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.)

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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.)

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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.)

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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

adequate measures to ensure the safety of those who perform abortions or work in facilities where the procedure is performed. Doctors and other health care workers who dedicate their lives to meeting the health care needs of Americans should be ensured the right to work in a safe environment. Violence against health care workers is unacceptable. The American Medical Association has long condemned acts of terrorism against health care workers and will continue to do so.

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1 Ironies in the abortion war. *BMJ* 1995;310:267. (28 January.)

Suing for unpaid overtime payments

EDITOR,—In response to the news headline stating that three junior doctors are suing Raigmore Hospital Trust for unpaid overtime payments¹ I would like to point out that doctors at the Luton and Dunstable Hospital NHS Trust have recently been successful in their claim for increased overtime payments. Juniors demanded that each additional duty hour worked since they started work at the trust should be paid at class 2 instead of class 3 rates. After negotiation the claim was met in full by the trust, which had agreed to abide by the BMA's guidelines for working conditions. Each junior received about £1000 extra pay per six months worked.

Luton and Dunstable NHS Trust has probably set a precedent in this matter, and juniors all over Britain can probably pursue similar retrospective claims for money they are entitled to.

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1 British junior doctors sue for unpaid overtime. *BMJ* 1995;310:348. (11 February.)

Electoral reform of GMSC

EDITOR,—As a member of the General Medical Services Committee of many years' standing who may have to answer to an electorate of ordinary general practitioners, J David Watts has one view of the need for changes in the method of election to the committee.¹ I, as one of those ordinary doctors, have another view.² It is perhaps understandable that they differ considerably. I am grateful to Watts, however, for telling us why Leicestershire's motion at the BMA's annual representative meeting last year was deliberately placed low on the order paper.

What Watts seems not to understand is that the current, somewhat archaic system, unchanged in "its constitution and procedures" in any major way for over 80 years,^{3,4} has finally given way under the pressures of the late 20th century. A committee that represents doctors and directly negotiates with the government on behalf of doctors should be directly answerable to those doctors for its performance. I find it intriguing and revealing that Watts calls my argument in favour of democracy "spurious."

Watts's argument that the local medical committees raise the quota for the defence fund is weakened by the fact that they raise it from general practitioners and that it is the general practitioners who are expressing their dissatisfaction with the present system by encouraging me in my efforts to reform the voting procedures of the GMSC. These doctors feel remote and unable to influence events on a national scale. Direct elections would give

them that influence, would keep GMSC members' eyes more closely on the ball, and would allow a greater range of candidates for seats on the committee.

Under my proposed procedure, local medical committees would remain untouched and would still be able to exert an influence on the GMSC. Members of local medical committees would be able to stand, with other general practitioners, for election from the larger GMSC constituencies. The difference is that all general practitioners would be able to express their vote for them. Is this suggestion "spurious democracy"? I maintain that it is far better that the GMSC carries out the "collective will" of all general practitioners rather than just that of local medical committees.

For the GMSC to resist the first step on this road to democracy—a referendum of all general practitioners carried out by the Electoral Reform Society—is to show either a Luddite mentality or electoral cowardice. In the meantime, general practitioners' morale remains low, recruitment is minimal, and retirements are increasing, and the government remains supreme. The GMSC cannot absolve itself from some responsibility for this.

Finally, it is perhaps as well for the future of general practice that neither Watts nor the GMSC can influence any requisition for an extraordinary general meeting of the BMA. A referendum would be preferable, but, one way or the other, ordinary general practitioners will speak.

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- 2 Roberts D. Reform of GMSC needed. *BMJ* 1994;309:1585. (10 December.)
- 3 GMSC. *GMSC 75 1913-1988. The General Medical Services Committee and local medical committees*. London: GMSC, 1988:16.
- 4 Ellis N. *GMSC and LMCs*. London: GMSC, 1985:2.

Junior doctors' hours

Position of the "English clause" is uncertain

EDITOR,—During the negotiations that led to the "heads of agreement" on junior doctors' hours in 1991 I gained general agreement from those concerned—namely, the junior doctors, the Joint Consultants Committee, the medical royal colleges, and the Department of Health—for what at that time became known as the "English clause." This was contained in paragraph 6 of the guidance from the Conference of Medical Royal Colleges on the training implications of the heads of agreement.¹ It read:

2. The arrangements for those in General Professional Training (GPT) are different from those in Higher Specialist Training (HST). In certain situations and under defined circumstances higher specialist trainees should continue to be available for duties in excess of 72 hours maximum average per week (see RCS guidelines).

The Royal College of Surgeons' guidelines referred to (paragraph 11) were as follows:

At a meeting of the Technical Group on Junior Doctors' Hours on 16 January 1991 the following statement was agreed, which has particular relevance to surgery.

"In certain situations higher specialist trainees should continue to be available for duties in excess of a 72 hour maximum average per week where it would be of benefit to their training and where they wish to do so, providing the proper supporting staff structure exists and providing the duties were not harmful either to the trainees or to patients. If management has concerns about such an agreement, they should consult the relevant Royal College."

The main reason for introducing this clause, which to my knowledge has never been rescinded,

was the widely held professional view that the quality of training among higher surgical trainees (registrars and senior registrars) depended on adequate exposure to emergencies and that this would be unlikely if their contracted hours were reduced to 72 a week. In addition, there was concern over the practicality of organising 1 in 5 rotas in surgical units in smaller hospitals, particularly as partial shift systems were not deemed appropriate for higher trainees where continuity of care of patients is more demanding and important.

NHS trusts and health authorities have been urged by the minister for health, Mr Gerald Malone, to ensure that no doctor should be contracted to work more than 72 hours on an on call rota in hard pressed posts or to work for more than 56 hours a week; changes in contracts must genuinely reflect reductions in rostered hours and in the intensity of hours of work. Thus it seems that, unless higher surgical trainees can be classified as being in posts that are not hard pressed, they will not be able to opt for continuing to be contracted for an average 83 hours a week (equivalent to a 1 in 4 rota) and the spirit and intention of the English clause will be effectively thwarted.

An unambiguous statement from the NHS Executive on the current position of the English clause is indicated and would, I know, be appreciated by employing authorities, postgraduate deans, consultants, and higher trainees.

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1 NHS Management Executive. *Hours of work of doctors in training: guidance from the medical royal colleges and their faculties in the UK*. Leeds: NHSME, 1991.

NHS Executive's reply

EDITOR,—I can confirm that the English clause is very much part of the new deal. I wrote to chief executives and general managers of trusts and authorities in February last year with a plan of action for reducing hours. My letter specifically restated the criteria for those wishing to adopt the English clause. Since then I have reminded our task forces of those criteria and, indeed, we began to monitor the take up of the clause during the reporting round last September. I later wrote to the chairpeople of task forces to begin action on the monitoring exercise in February this year and emphasised the need to ensure that the clause was well understood. This was the first occasion on which its effect could be gauged fully.

Ministers tend, when making statements about the new deal, to dwell on the broader themes. But their letters are followed up by officials with detailed discussions of the implementation arrangements, who have not neglected the English clause.

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National survey of hospital patients

Has a management dominated agenda

EDITOR,—We ask patients about their satisfaction with health services in order to achieve greater responsiveness to their needs and thereby improve standards of care. Stephen Bruster and colleagues seem to have taken a limited view of the value of seeking patients' views.¹ Their focus on standards set out in the patient's charter and national charter inevitably leads to a management dominated agenda in the formulation of the questions. The investigators provide no evidence that standards