were not supported¹³; other studies have failed to confirm this.¹⁰⁻¹²

What of the impressive theoretical arguments for using albumin as the preferred colloid solution? If albumin is effective for binding drugs and toxic substances, is a scavenger of free radicals, and is important for vascular integrity and blood coagulation we would expect it to be better than other agents. As administration of colloid is a substantial component in the management of critically ill patients the long term benefits of albumin should be easily identifiable. Curiously, there is a dearth of studies on this. While many studies have shown the comparative haemodynamic efficacy of albumin and synthetic colloids, few have examined longer term use. One study comparing gelatin and albumin found no difference in outcome, length of stay in an intensive care unit, or requirement for blood products and coagulation factors.¹⁰

Should we use albumin for volume replacement? It is expensive. It is a human product. In critically ill patients its impressive array of theoretical advantages over synthetic agents does not translate into overt clinical benefits. If it is unhelpful in this population then whom is it likely to benefit?

What is the role of albumin solutions? There is no convincing evidence that albumin is better than synthetic alternatives for volume replacement; nor is there clear evidence for maintaining the serum albumin value concentration above a certain level. Currently, the widespread use of albumin has more to do with word association and the treatment of items that are marked on the pathology form

with an asterisk than with scientific medical management. At a time when molecular biology and genetic engineering are the focus of our research we would do well to review critically some of our beliefs about more basic science.

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- 1 Holt M, Ryall M, Campbell A. Albumin inhibits human polymorphonuclear leucocyte luminol dependent chemiluminescence: evidence for oxygen scavenging. *Br J Exp Pathol* 1984;65: 231-41.
- 2 Emerson T, Redens T, Lindsey C. Human serum albumin pretreatment attenuates the lung dysfunction in the endotoxemic sheep ARDS model. *FASEB J* 1988;2:A977.
- 3 Jorgensen K, Stoffersen E. On the inhibitory effect of albumin on platelet aggregation. *Thromb Res* 1980;17:13.
- 4 Jorgensen K, Stoffersen E. Heparin like activity of albumin. *Thromb Res* 1979;16:573.
- 5 Demling R. Effect of plasma and interstitial protein content on tissue edema formation. *Curr Stud Hematol Blood Transfus* 1986;53:36.
- 6 Fleck A, Raines G, Hawker F. Increased vascular permeability; a major cause of hypoalbuminaemia in disease and injury. *Lancet* 1985;i:781-4.
- 7 Grootendorst AF, van Wilgenburg MH, van de Laet PH, Vander Hoven B. Albumin abuse in intensive care medicine. *Intensive Care Med* 1988;14:554-7.
- 8 Vaughan T, Erdmann A, Brigham K, Woolverton W, Weidner W, Staub N. Equilibration of intravascular albumin with lung lymph in unanaesthetized sheep. *Lymphology* 1979;12:217-23.
- 9 Woods MS, Kelley H. Oncotic pressure, albumin and ileus: the effect of albumin replacement on postoperative ileus. *Am Surg* 1993;59:758-63.
- 10 Stockwell M, Soni N, Riley B. Colloid solutions in the critically ill. A randomized comparison of albumin and polygeline. 1. Outcome and duration of stay in the intensive care unit. *Anaesthesia* 1992;47:3-6.
- 11 Kaminski M J, Williams SD. Review of the rapid normalization of serum albumin with modified total parenteral nutrition solutions. *Crit Care Med* 1990;18:327-35.
- 12 Golub R, Sorrento J, Cantu R, Nierman D, Moideen A, Stein H. Efficacy of albumin supplementation in the surgical intensive care unit: a prospective randomized study. *Crit Care Med* 1994;22:613-9.
- 13 Brown RO, Bradley JE, Bekemeyer WB, Luther RW. Effect of albumin supplementation during parenteral nutrition on hospital morbidity. *Crit Care Med* 1988;16:1177-82.

Professional negligence: a duty of candid disclosure?

