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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- 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 anaesthetic 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

was called a "trivial if easily explicable error," but it calls into question the competence of the operator. If not, we should have to say to female patients not only "during anaesthesia you will be given a suppository which will help numb the pain afterwards" but also that there is a possibility of accidental placement in the vagina with resulting signs. Fewer might then accede.

There are other areas in which explanation may be insufficient or misunderstood. The Welsh Pain Society (of which I am president) is developing fact sheets (widely circulated and agreed) to be given to the patient before a procedure is undertaken, to supplement the oral explanation. These might be of value in situations envisaged in the articles and, indeed, in other situations.

I believe that it is probably true that "when the music stopped the serious professional misconduct spotlight was on him." Nevertheless, good may flow. It would surely have been better, however, to have achieved progress by intraprofessional appraisal at an earlier stage (and by applying common sense).

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1 Mitchell J, Jones MA, Lunn JN. A fundamental problem of consent. *BMJ* 1995;310:43-8. (7 January.)

Rectogenital region is associated with strong cultural and sexual aesthetic beliefs

EDITOR,—Like many anaesthetists, I was alarmed by the finding by the professional conduct committee of the General Medical Council discussed by John Mitchell and others.¹ It is important, however, to recognise that in our society there are strong cultural and sexual aesthetic beliefs regarding intimacy of the rectogenital region, which is thus often referred to as our "private parts." There is evidence that patients show reluctance to accept simple medical procedures involving the rectum,^{2,3} so suppositories should not be equated with other standard forms of pain relief but require specific discussion and informed consent. In a study of 100 day surgical patients given an anonymous questionnaire I found that 98 considered this to be essential. With knowledge that rectal diclofenac was not the only analgesia available, 54 patients declined to have a suppository during their anaesthesia and 69 preferred to take diclofenac orally preoperatively.

I agree with Mitchell that the respondent was unlucky, in that before this case there had been no guidance on obtaining consent for suppositories. Now guidance exists, and anaesthetists must do more than select the best form of postoperative analgesia for each patient: they must discuss what they propose. Many anaesthetists who perform regional anaesthesia already do this.

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1 Mitchell J, Jones MA, Lunn JN. A fundamental problem of consent. *BMJ* 1995;310:43-8. (7 January.)

2 Kai J. Parents' perceptions of taking babies' rectal temperature. *BMJ* 1993;307:660-2.

3 Ng DPK, Mayberry JF, McIntyre AS, Long RG. The practice of rectal examination. *Postgrad Med J* 1991;67:904-6.

Patients' views have been surveyed

EDITOR,—We are concerned that the anaesthetist who inserted a diclofenac suppository into a patient under general anaesthesia without her prior consent was found guilty of serious professional misconduct.¹ Non-steroidal anti-inflammatory drugs are particularly effective in relieving pain after dental extractions.² Suppositories are widely used by anaesthetists for postoperative analgesia.

They have several advantages over injectable forms, having a longer duration of action, cost benefits, and a lack of side effects related to injection itself. This is particularly relevant to the intramuscular injection of diclofenac.³ While specific verbal consent is usually obtained in our hospital, this is not universal.

Evidence from expert witnesses in court pointed out that objection to the use of suppositories is, in their experience, extremely rare.¹ It was also noted that, before this case, no source had ever given guidance on obtaining consent for the use of a suppository, and there was debate over the relative degree of personal invasion between a suppository and an intramuscular injection into the buttock.

In view of this, we asked our patients their opinions on the acceptability of suppositories for postoperative analgesia. We devised a simple questionnaire and visited 112 consecutive patients preoperatively, selected from different specialties, over two weeks; none had received premedication. Seventy eight of the patients were female. Although 96 patients had no objections to a suppository being inserted while they were under general anaesthesia, 63 said that they would want to know preoperatively that this would be done. One hundred and eleven patients had no objections to the use of an intramuscular injection, but 40 said that they would still like to know preoperatively.

