molar in the upper jaw — £500!

SHORT REPORTS — DENTAL CASES

Hepatitis B and the hygienist

A patient brought a claim against the Society's member, a general dental practitioner, alleging that she became infected with hepatitis B virus as a result of transmission in the course of injection of local anaesthetic given for conservative treatment. The case was pleaded on the basis that the dentist had failed to ensure that the local anaesthetic syringe and needle were properly sterilised. It was found that disposable syringes and needles were used for local anaesthetic on a once-only basis. When a defence to this effect was filed, the patient amended her claim to allege that the dental instruments used in the treatment had been inadequately sterilised. The methods used at the surgery to sterilise instruments were investigated and expert opinion obtained that it was adequate to guard against the dangers of transmission of hepatitis virus. However, we learned that dental instruments used by the dental hygienist were not subject to the same method of sterilisation as those used by the dentist, and the patient had attended the dental hygienist during the course of her conservative treatment.

The member's hygienist used instruments which had been inadequately cleansed before immersing them for 10 minutes in a chemical sterilising solution. The dentist understood that the instruments were subsequently sterilised by dry heat at 160°C for 1 hour. It emerged that the instruments had not received the appropriate dry heat sterilisation before use by the hygienist. On this basis, a settlement of the patient's claim was negotiated but the damages of £2,300 were shared by the defence society of the member's partner on the grounds that the actions of the hygienist were a joint practice responsibility.

Coda

The above cases are merely examples from the Society's files and do not by any means exhaust the kind of matters which come daily to the attention of the Secretariat and upon which we are always pleased to offer advice and assistance to members.

CHAIRSIDE ASSISTANCE

The Society has been asked on many occasions for advice in circumstances where dentists are required to see and treat patients without a dental surgery assistant being present. Such a situation is not rare in the Community Dental Service but can only be deprecated. It flies in the face of advice and warnings often repeated in risk management lectures given by members of the Society's Secretariat.

Chairside assistance has two main benefits. The first is the presence of a witness and chaperone whose testimony on such matters as patient consent, confidentiality, assault or contractual agreement can bear vitally upon the outcome of disputes, General Dental Council hearings or court cases.

The second is that many techniques in dentistry require a four-handed approach. The presence of and active assistance in the treatment of the patient by a properly-trained dental surgery assistant are necessary to the provision of dental treatment to a proper standard. It is usual for both functions to be performed by the same person, though the first function can be discharged by a responsible adult such as a parent, female friend or another health worker.

The General Dental Council's Notice for the Guidance of Dentists states: *"Where intravenous or inhalational sedation techniques are to be employed a suitably experienced practitioner may assume the responsibility of sedating the patient, as well as operating, provided that as a minimum requirement a second appropriate person is present throughout. Such an appropriate person might be a suitably trained dental surgery assistant or dental auxiliary, whose experience and training enables that person to be an efficient member of the dental team and who is capable of monitoring the clinical condition of the patient. Should the occasion arise, he or she must also be capable of assisting the dentist in case of emergency."*

The Society constantly stresses the importance of a trained dental surgery assistant being available to assist the dentist so that patient care can proceed safely and efficiently. It is disappointing to learn from members that they are being asked to disregard this advice. However, hospital and community dentists under their contract of employment, can properly expect Health Authorities to provide them with suitable facilities and support staff in order that they may provide proper treatment for their patients. If a Health Authority fails to provide trained support staff, members must judge whether or not they should continue to provide treatment for some or all of their patients. Certainly such a situation should be brought to the attention of the appropriate administrator or manager in writing. Liability may fall on the Health Authority if there are shortcomings in the provision of patient care. Members may wish to seek the advice of the Society when such problems arise. (See the item 'Shortfalls in Resources' on Page 13 of this report).

The Society's advice is clear. A dentist should avoid being present alone with a patient in the surgery.

MIXING NHS AND PRIVATE DENTISTRY

A straw poll taken at a lecture given by a member of the dental secretariat indicates that some general dental practitioners are inadvertently mixing private and NHS dentistry without realising the possible consequences of such an action. This fact, together with the concern already felt within the Society at the large number of cases in England and Wales referred by members for advice on the subject of mixing, has prompted the writing of an article to clarify the issues. The same principles apply in Scotland and Northern Ireland. There are many pitfalls and although the solutions at first appear very easy, each solution leads to further problems. With current legislation within the NHS it is impossible for a dentist to be totally confident that, if mixing has taken place, he can avoid scrutiny by the GDC, should the matter be brought to their attention.