Doctors should explain in full when care has gone wrong

Lawyers, whether barristers or solicitors, owe their clients a duty to disclose any conflict of interest that has arisen and to inform their clients that they should thereafter go to another lawyer for advice and help. In legal terms, a conflict of interest arises between a lawyer and client when their interests are no longer the same. There are many ways in which this may arise in practice—for example, if a lawyer has conducted a client's case negligently. Lawyers are in breach of their professional code of conduct if they fail to comply with these duties. Understandably none of us like to find ourselves in such a position; but no client should suffer from a lawyer's mistakes or ineptitude. We all, however, make mistakes. No sensible lawyer thinks that it can never happen to him or her.

Why should the same rule not apply to doctors? Why should it not be part of doctors' ethical code to inform their patients if they have been negligent in their care and treatment? Why should doctors not be subject to disciplinary action if they fail to comply with such a duty?

In 1987 the then master of the rolls, Sir John Donaldson, stated, "I personally think that in professional negligence cases, and in particular in medical negligence cases, there is a duty of candour resting on the professional man. . . . It is but one aspect of the general duty of care, arising out of the patient/medical practitioner or hospital authority relationship. . . ."¹ His views were not, however, necessary for the purposes of deciding the case, and thus far no binding decision of the courts has been given that recognises such a duty in medical practitioners. Should not the medical profession itself recognise such a duty and bring it into effect?

It is invariably the experience of those who practise in the field of medical negligence that if a patient's care has gone

wrong then a full and frank explanation will do much to defuse the anger, upset, and resentment that the patient feels and may substantially reduce the risk that the patient will seek redress in court. Obviously, if major injury has been suffered then, however full the explanation, patients are likely to sue to obtain damages to compensate them—for example, for their continuing loss of earnings or for the cost of future care.

A full and candid explanation will go far to ameliorate the problems that have arisen and also to identify a cause so as to prevent recurrence. A recent study found that one of the four main reasons why people sue doctors is "the need for an explanation—to know how the injury happened and why."² Medical care no longer goes unquestioned; nowadays if something goes wrong patients want to know why.

Although many doctors already give an explanation to their patients, the practice is not universal. The relationship between doctor and patient is based on trust, and doctors may well feel that they do not wish to prejudice that trust or demean themselves in front of their patients or colleagues. In our view, however, the mentality of "never admit anything" (as drivers in car accidents are advised) has no place in the professional world. A doctor would probably wish to discuss the matter with a colleague before giving his or her explanation to the patient and occasionally would want to discuss it first with the defence union. But a prompt explanation is vital; delay will be seen as a cover up.

We believe that the relationship between patient and doctor is likely to be enhanced by a willingness to talk to (not down to) the patient, to explain what has gone wrong, and to show a little humility. Leaving this to "good practice" is not enough; that has not worked in the past. Some doctors will argue that

time is too short in the modern NHS to give such an explanation, others will say that they never explain and will not do so now, and others will feel natural inhibition at admitting that they have been negligent. It is therefore vital that a professional duty of candid disclosure is imposed on doctors so that patients are told when doctors have been negligent in their care and treatment and are given a clear, full, and honest explanation.

The knock on effects should be that patients have much greater confidence in doctors and hospitals, that they trust their doctors more, and that many potential actions for medical negligence will be defused before the patient even considers bringing a claim. If the patient, even in the light of a full explanation, nevertheless decides to bring a claim against the doctor the case is likely to be cheaper and less painful for both the doctor and the patient. Furthermore, full

explanation may prevent those claims against doctors that are not justified and that are so time consuming for busy practitioners that they cannot care for the other patients in need of their skills. There seem to us to be advantages on every side.

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1 Naylor v Preston Area Health Authority [1987] 2 All ER 353 at 360.

2 Vincent C, Young M, Phillips A. Why do people sue doctors? A study of patients and relatives taking legal action. *Lancet* 1994;343:1609-13.