This study shows that the use of analgesic suppositories is well accepted by our patients. Suppositories are, however, less acceptable than an intramuscular injection, and many of our patients said that they would like prior discussion before the insertion of a suppository. There is a large difference between having a suppository inserted in an operating theatre and while fully dressed in a dentist's chair. Our hope is that this case will not undermine the use of a simple, well established, and effective technique providing postoperative analgesia.

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1 Mitchell J, Jones MA, Lunn JN. A fundamental problem of consent. *BMJ* 1995;310:43-6. (7 January.)

2 Walton GM, Rood JP, Snowden AT, Rickwood D. Ketorolac and diclofenac for postoperative pain relief following oral surgery. *Br J Oral Maxillofac Surg* 1993;31:158-60.

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Information on anaesthesia for caesarean section is tailored to the woman

EDITOR,—We and our colleagues view the case reported by John Mitchell with grave concern.¹ Informed consent is particularly important in mothers awaiting caesarean section as there may be a choice between regional and general anaesthesia and mothers are usually fit. We recently surveyed the information about risk offered by 523 members of the Obstetric Anaesthetists' Association before anaesthesia for elective caesarean section.² A fictitious case history with a list of sample statements was supplied. Broad agreement on what information should be provided existed, with a consensus value of ≥ 0.60 in 15 of 20 statements. Nevertheless, 13 statements were considered to be "not worth mentioning" or "definitely not to be mentioned unless specifically asked" by more than a tenth of those surveyed.

The overwhelming impression from comments received was that doctors in Britain and Ireland tailor information on the risks of anaesthesia for caesarean section to what the individual mother needs and wants to know. We believe that this is good medical practice that accords with optimal

care of the patient and that it should not be regarded as paternalistic. Nor can it ever be considered good practice to deter a patient, by fear, from having an operation that may be life saving for her or her baby. Unfortunately, on the basis of the General Medical Council's recent judgment,¹ many anaesthetists of good standing seem to be potentially guilty of serious professional misconduct for failing to disclose full information on the risks and forms of anaesthesia that they provide. Urgent reconsideration of this ill informed judgment by the General Medical Council is required.

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1 Mitchell J, Jones MA, Lunn JN. A fundamental problem of consent. *BMJ* 1994;310:43-8. (7 January.)

2 Lanigan C, Reynolds F. Risk information supplied by obstetric anaesthetists in Britain and Ireland to mothers awaiting elective caesarean section. *International Journal of Obstetric Anaesthesia* 1995;4:7-13.

American Medical Association condemns acts of terrorism against health care workers

EDITOR,—I am astonished that the anonymous author of the personal view entitled "Ironies in the abortion war" believes that the American Medical Association has been silent on an issue that threatens the lives of doctors.¹ The association has fought against any type of terrorist attack directed at health care workers for years. At a press conference on 19 January held in response to the killings in Brookline, Massachusetts, Nancy Dickey, the vice chairperson of the association, strongly condemned the wave of violence directed at doctors and health care workers.

In 1993 the American Medical Association appealed to Congress with a request for it to enact the association's Healthcare Provider Protection Act. The plan would dedicate resources to investigate, track, and work to prevent violence in all places where care is provided; initiate congressional hearings on violence against health care workers at clinics, hospitals, laboratories, pharmaceutical companies, and medical schools; and establish "safe zones" to surround hospitals, research laboratories, academic health centres, and other health facilities.

In 1994 the association joined the American College of Obstetricians and Gynecologists in filing an *amicus* brief in the case of the National Organization of Women v Scheidler. This case supported the argument that the United States Racketeer Influenced and Corrupt Organizations Act can be applied in cases in which a conspiracy exists to perform illegal acts. Before this case's successful appeal to the Supreme Court, the act's laws were held to apply only to cases involving economically motivated activities.

In March 1993, after David Gunn, a doctor, was murdered by a pro-life activist, the American Medical Association asked for an immediate investigation by the Justice Department into groups and individuals known to target doctors. At that time it also called for congressional hearings on violence against health care workers by introducing the Healthcare Provider Protection Act.

Abortion is an extremely divisive issue throughout the United States. The American Medical Association's policy on abortion is that it is a matter for members to decide individually. The action that the association has taken and will continue to take is to appeal to the government to put in place