Trends in use of minocycline in United Kingdom, 1992-7

always the largest). Use in subsequent quarters fell further to 62% of the level before the paper was published. This lower level has now been maintained for 15 months. Since the quarter to June 1996 the use of oxytetracycline has increased slightly. This seems partially to replace the reduction in prescriptions of minocycline. The average length of treatment per prescription for minocycline remained at nearly 26 days.

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- 1 Gough A, Chapman S, Wagstaff K, Emery P, Elias E. Minocycline induced autoimmune hepatitis and systemic lupus erythematosus-like syndrome. *BMJ* 1996;312:169-72.
- 2 Ferner RE, Moss C. Minocycline for acne. *BMJ* 1996;312:138.

Experience of clinical risk management in obstetrics in Oxford

EDITOR—We agree with Charles Vincent that clinical risk management should be integrated with other quality assurance programmes and that its aim should be more ambitious than simply avoiding litigation.¹ Indeed, evidence that clinical risk management can reduce litigation is limited,² so continued justification for the approach may depend on its ability to improve patient safety.

We introduced a clinical risk management programme in obstetrics in Oxford in September 1994. The cornerstone of the programme was an early warning system for adverse events. Our definition of an adverse event was any unexpected event or outcome of pregnancy that has (or might have) a significant short or long term detrimental effect on either mother or infant. All clinical staff were encouraged to report such events to a perinatal risk coordinator, who was a

midwife. In addition, the perinatal risk coordinator screened the birth registers of delivery suites for possible adverse events.

Over one year 423 adverse events were identified, which is the equivalent of one for every 15 deliveries. Fourteen of the events were assessed as carrying some risk of litigation. In these cases, written statements were taken if appropriate from relevant clinical staff and the trust's solicitors were contacted at the discretion of the trust's legal department. Staff were encouraged to discuss what had happened with the family. A multidisciplinary clinical risk management group met every fortnight to review contemporary adverse events and make recommendations for clinical practice and service development. Between September 1994 and December 1996 six claims were made against the unit that related to obstetric care over these 28 months. Only three of these claims had been identified prospectively by the early warning system. However, the average time lag from incident to claim is five years, so further claims are likely to arise.³

Our initial experience is that an adverse event detection system is neither sensitive nor specific for possible medical negligence claims. The Harvard medical practice study reached similar conclusions.⁴ Thus, an early warning system for adverse events is likely to have only a limited impact on the direct costs of medical negligence litigation relating to such events since it will identify only some of those that will lead to claims. Clinical risk management may have only a limited impact on medical negligence litigation, but it might have potential in improving patient safety.¹ Formal evaluations of clinical risk management in this role should be performed.

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- 1 Vincent C. Risk, safety, and the dark side of quality. *BMJ* 1997;314:1775-6. (21 June.)
- 2 Mant J, Gatherer A. Managing clinical risk. *BMJ* 1994;309:1522-3.
- 3 Capstick JB, Edwards PJ. Trends in obstetric malpractice claims. *Lancet* 1990;336:931-2.
- 4 Localio AR, Lawthers AG, Brennan TA, Laird NM, Hebert LE, Petersen LM, et al. Relation between malpractice claims and adverse events due to negligence. Results of the Harvard medical practice study III. *N Engl J Med* 1991;325:245-51.

Compensation for victims of medical accidents

One particular case recently took five years to be settled

EDITOR—I am outraged that Harris thinks that victims of medical accidents should wait for their compensation after it has been agreed by their lawyers or decided by a court.¹ Most victims have already waited five to seven

years for the case either to come to court or be settled. It does not seem to have occurred to Harris that plaintiffs have already done more than their share of waiting.

I am one such plaintiff. In April 1992 I went into hospital for an elective endometrial resection. I awoke to find that I had had an "elective" (non-emergency) hysterectomy for benign disease and that my still-ovulating ovaries had been "prophylactically" removed to prevent the possibility of ovarian cancer. This was not something made necessary as a result of an accident or mishap but was a decision by the surgeon. I had no say in it. I was, and still am, distraught.

After a decision by the Crown Prosecution Service not to bring charges—a decision which, I might add, had a lot to do with witnesses being unwilling to "remember" my expressed aversion to hysterectomy or recall what had taken place in the operating theatre—I brought an action for negligence, and battery or trespass to the person, against the surgeon and the health authority. It took over five years for the case to be settled out of court, even though the defendants knew that I was dying of lymphoma. My career as a medical journalist suffered. I lived in straitened circumstances on borrowed money while the lawyers slugged it out in a desultory fashion.

Were I the defendants I hope I would have had the decency to admit having been at fault and pay up. This would have had the additional advantage of saving huge legal fees, unofficially estimated at £100 000, which were paid jointly by the Medical Defence Union and the NHS. As it is, if the NHS wants to save money it could stop doing expensive and unnecessary operations on people who don't want them, and stop paying expensive law firms huge sums of money to defend the indefensible.

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- 1 Harris J. The injustice of compensation for victims of medical accidents. *BMJ* 1997;314:1821-3. (21 June.)

Victims do not always take precedence

EDITOR—Harris correctly points out that it is not obvious why victims of medical accidents should always have first call on scarce resources made available for health care.¹ Certainly a case can be made in favour of integrating the consideration of victims into an overall assessment of priorities for the commitment of funds, in total and at the margin.

It is unlikely, however, that victims in general do always take precedence, although the courts or NHS organisations themselves may decide that some of them do sometimes; court awards are only a fraction of total NHS expenditure on negligence claims. It is also not obvious that any part of the NHS should always decide on the relative priorities, especially if an NHS defence against a claim of negligence has been unsuccessful in the courts.

The NHS Executive asked that providers take all possible steps to reduce claims for