The main area of concern is the provision of posterior composites. Many dentists are pleased to be able to offer patients an alternative to amalgam and many patients who are aware of the availability of such materials request their use in the restoration of posterior teeth. Whilst the material itself is no more costly than amalgam, it is extremely technique-sensitive and most dentists find that an extensive three-surface composite restoration in a molar or pre-molar takes between three and six times as long to prepare and fill as an equivalent amalgam restoration. This has resulted in many dentists charging between £20-£50 for a composite where the equivalent amalgam on the NHS will attract a fee of between £4.40 — £11.00.

Posterior composites

As posterior composites do not appear in Part I of the Statement of Dental Remuneration, some patients have been advised that such restorations are not available on the NHS. Dentists have then charged a fee commensurate with the time involved to effect a successful restoration. The use of posterior composites is further complicated because many patients during their course of NHS treatment, perhaps two or three visits into that course, will ask if the amalgam restoration anticipated at an appointment can be changed to "a white filling because it shows". The dentist is then encouraged to change both treatment plan and charging method (NHS to private) during an agreed course of NHS treatment.

Unfortunately, Paragraph 6 of Determination I of the Statement of Dental Remuneration defines a composite filling under item 6 b as *"composite resin including any necessary acid etched retention, one filling £8.40"*. Under Determination III, *"Conditions with regards to materials"* Paragraph 4B advises that *"synthetic resin filling material shall not without prior approval of the Board be used for permanent filling of permanent teeth posterior to the second pre-molars or cavities involving the occlusal surfaces of pre-molar teeth"*. Thus, a posterior composite, (a single filling in the tooth, but of no specific size or number of surfaces covered) is available on the NHS subject to prior approval.

Assuming that posterior composites are necessary to secure dental fitness, if they are provided privately during a NHS course of treatment because the dentist is unaware that they are available on the NHS the dentist could be in breach of Paragraph 19 of the GDC Notice for the Guidance of Dentists for *"inducing patients to accept private treatment by falsely suggesting that similar treatment could not be carried out under the NHS"*. Such a breach could be construed by the GDC as serious misconduct and the dentist risks erasure.

A Dental Service Committee investigating allegations of such mixing of private and Health Service treatment may find a dentist in breach of his Terms of Service under Paragraph 2 (b) and 7 (2) (a) (i). This in turn might cause a dentist to appear before the GDC. Ignorance of the NHS Regulations will not be an excuse in these cases.

MIXING NHS AND PRIVATE DENTISTRY

Area of concern

A dentist might be prepared to provide composite fillings only under private contract to a patient already receiving treatment under NHS contract. In such circumstances, it would necessitate either the dentist seeking approval of the FPC to withdraw from the case or the patient cancelling the contract. Consider the patient breaking the contract and asking for the fillings to be provided privately. Even if a form recording consent to private treatment was signed by the patient and that consent was worded to show that the patient had been fully informed as to the availability of the composites on the NHS, in the event of failure of the composite the patient might claim he was coerced into having the treatment privately.

The contract for NHS treatment is between three parties; the dentist, the patient and the NHS. Whether it is open to two of the parties, the dentist and the patient, to vary the terms of the contract without the agreement of the third party must be open to doubt.

Should the posterior composite be necessary to secure dental fitness, the dentist should apply for approval to the Dental Estimates Board. If the Dental Estimates Board refuses approval, the dentist is free to offer the treatment privately but there is the possibility that he could be found in breach of Paragraph 2 (a) of his Terms of Service if he is not employing a proper degree of skill and attention in treatment planning and deciding that composites were indicated. The important criterion is whether the treatment is necessary to secure dental fitness. This is defined in the 1973 NHS GDS Regulations as *"such a reasonable standard of dental efficiency and oral health as is necessary to safeguard general health"*. With current trends and changing attitudes of patients towards dental awareness, there are now circumstances when a posterior composite could be necessary to secure dental fitness and could be accepted by the Dental Estimates Board. For example, if a large, leaky, unsightly composite in the distal aspect of a canine can be justification for crowning a tooth, similarly a large leaking amalgam restoration extending onto the mesio-buccal surface of an upper first pre-molar could indicate the necessity for a posterior composite to secure dental fitness. In brief, the Dental Estimates Board do approve provision of posterior composites in certain circumstances.

