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CORRESPONDENCE

Correspondents are asked to be brief

Negative Response

SIR,—Reference has been made (*Supplement*, 5 August, p. 126) to the use of the so-called "negative response" system, whereby a general practitioner is informed by letter that certain action is proposed for one of his patients unless within a stated time he indicates his disapproval of the proposal. This system is employed, with the intention of relieving the recipient general practitioner of an extra burden, in several contexts—by the Family Planning Association, for example, and by industrial and school medical officers.

Doctors recognize that they are under an obligation to communicate with colleagues in the interest of any patient for whom they share a mutual responsibility. The three professional defence organizations feel it desirable to remind the profession of the fact that over and above this obligation a practitioner on receipt of a communication of the negative-response type is placed under a positive duty to take note of the inquiry and to act upon it if, as a consequence, it becomes apparent that a reply is called for.

A general practitioner, for instance, on receipt of an inquiry along these lines from an F.P.A. clinic doctor is required as a matter of law to refer to the patient's records and to apply his mind to the question before deciding that no response on his part is necessary. A failure to act in such a manner on receipt of a negative-response inquiry could, in the event of the patient suffering any injury as a result, render the practitioner liable in damages.—We are, etc.,

PHILIP H. ADDISON
Secretary, Medical Defence Union

H. A. CONSTABLE
Secretary, Medical Protection Society

JAMES PATTERSON
Joint Secretary, Medical and Dental Defence Union of Scotland

Continuous B.P. and E.C.G. Recording

SIR,—Dr. W. A. Littler and his colleagues (8 July, p. 76) have described an elegant technique for beat-to-beat analysis of blood pressure and E.C.G. over periods of up to 24 hours in patients with hypertension and angina pectoris. The technique involves catheterization of the brachial artery, though the catheter used is of smaller dimensions than that used for routine cardiac investigations. The catheter does, however, lie within the artery for a much greater length of time. The authors state that the procedure is safe, but no evidence is presented to show the incidence of complications in their paper or in one other from the same laboratory quoted in their bibliography. Their experience covers 47 patients, 22 of them subjects to similar experiments more than three years ago.

Any account of a new "invasive" technique should surely be expected to include evidence that steps had been taken to observe and record complications that might reasonably be expected, and this stricture applies especially to techniques which are primarily of research interest and which may be performed on normal subjects.

With respect to the present studies it would be of importance both to other investigators in the field and to the wider audience reached by the *B.M.J.* to know what steps had been taken to observe the incidence in the 47 patients up to the present time of: (1) haematoma formation during catheter insertion or following failed insertion; (2) embolization to the hand from the catheter site during and after catheterization; (3) changes in brachial artery flow—both short-term and long-term; (4) thrombus formation at the catheter site; (5) functional changes resulting from injury to the artery, such as claudication on forearm exercise; (6) differences in the frequency of complications between normal, hypertensive, and angina subjects.—I am, etc.,

DAVID J. WARREN

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SIR,—There has been recent quite justifiable concern about the incidence of brachial artery thrombosis following arterial catheterization. As Dr. D. J. Warren infers, most complications of arterial cannulation follow the use of large catheters (outer diameter about 3 mm) used for diagnostic cardiac investigation. It is, however, important to distinguish between this procedure and the very much smaller cannulae widely used in intensive care units and some coronary care units, where they may be left in situ for several days. In this hospital similar cannulae have been used in patients suffering from tetanus who require long periods of blood pressure monitoring during autonomic crises.[1] These small cannulae (outer diameter about 1 mm) have been left in situ without complications for up to 21 days. In addition in our department we have carried out well over 100 shorter cannulations of about three hours duration by the same technique[2] with only occasional minor