GMC may not be entitled to conclude that assault occurred

EDITOR,—The finding by the General Medical Council's professional conduct committee that the anaesthetist in the case discussed by John Mitchell and others was guilty of serious professional misconduct raises serious issues.¹ The merits or otherwise of the finding are one thing; more serious is the fact that the committee seemed to conclude that, in inserting a suppository without specific consent, the doctor assaulted his patient. This is a grave conclusion and arguably one that the committee is not entitled to reach.

Assault is either a criminal offence or a civil wrong. In either case it is a technical legal matter, and a person cannot be said to have assaulted another unless the specific legal requirements of assault are present. If in saying "and thus assaulted her" the committee is suggesting that the criminal offence of assault was committed then one must ask what right it has to reach this conclusion. Was the doctor convicted by a court of the criminal offence of assault? If not, did the committee take on itself the task of determining whether this criminal offence was committed? It is difficult to imagine a doctor who performed a recognised medical procedure in good faith being convicted of assaulting his or her patient, given the definition of broad consent provided in the case of *Chatterton v Gerson*.² In the current case an important question must be whether the committee based its decision on a conclusion of assault, which we suggest it might not have been entitled to do.

Is the determination of criminal guilt or innocence within the powers of the General Medical Council, or is the council, perhaps unintentionally, arrogating to itself a power that the statute does not provide? In the absence of any right to appeal this could possibly be a matter for judicial review, and we suggest that the BMA, as a party with standing, might pursue the point.

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- 1 Mitchell J, Jones MA, Lunn JN. A fundamental problem of consent. *BMJ* 1995;310:43-8. (7 January.)
- 2 *Chatterton v Gerson* [1981] QB 432.

Consent forms are unhelpful

EDITOR,—I suspect that the case of an anaesthetist found guilty by the General Medical Council of an assault through lack of consent to his actions will precipitate the full range of emotions among doctors, from concern to outrage.¹ The council may, however, have done the profession a favour in the troubled area of consent, which continues to languish in the era since the case of *Sidaway v Governors of Bethlehem Royal Hospital*.² In that case it was sufficient to show that other doctors (even a minority) would not have informed a patient of certain matters related to his or her treatment to mount a defence to a charge of having negligently failed to obtain consent. In the present case the General Medical Council was clearly not swayed by the evidence that it was the practice in many hospitals not to inform patients of the use of diclofenac suppositories. This may go some way towards moving the issue of consent away from professional dominance towards what prudent patients ought to be and should expect to be told. The case of *Sidaway* does not sit easily with society's present day expectations, and the profession itself should take the lead in bringing about change—preferably without doctors having to be pilloried before the courts or the General Medical Council.

The other major issue highlighted by this case is

the doubt about the value of signed consent forms. A consent form would not have protected this anaesthetist since he would not have mentioned the use of diclofenac suppositories, and Michael A Jones rightly states that "it will no longer be possible, if it ever was, to rely on a signed consent form."³

In my specialty of oncology I have criticised the introduction of consent forms as being largely unhelpful in improving meaningful consent.³ Perhaps now we will escape from the false security resulting from the *Sidaway* case and attend to the real issues in consent. This means doctors, legal experts, and patients' representatives meeting to discuss what should and should not be told to patients in particular situations together with ways to improve communication and understanding. Had this happened among anaesthetists perhaps the anaesthetist in this particular case would have become aware of the opinions of some colleagues that failure to inform a patient of the intention to insert a suppository was regarded as "unwise, naive, and even unreasonable"; perhaps he would have modified his practice earlier than he did. Everyone would benefit from such a dialogue, and the risk of potential harm from defensive medicine might be reduced. The royal colleges should ensure that the practical issues in consent are discussed and that national guidelines are issued and implemented.

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- 1 Mitchell J, Jones MA, Lunn JN. A fundamental problem of consent. *BMJ* 1995;310:43-8. (7 January.)
- 2 *Sidaway v Governors of Bethlehem Royal Hospital* [1985] 1 AC 871.
- 3 Paterson ICM. Consent to treatment: somebody's moved the goalposts. *Clin Oncol* 1994;6:179-82.