Professional misconduct

Consider the permutations offered in Paragraph 19 of the GDC Notice for the Guidance of Dentists — *"Making a statement or declaration, or signing a certificate or other document, or inducing or permitting any other person, such as an employee of the practice or a patient, to sign a certificate or document which the dentist knows, or ought to know, to be untrue, misleading, or otherwise improper, may render him liable to proceedings for misconduct. Included under this heading are false certification and improperly demanding or receiving fees under the NHS Regulations, and inducing a patient to accept private treatment by falsely suggesting that similar treatment could not be carried out under the NHS. The Council considers that it is the responsibility of the dentist to ensure that the patient understands the nature of the contract, that is, whether he has been accepted to receive treatment under the NHS Regulations or privately; and that the dentist has a duty to explain what treatment he proposes to carry out with an indication of the probable cost. A dentist is better placed to refute an allegation that he has misled a patient if the latter has been provided with a written treatment plan and estimate. In general, the Council considers that any act or omission by a dentist in connection with his practice which is calculated to mislead the public may be held to constitute serious professional misconduct"*.

Within the terms of Paragraph 19, there are many combinations which could be considered a breach. A few examples are listed:

- advising the patient that treatment is not possible on the NHS
- advising a patient that treatment is not necessary to secure dental fitness when it may, in fact, be necessary.
- incorrectly informing a patient of the situation.
- completing an FP17 incorrectly with regard to the treatment necessary to secure dental fitness.
- misleading the patient or the Dental Estimates Board as to the treatment necessary to secure dental fitness.
- coercing a patient to sign either an FP17 or a private consent form.
- not fully informing a patient before obtaining consent to private treatment.
- not recording consent to show the patient was informed.

MIXING NHS AND PRIVATE DENTISTRY

Avoidance of risk

These confusions can be avoided by not accepting a patient for NHS treatment until after examination and by providing a full and extensive treatment plan indicating choice of materials, alternatives and whether treatment would be provided privately or on the NHS. The patient should then consent to the treatment and, if appropriate, sign an NHS form. All private treatment should be carried out before the patient signs the NHS form. Treatment of a patient implies that an examination has been performed, a diagnosis made and a treatment plan evaluated. If a private fee is not raised prior to the insertion of a private composite, it is implicit that the fee for the composite includes the examination fee. Acceptances on the NHS would demand a further examination to involve the fee per item treatment plan on the FP17.

Duplication of examinations or private examinations only could be held to be a breach of Paragraph 7 (2) (a) (i) and (ii), and lack of an NHS examination a breach of Paragraph 2 (a) of the GDS Terms of Service.

The NHS form should only carry treatment appropriate to the Regulations and Determinations and on completion of treatment the patient should be dentally fit. This normally implies that the patient needs no further treatment. If it is claimed that additional treatment is necessary on purely aesthetic terms, then it is possible that either one might be in breach of the Regulations by not securing dental fitness in the first place or be accused of treating a patient unethically because a sound tooth, restoration, or even worse, a recently-inserted restoration, require the likely loss of further sound tooth tissue removal purely on the grounds of aesthetics. It is likely that the GDC would consider the ethics of providing such "unnecessary" treatment as professional misconduct.

Even if a patient agrees the principle of private composites first and then acceptance on the NHS for the balance of treatment, he or she might subsequently object to the treatment received, claiming that they thought they were being treated on the NHS. The dentist could once more be in breach of Paragraph 19 of the GDC Notice for the Guidance of Dentists.

Conclusion

The problem of the provision of posterior composites is complicated by the fact that the Health Service charge is less than that for an equivalent two-surface amalgam and it is difficult to establish whether a composite is necessary to secure dental fitness. These matters need urgent adjustment and clarification. It is hoped that the new "dentist's contract" and possibly a future "relativities study" will correct these anomalies. Even if the composite dilemma is corrected, members are reminded that the points raised in this article apply to any mixing of NHS and private treatment.

Currently, members should be extremely careful when providing posterior composites on patients who are normally expecting treatment on the NHS. Examine all patients "privately", produce a detailed treatment plan, explain it to the patient, and obtain signed consent to the composite. Carry out the private work and then open an FP17, being mindful of the possible examination pitfalls, and complete the balance of the work on the NHS.

