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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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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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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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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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