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SUPPLEMENT

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Correspondence

Correspondents are asked to be brief.

Wrong Operations

SIR,—The Medical Defence Union continues to be perturbed by the number of wrong operations that are reported to it. In 1969 the Union dealt with 25 such cases and during the first 7 months of this year it has received reports of no fewer than 17 of these avoidable mishaps.

In 1960 the Union appointed a committee to examine the problem and to report on the safeguards that ought to be taken to minimize the possibility of a surgeon performing a wrong operation. The co-operation of the Royal College of Nursing was enlisted, and in 1961 a joint memorandum on the subject was prepared. The memorandum was published in full in the *B.M.J.*[1], the *Medico-Legal Journal*, and the *Nursing Times*. The memorandum was revised in 1964 and in 1969, and approximately 20,000 copies have been distributed to hospital authorities and other bodies. The Union's film "Make no Mistake," produced in 1964, illustrates the steps that ought to be taken to lessen the possibility of a surgeon performing the wrong operation. The film has been shown extensively throughout the country.

In its letter dated 5 June 1967 on surgical accidents addressed to the secretaries of boards of governors and hospital management committees the Ministry of Health suggested that hospital authorities should review their procedures in the light of the recommendations outlined in the memorandum. Despite the steps that the Union has taken to reduce these avoidable errors it is to be deplored that there is no evidence to indicate that these mistakes are decreasing in number.

In the memorandum it is suggested that a mark should be made with an indelible skin pencil on or near the operation site before the patient is taken to the theatre. It would seem that this recommendation is only rarely implemented. The Union is confident that if this simple safeguard were always to be adopted the number of these regrettable cases would decrease markedly.

It is hardly necessary to point out that any claim based upon the performance of a wrong operation cannot be resisted and must therefore be met. In one such case the patient was paid £8,750 by way of damages.—I am, etc.,

PHILLIP H. ADDISON,
Secretary, Medical Defence Union.
London W.C.1.

REFERENCE
1 *British Medical Journal*, 1961, **2**, 1157.

G.P.s in the Hospital

SIR,—In your article "Has the G.P. a Place in the Hospital?" (8 August, p. 335) "Dr. Phys." worries that "the whole question of whether a patient sees a consultant will lie at the discretion of the G.P.," and makes the point that the G.P. may be unaware of mistakes he is making. This must apply alike to inpatients and outpatients.

"Dr. Phys." implies that the G.P. is not even to be trusted to do his sorting for him. (One might suppose that he would prefer to go out and do it for himself.) Is this a widely held attitude? Surely it is better to let the G.P., rather than a feldsher, or even the patient himself, do it? But given that "Phys." is lucky enough to have "Apoth." to do his sorting for him, he is obviously right in wanting "Apoth." to be as highly trained as possible (and probably three jobs are not enough), but wrong in not wanting to let him treat, as well as sort and diagnose, those cases which fall within his competence, and stupid not to realize that he may be doing serious damage to "Apoth's." self-respect.

I am sure most G.P.s would agree with "Phys." that melæna and intensive coronary care were well outside their scope, but it should perhaps be remembered that although the Oxford R.H.B. Survey showed 70% of G.P.s did not wish to have "total clinical control of patients in acute beds" (probably imagining melæna and cardiac massage etc.), it also showed that 56% of doctors under 50 wished for beds to care for those who require admission on social grounds; and that in the Wessex survey (*Supplement*, 26 December 1964, p. 231) 80% of all doctors (90% of doctors aged 25-34) thought maternity and general beds should be available to family doctors. Stephen[1] found a similar proportion of medical students wanting beds.

"Admin." held that social admissions should not go to hospital. This is a semantic point. It is sensible to collect them together in one place reasonably near their homes (if their relatives cannot nurse them, they probably can't visit far either), and put them in the care of trained and semi-trained nurses. Some will need *x*-rays and physiotherapy; and while you are about it "for administrative convenience," why not put them in the same building as consulting-rooms and outpatients etc.? Some might call such a place a hospital, but perhaps "Admin." prefers "community care centre," and if that is the general feeling, I for one will not quarrel.

In my submission the state of medical manpower in Britain (not to be considered in isolation from the rest of the world) is not at present, and will not in the foreseeable future, be such as to allow the authorities to discourage those doctors able and willing to treat their patients in hospital from so doing.—I am, etc.,

MICHAEL TUCK,
Secretary,
Association of General Practitioner Hospitals.
Bishopsteignton,
Devon.

REFERENCE
1 Stephen, J., *Journal of the Royal College of General Practitioners*, 1968, **16**, 248.

SIR,—In the article "Has the G.P. a Place in the Hospital?" (8 August, p. 335) the following sentence appears: "The Oxford Regional Hospital Board found that 70% of general practitioners did not want hospital facilities." It is particularly unfortunate that this part of the report continues to be quoted so often, for it showed nothing of the sort. The report[1] was based on a postal survey of general practitioners and the question on which the above statement is based required the general practitioner to indicate whether he was interested in "total clinical control of patients in acute beds." The question itself was obscure, and it was sandwiched between other questions (questions 2, 3c, and 3d) which referred to gen-