For many patients it is not possible to carry out treatment planning in this manner as on some occasions it will be necessary to perform some NHS work before a composite can be inserted. For example, the gingival condition may warrant attention, or the tooth may require root-filling. The balance of treatment should be secured under the NHS. In the case of composites, should a decision be made to restore in amalgam with a view to later restoration in composite on a private basis, consideration must be given to the unethical concept of planned obsolescence which might once more attract the attention of the General Dental Council.

The opening paragraph of this article noted that there are no easy solutions. Members are advised not to mix private and NHS treatment and seek early assistance from the Society if a situation should arise where a problem of mixing becomes apparent.

MANAGEMENT OF CHILD PATIENTS

While dental disease levels in children have fallen and we can look forward to a time when minimal treatment will be required for young people, problems still arise in the management of the child patient. Some examples have come to the Society's attention in the past year which have concerned not only old and new clinical practices but reflect increasing expectations of both child and parent to be involved in the making of decisions about their treatment.

Consent to treatment

Typical problems arising about consent for treatment relate to the failure to provide adequate information to the parent about the treatment which is proposed. This is a greater problem when the child attends the surgery unaccompanied and the dentist is unable to explain directly to the parent what is intended. Similarly, problems are arising in the Community Dental Service where the traditional "blanket" consent forms are no longer acceptable. When parents receive a note after school dental inspections, they are not prepared to give unlimited and unspecified consent to treatment by the Community Dental Service. Where there is no direct contact with parents, there is a need to establish a satisfactory way of informing them. This may have to be done in writing with a request to them to sign a written form of consent on which the treatment has been specified. Where large numbers of children are involved in the Community Dental Service a proforma is used by some Health Authorities.

A dentist consulted the Society about a 16-year-old boy, who is entitled to give consent to his own treatment (Family Law Reform Act 1969). However, in this instance the parents raised objections claiming that their child was not yet old enough to comprehend the consequences of the proposed treatment. A dentist must necessarily exercise professional judgement in such situations. It may be helpful to bear in mind that the apparent dispute between parent and child may be a symptom of underlying family tensions. If the practitioner is unable to resolve the conflict then he or she would be well advised to seek a second opinion from a dental consultant. The dentist should explain the rather unusual circumstances surrounding the request for a second opinion.

The practitioner would also be prudent to allow time for young people to consult with their parents about any proposed treatment. A practitioner examined a 16-year-old girl who was complaining of pain from an unerupted wisdom tooth. As the next patient had cancelled, time was available to extract the wisdom tooth which the practitioner proceeded to do after explanation to the patient and with her consent. The surgical removal of the tooth went well in the practitioner's opinion and he was surprised to receive a solicitor's letter alleging that he had assaulted the patient and had carried out extensive treatment without her consent, leading to pain and distress. The Society considered that the member should be defended and the claim was not pursued. Nevertheless, the practitioner was caused considerable worry and with hindsight agreed that it would have been preferable to delay the removal of the offending tooth so that the young patient could have discussed the proposed treatment with her family and had their support when undergoing demanding treatment.

Restraint

The Society continues to receive notification of cases in which a charge of assault is threatened against a practitioner. These are usually accusations of the use of force to carry out dental treatment. The Society counsels members that in the event of a child proving difficult and obdurate, treatment should cease and matters should be discussed with the parent(s). It is not acceptable to achieve treatment through physical restraint. Controlling hysteria by slapping a child is neither an acceptable method of handling the patient nor necessarily an acceptable defence to a charge of assult. The "hand over mouth" technique, while it may be practised in some paedodontic circles in the USA, may not be an acceptable defence to a charge of assault and battery in English law.

However, a dentist must expect that a child will not sit still in the chair as adults can be expected to do. The practitioner is required to exert appropriate restraint if, in the middle of carrying out a procedure, injury could be caused to the soft tissues by unexpected movement of the child. What is or is not appropriate depends on the circumstances of the particular case, but the general guiding principle is one of 'reasonableness' — what would that paragon 'the reasonable man (practitioner)' do in similar circumstances?

The Society has dealt with a number of cases in which trauma has occurred to cheeks and tongue. When this occurs, the practitioner will of course note this on the record and should discuss it with the parents advising them of the circumstances and the prognosis. In the case of extensive lacerations, the child should be referred to a consultant and the Society informed.