Hospital doctor's role in the Health of the Nation

To recommend an apple, a condom, and a snapped cigarette

Last month England's chief medical officer launched an important new initiative aimed directly at hospital doctors, which recognises for the first time their important and wide ranging role in implementing the targets set out in the *Health of the Nation*. For too long hospital doctors have been regarded as fulfilling only a specialist role in service and education, yet hospital consultants often have wide access to patients and their families and friends. Junior hospital doctors also have great opportunities to advise on lifestyle, diet, smoking, and so on—which in the long run could prove more valuable than the drugs that they write up for patients at discharge. The chief medical officer reminds us in his launch message: "Effective health promotion by the medical profession is vital if patients are to benefit fully from the health improvements outlined in *Health of the Nation*."¹

A committee (of which I am a member) has met over the past few months under the chairmanship of Sir Christopher Paine, president of the Royal College of Radiologists, to discuss the best ways of getting the chief medical officer's message across. Early on, a straw poll of hospital colleagues convinced me that many remained in profound ignorance of the *Health of the Nation*'s targets, though most could name the five key areas for health promotion—coronary heart disease and stroke, cancers, mental illness, accidents, and HIV/AIDS and sexual health. As good evidence now exists that relatively minor changes in lifestyle can substantially reduce morbidity and mortality,^{2,3} much of the task of hospital doctors will be to offer practical advice to patients, their families and friends, and other staff at work. For many of us the essentials of the advice may be familiar, though details relating to the size and scope of particular risks to health, potential benefits to the public, and the *Health of the Nation*'s targets may be less familiar. As an oncologist, for instance, I was unaware that the prevalence of obesity, one of the issues highly relevant to the "heart and stroke" targets, almost doubled in England from 1980 to 1992 or that the average salt intake (9 g a day) is 50% more than recommended. Nor did I realise that the main targets for coronary heart disease and stroke include specific aims not only for a reduction in death rates (by 40% in the under 65s and 30% in people aged between 65 and 74 by 2000) but highly specific recommendations on diet, control of blood pressure, alcohol intake, and physical activity. As far as diet is concerned, achieving the nutritional targets should reduce

average cholesterol concentration from 5.8 mmol/l to about 5.4 mmol/l, which in turn should reduce deaths from coronary heart disease by 20%.⁴

The Paine committee's advice has tried to be as practical as possible in both the messages to be given to colleagues and the specific advice for patients. For example, the main messages about lung cancer are that five minutes' advice by doctors is effective in helping people to stop smoking,⁵ that stopping smoking is the single most beneficial change in lifestyle that a smoker can make, that buying 20 cigarettes a day costs around £1000 a year, and so on. Although the obvious advice is to kick the habit, many British doctors may be sceptical or unaware of the established benefits of nicotine replacement treatment for heavily addicted people.⁶ Traditionally immersed in their chosen specialty, hospital doctors may not realise that smoking kills about twice as many people through other diseases as it kills through lung cancer, that 80% of skin cancers are avoidable,⁷ or that in cervical cancer a five yearly smear test with treatment of premalignant conditions reduces the incidence of invasive disease by well over 80%.⁸

The profession has been slow in recognising that hospital doctors have a key role in educating the public, and the chief medical officer's initiative seeks to kick start a new phase of hospital doctors' work. Although the nutritional, demographic, actuarial, and other statistics may be complex, the messages are simple: at the final meeting before the launch we decided that our logo should consist of an apple, a condom, and a snapped cigarette.

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1 Department of Health. *The Health of the Nation: a strategy for health in England*. London: HMSO, 1992.

2 McCoy G, Johnston I, Nelson I, Duffy R. A review of fatal road accidents in Oxfordshire over a 2 year period. *Injury* 1989;20:65-8.

3 Figard RH. Physical fitness and blood pressure. *J Hyperten* 1994;11(suppl 5):547-52.

4 Law M, Wald NJ, Wu T, Hackshaw A, Bailey A. Systematic underestimation of association between serum cholesterol concentration and ischaemic heart disease in observational studies: data from the BUPA study. *BMJ* 1994;308:363-6.

5 Department of Health. *Health of the nation key area handbook: Cancers*. London: HMSO, 1993.

6 Tang JL, Law M, Wald N. How effective is nicotine replacement therapy in helping people stopping smoking? *BMJ* 1994;308:21-6.

7 British Association of Dermatologists. *Consensus statement by the UK skin cancer prevention working party*. London: BAD, 1994.

8 Royal College of Obstetricians and Gynaecologists. *Report of the intercollegiate working party on cervical cytology screening*. London: RCOG, 1987.