Chaperones are necessary for female patients

EDITOR,—John Mitchell's account of the anaesthetist who was found guilty of serious professional misconduct after, in good faith, administering a diclofenac suppository to an anaesthetised female patient without having informed her of his intention raises several issues.¹ Some of these are dealt with in the two commentaries on the case, but one that receives only passing mention is important. This is the need for a chaperone when an anaesthetist is being given to a female patient by a male doctor.

In my hospital the theatre nurse manager clearly thinks that I am being unnecessarily fussy in insisting on having a female member of staff in the anaesthetic room and claims that few of my colleagues require a chaperone. But, as John N Lunn points out in his commentary, procedures such as the application of electrocardiographic electrodes to the chest of a premedicated patient may place the anaesthetist (and, for that matter, a male assistant) at the same risk as the anaesthetist in the case reported by Mitchell. This may be compounded by the erotic confusion that has been reported with the use of some anaesthetic induction agents.²

I believe that a female member of staff should be present for the whole time a female patient is in the anaesthetic room if otherwise only male staff would be attending to the patient. Whether the reverse applies (for a male patient and female staff) is a matter for debate.

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- 1 Mitchell J, Jones MA, Lunn JN. A fundamental problem of consent. *BMJ* 1995;310:43-8. (7 January.)
- 2 Hunter DN, Thornily A, Whitburn R. Arousal from propofol. *Anaesthesia* 1987;42:1128-9.

GMC prefers "prudent patient" test

EDITOR,—Failure to obtain consent for rectal administration of postoperative analgesia, as described by John Mitchell,¹ is common clinical practice in day case units. I wonder how the professional conduct committee of the General Medical Council would have responded if the patient had complained of pain at the site of an unexpected intramuscular injection of the same active substance: did the route of administration influence the decision making process?

The practitioner was found guilty of serious professional misconduct in that, among other things, "he . . . did not explain to the patient what form the general anaesthetic would take." Many practitioners had thought that the *Bolam* test was to be applied in deciding the amount of information to be given to patients.² The "prudent patient" test seems to be preferred by the General Medical Council. This implies that the patient must be given such information about the procedure, side effects, and complications as might be required by a prudent patient.

Michael A Jones believes that consent to the anaesthetic may not necessarily imply consent to postoperative analgesia.¹ This approach is akin to "salami publication" of scientific results, which is rightly condemned by biomedical editors.

Further clarification by the General Medical Council is urgently required. The defence organisations may wish to modify their recommendations in the light of this advice. Anaesthetists and others who may be called on to give drugs to premedicated, sedated, or unconscious patients would be well advised to retain membership of a defence organisation since crown indemnity is unlikely to be available to defend an action before the General Medical Council that could deprive a practitioner of his or her livelihood.

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- 1 Mitchell J, Jones MA, Lunn JN. A fundamental problem of consent. *BMJ* 1995;310:43-8. (7 January.)
- 2 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.

Fact sheets may be useful

EDITOR,—John Mitchell and others discuss what seems an amazing decision by the General Medical Council's professional conduct committee.¹ A consultant anaesthetist practising as his peers do was found guilty of insufficient explanation, assault on the patient, and serious professional misconduct beyond reasonable doubt; the dentist was also similarly found guilty by the General Dental Council. Although this seems outrageous, we should read the transcripts carefully before reaching any conclusion.

It is implied that these decisions go beyond just the use of diclofenac suppositories and that the decision has "considerable resource implications for the NHS." I agree with the former but disagree with the latter.

I have always taught that any manoeuvre or drug that may reasonably be expected to affect the postoperative period should be discussed with the patient preoperatively. This would include intravenous and intra-arterial cannulation (bruising and pain); endotracheal intubation (sore throat); postoperative pain relief (numbness, discomfort); nausea and vomiting (avoidance); postoperative oxygen (waking up with a mask); and intravenous fluids (the drip) and gastric tubes (discomfort). This has seemed common sense, and I cannot recall any frightened patients.

In this particular case the special feature was the use of a suppository; the anaesthetist and other anaesthetic experts argued that objection to this was unknown or rare even if the patient was told only afterwards. Maybe. But this was not a rectal insertion but an accidental vaginal placement. This