From time to time, children will try to seize the instruments the practitioner is using and while it is reasonable for a dentist or a dental surgery assistant to restrain the child, care should be taken not to use excessive force. A member consulted the Society after receiving a solicitor's letter alleging that he had assaulted a patient, a 13-year-old boy, and had carried out treatment using excessive force. This had resulted in the child sustaining a fractured wrist and he was now very frightened of dentists. The member recollected that this young patient had first presented with toothache and had been prescribed antibiotics. A lower molar tooth required extraction and this was to be carried out under local anaesthesia. The boy was anxious and uncooperative but the member persisted with treatment after careful explanation, as facilities for general anaesthesia were available only at the General Hospital some distance away. During the administration of the local anaesthetic, the boy grabbed the syringe and the member 'pushed his hand away'. Treatment was then completed. Solicitors acting on behalf of the patient claimed that the boy's fractured wrist was caused by the member grasping the wrist with excessive force. The Society settled this case out of court for £5,000, inclusive of legal costs, as it was clear that excessive force had been used.

Warnings

The practitioner should also remember to warn and advise parents about the effects of treatment. For instance, it should now be routine practice to advise parents about the danger of chewing lip and cheek before the effects of a local anaesthetic have worn off. A bitten lip is not only painful but its appearance causes great anxiety. Injudicious comments from other health workers suggesting that the dentist has caused an infection by using an unsterile needle or instruments may compound the problem.

Non-accidental injury

Members will be aware of public concern about non-accidental injury to children (child abuse). From time to time damage sustained by the child may affect mouth and teeth. As members of a caring profession, dentists have a responsibility, where they suspect that damage to mouth and teeth may not have been accidental, to take steps to protect the child. Members should refer any such child to a dental consultant with a preceding telephone call to alert the consultant and follow up in another telephone call later to (a) ensure the child did attend, (b) discuss the findings and (c) decide upon further management

If practitioners have serious doubt about whether an injury is non-accidental two courses of action are open to them. If the oral and other injuries are sufficiently severe, they may wish to refer the child to a hospital dental department using a simple and non-specific letter of referral, meanwhile contacting the consultant by telephone to express concern that the injury may have been non-accidental. Hospitals are used to handling serious cases of child abuse and if it is felt that children are in danger they can be admitted for their own safety. Where the practitioner's suspicions are aroused but the child does not appear to be in any immediate danger, it is suggested the practitioner either follows the local guide-lines laid down by the Health Authority and the Local Authority Department of Social Services or, if not aware of these, contact the child's general medical practitioner who can, if he sees fit, initiate action. However, a full record should be kept of both the history and signs which arouse the practitioner's suspicions. Similarly, a record should be kept of any referrals to a general medical practitioner or hospital.

Footnote: For a more detailed treatment of the subject of Consent members are referred to the Society's booklet "Consent to Dental Treatment".

MEMORANDUM ON OVERSEAS MEMBERSHIP

A member practising outside the United Kingdom (excluding the United States of America and Canada) is indemnified, subject to the Memorandum and Articles of Association, against legal expenses incurred in defending or conducting a case on his/her behalf in the protection of his/her professional interests and against costs and damages which may be awarded against him/her (including a settlement out of Court) in any such case.

An overseas member is required to comply with the following rules when seeking the assistance of the Society.

1. Immediately on becoming aware of any claim or likelihood of a claim, a member must notify the Society by air mail (in real urgency by telephone, telex, telegram or facsimile transmission). Members through Schemes of Co-operation should notify the local scheme.
2. When necessary, a local solicitor will be instructed and, in cases of urgency, the member will be invited to contact the solicitor direct so that an interview may be arranged as soon as possible.
3. A member must send to the Society, or its local legal agent, any writ, summons or other process, with which he/she may be served and must give to the Society full particulars as to the matter and circumstances giving rise to the claim.
4. In any case undertaken on the member's behalf, he/she must assist the Society in every way possible, in any action which may be undertaken on his/her behalf whether this be by the resisting of proceedings or by settlement.
5. A member must not negotiate, pay, settle, admit, nor make any offer, or to promise to settle or compromise any claim without the written consent of the Society.

MEMBERS SHOULD NOT INCUR LEGAL EXPENSE WITHOUT THE SOCIETY'S PRIOR APPROVAL. The Society cannot accept responsibility for legal costs incurred by members without prior authority. Before incurring any legal expense members are therefore urged to contact the Society:-

either

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

or

b) Through the appropriate Scheme of Co-operation.

Sympathetic consideration will, however, be given to a request for reimbursement of limited legal costs reasonably and necessarily incurred for the immediate protection of a member's interests in a bona fide medico-legal emergency (e.g. the service of a Writ) pending advice from the Society.

SUBSCRIPTION

Notification of 1989 subscription rates

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

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

Prompt payment of subscription

The Society's Articles of Association provide that any member whose subscription or other liability to the Society is in arrear for more than one month shall cease to be entitled to the benefits of membership from the date when that subscription or other liability fell due (Article 6.3). Further, the Society may by notice terminate the membership of any member whose subscription or other liability is in arrear for more than three months (6.4). Prompt payment of every subscription is recommended, and will help to keep down running costs.

Changes of address

Reminders that a subscription is overdue and the notice that membership has been terminated for non-payment may not be received because of a failure to notify the Society of a change of address. Members are bound by the Articles of Association (7.1) to supply to the Secretary their current residential or professional address. Members without a permanent address should always provide a reliable forwarding address — in the same country as that in which they are practising, if at all possible, to avoid confusion over subscription rates. (Different rates apply in different countries.)

Methods of payment

1. Payment by cheque or credit card (Access Mastercard or Visa only), upon receipt of a renewal notice.

Members other than those who have arranged to pay by Direct Debit (annual or monthly — see below) will each be sent a renewal notice one month before their subscription expires. This form should be completed carefully and returned in good time, either with a cheque to pay the relevant subscription in full or with an Access Mastercard or Visa number written in the boxes provided. Post-dated cheques cannot be accepted. Please note that a valid membership certificate can be issued only when the subscription has been paid in full.

2. Payment by annual Direct Debit.

This method is recommended above all others for its convenience and reliability. Members who wish to pay by annual Direct Debit should write for a Direct Debiting Instruction well before their current subscription expires: arrangements with the bank concerned can take several weeks to set up. Letters giving individual advance notice of the amount to be collected by Direct Debit are despatched about a month before the due date allowing members time to raise queries (and to transfer funds into their current accounts, should that be necessary). Membership certificates are issued in the usual way as proof of payment.

3. Payment by monthly Direct Debit — the Monthly Subscription Scheme. Only available to members in the UK and Eire.

'Monthly' and 'annual' subscribers are two separate and distinct classes of member: they pay at different rates, and their payments fall due at different times. Strictly speaking, 'annual' or lump-sum subscribers ought to renew on the anniversary of the day they joined the BPS (on 4th July each year if they joined on 4th July 1952, for example). Members in the new 'monthly' category undertake instead to make *ten consecutive monthly payments* in months 2-11 of the subscription year — nothing in month 1, nothing in month 12.

Dr F supplies a convenient example. His subscription for 1987 88 expires in October 1988, and he would rather pay for the following year on a 'monthly' basis.

Before the end of October 1988: Dr F completes a monthly Direct Debiting Instruction and a monthly subscriber's renewal notice. He undertakes to make ten monthly payments, one in each of the ten consecutive months November '88 — August '89; and the Society issues a membership certificate showing clearly that the benefits of membership will remain available provided he does so.

20th November 88... 1st monthly payment collected.
20th December 88... 2nd monthly payment collected.
20th January 89... 3rd monthly payment collected.
and so on until 20th August 89... 10th and last monthly payment collected.
mid-September 89 ...
the Society issues a *receipt* for all ten payments, sending it to Dr F along with a payment schedule for the following year 1989/90. He has a month in which to query the payment schedule, and the Society will adjust it in the light of any recent changes in his membership status.
October 89 ...
Dr F's subscription for 1988/89 expires. With Direct Debiting arrangements still in place, the Society is able to issue a certificate for 1989/90 showing that the benefits of membership will remain available provided Dr F pays his next subscription according to plan.
November 1989 — August 1990 ...
Dr F's subscription for 1989/90 is collected — 10 monthly payments.
And so the cycle continues.

For further information about the Society's Monthly Subscription Scheme, please write to the Membership Officer.

Practice in the USA and Canada — overseas membership

Owing to the very high cost of litigation and the level of awards in the USA and Canada, MP membership benefits are not available in either country. No indemnity is provided in respect c legal proceedings in the USA or Canada, nor in regard to any claim arising from such proceedings whether such a claim is made in the USA or in Canada or elsewhere.

Membership of the Society is open to practitioners in other parts of the world (outside the US and Canada) if they possess a qualification registrable with the United Kingdom General Medica Council or General Dental Council and are on the appropriate register of the country in which the practise.

Members who change their country of practice (in Australia, their *State* of practice) must notif the Society promptly. Subscription rates vary from place to place, and the correct subscriptio must be paid to ensure that the full benefits of membership remain available. IN GENERAL MEMBERS ARE ASKED TO PAY FOR A WHOLE YEAR'S MEMBERSHIP AT THE APPLICABLE RAT FOR THE COUNTRY IN WHICH THEY ARE PRACTISING WHEN THEIR SUBSCRIPTION FALLS DUE Subscriptions for less than a year's membership are acceptable only in exceptional circumstance (see below), and proportional arrangements are not at all common (say 6 months at one rate, months at another). The Membership Officer will be pleased to advise in cases of doubt.

Members who intend to practise in countries in the Middle East are advised to contact th Society before finalizing their arrangements, because the assistance which the Society may b able to provide is greatly circumscribed by local law, culture and custom.

CATEGORIES OF MEMBERSHIP

Ship surgeons

A ship surgeon is liable to be sued in overseas courts, including those of the United States of America and Canada, by patients treated on board ship. Members contemplating employment of this nature should contact the Society to ascertain the benefits of membership available to ship surgeons before finalizing 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 (see above).

Special membership categories

A number of special membership categories have been created over the years to serve the needs of particular groups of members. Three of the most important are described below. Information about the rest is available from the Membership Officer — and it is now the Society's policy to print on every renewal notice a list of the different categories that may possibly be of interest.

Non-clinical membership

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. Those 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

Members who have retired completely from all forms of active practice, clinical and non-clinical, may apply for admission to retired life membership of the Society — available free of charge on condition:

1. that the applicant is wholly retired from practice, and does not intend to resume practice at least for the time being;
2. that, if the applicant resumes practice either permanently or temporarily, full- or part-time, he or she will resume ordinary membership at once and pay the appropriate annual subscription.

Retired life members are asked to notify all changes of address in the usual way.

Retired life members may seek the Society's assistance in respect of any matter arising from their 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 has been terminated by notice for failure to pay subscriptions.

Those on maternity or study leave and who are not practising when their subscription falls due may apply for admission to retired life membership, and remain retired life members until they return to work.

Any active practice undertaken whilst a retired life member, however little and whether on a paid or voluntary basis, may limit the indemnity available at Council's discretion. The same is true of attendance at sporting events in any medical capacity. Retired life members should contact the Membership Officer before returning to work so that arrangements can be made for their ordinary membership to resume; and should pay the appropriate subscription promptly.

Subscriptions for less than a whole year's membership

Members who at the time of renewal have reason to think that within three or within six months they will be eligible for admission to retired life membership, should contact the Membership Officer and ask about the special arrangements that may apply. Ordinary membership for less than a whole year is not otherwise available.

CATEGORIES OF MEMBERSHIP

Ship surgeons

A ship surgeon is liable to be sued in overseas courts, including those of the United States of America and Canada, by patients treated on board ship. Members contemplating employment of this nature should contact the Society to ascertain the benefits of membership available to ship surgeons before finalizing 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 (see above).

Special membership categories

A number of special membership categories have been created over the years to serve the needs of particular groups of members. Three of the most important are described below. Information about the rest is available from the Membership Officer — and it is now the Society's policy to print on every renewal notice a list of the different categories that may possibly be of interest.

Non-clinical membership

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. Those 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

Members who have retired completely from all forms of active practice, clinical and non-clinical, may apply for admission to retired life membership of the Society — available free of charge on condition:

1. that the applicant is wholly retired from practice, and does not intend to resume practice at least for the time being;
2. that, if the applicant resumes practice either permanently or temporarily, full- or part-time, he or she will resume ordinary membership at once and pay the appropriate annual subscription.

Retired life members are asked to notify all changes of address in the usual way.

Retired life members may seek the Society's assistance in respect of any matter arising from their 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 has been terminated by notice for failure to pay subscriptions.

Those on maternity or study leave and who are not practising when their subscription falls due may apply for admission to retired life membership, and remain retired life members until they return to work.

Any active practice undertaken whilst a retired life member, however little and whether on a paid or voluntary basis, may limit the indemnity available at Council's discretion. The same is true of attendance at sporting events in any medical capacity. Retired life members should contact the Membership Officer before returning to work so that arrangements can be made for their ordinary membership to resume: and should pay the appropriate subscription promptly.

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SCHEMES OF CO-OPERATION — MEDICAL

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:

AUSTRALIA
Queensland
The Medical Defence Society of Queensland,
P O Box 26
Royal Brisbane Hospital
Herston
Queensland 4029
Tel: (07) 854 1331
Fax: (07) 252 3389

South Australia
Medical Defence Association of South Australia
Newland House
80 Brougham Place
North Adelaide 5006
Tel: (08) 267 4355
Fax: 010 61 8 267 5349

Tasmania
The Medical Protection Society of Tasmania
153 Davey Street
Hobart
Tasmania 7000
Tel: (002) 23 7535
Fax: (002) 232 579

Western Australia
Medical Defence Association of W A Inc
P O Box 263
West Perth 6005
Western Australia
Tel: 4810977
Fax: GOREY MIDDLETON & FORBES
(09) 481 3686

HONG KONG
Hong Kong Medical Association
Duke of Windsor Building
5th Floor, 15 Hennessy Road
Wanchai, Hong Kong
Tel: 5 278 285
Fax: 852 5-8650943
Cable: MEDICASSOC HONG KONG

MALAYSIA
Malaysian Medical Association
4th Floor, M M A House
124 Jalan Pahang
P O Box S-20
Sentul
Kuala Lumpur 02-14
Malaysia
Tel: (03) 2980617

NEW ZEALAND
New Zealand Medical Association
26 The Terrace
P O Box 156
Wellington
Tel: (04) 724 741
Fax: 4-710838

SINGAPORE
Singapore Medical Association
Ground Floor
Housemen's Quarters
College Road
Singapore 0316
Fax: 65 2247827

SOUTH AFRICA
The Medical Association of South Africa
P O Box 20272
Alkantrant 0005
Pretoria
South Africa
Tel: 47-6101
Fax: 012 471815

SCHEMES OF CO-OPERATION — DENTAL

AUSTRALIA
Queensland
Australian Dental Association
Queensland Branch
61 Brookes Street
Bowen Hills
P O Box 455
Fortitude Valley
Brisbane
Queensland 4006
Tel: (07) 2529866
Fax: (07) 252 4488

South Australia
Australian Dental Association
South Australian Branch
P O Box 858
Unley
South Australia 5061
Tel: (08) 2728111

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

Victoria
Australian Dental Association
Victorian Branch
P O Box 434
Toorak 3142
Victoria
Tel: (03) 2408318
Fax: 010 61 2 923 1261

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

Northern Territory
Australian Dental Association
N T Branch
P O Box 4496
Darwin NT5794

HONG KONG
Hong Kong Dental Association
Duke of Windsor Social Service Building
8th Floor, 15 Hennessy Road
Wanchai, Hong Kong
Tel: 5-285327
Fax: 852 5-8650345
Cable: HKDENTA

MALAYSIA
Malaysian Dental Association
No 69-2, 3rd Floor
Jalan 1/70B
Plaza Damansara
Bukit Damansara
50490 Kuala Lumpur
Tel: (03) 2551532 & 2551495

NEW ZEALAND
N Z Dental Insurance Society Ltd
P O Box 28084
Remuera
Auckland 5

SINGAPORE
Singapore Dental Association
Ground Floor
Housemen's Quarters
Singapore General Hospital
College Road
Singapore 0316
Tel: 2202588

MPS PUBLICATIONS

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 (Revised edition, 1988)
- Statutory Notifications — A leaflet for U.K. Practitioners
- General Practice Complaints Procedure
- Considering Partnership — some basic questions and answers
- The Mental Health Act, 1983
- The Psychiatric Emergency; Responsibility for Suicidal Patients
- Damage to Teeth during Administration of General Anaesthesia
- Pitfalls for the Occasional Ophthalmologist
- The Abortion Act — comments and advice
- Medico-Legal Reports and Appearing in Court
- Legal Pitfalls for the Operating Surgeon
- '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 1988)*
- And Now to Practice — Summary of Dental Seminar for final-year students
- And Now to Practice — Checklist of points for students about to qualify
- Hepatitis and dental treatment

Films: 16mm colour and video cassette

Medical

- The Communicators
- The Letter
- For Your Ears Only

Dental

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

Tape Slide programmes

- Pitfalls in Hand Injuries

Audio cassettes

- Pitfalls of Attempted Suicide; Hazards of lithium carbonate therapy

Protection Matters

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

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