BRITISH MEDICAL JOURNAL

THE BRITISH MEDICAL ASSOCIATION MDCCC XXXII

SATURDAY 3 OCTOBER 1970

LEADING ARTICLES

PAPERS AND ORIGINALS

PRELIMINARY COMMUNICATIONS

MEDICAL MEMORANDA

MIDDLE ARTICLES

BOOK REVIEWS

NEWS AND NOTES

CURRENT PRACTICE

CORRESPONDENCE

OBITUARY NOTICES

SUPPLEMENT

No. 5726 British Medical Journal, 1970, Volume 4, 1-62 Weekly. Price 7s.
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Correspondence

Correspondents are asked to be brief.

Allegations of Negligence

SIR,—Correspondence in the *British Medical Journal* during the last months of 1968 revealed concern about the incidence of allegations of negligence against doctors in Britain (30 November, p. 576; 7 December, p. 643; 21 December, p. 770; and 28 December, p. 834). With the permission and co-operation of the Medical Protection Society Ltd. I carried out a preliminary investigation to elicit some facts about the subject. A larger research project is now being planned, but it may be of interest to report the principal conclusions of the first investigation. These conclusions are based on the records of the Medical Protection Society for the years 1963-8 inclusive and concern doctors in England and Wales only. The assumption that the medical membership of the Society is a random cross-section of the medical profession in England and Wales has been made for statistical purposes.

(1) There was no significant increase in the annual number of allegations of negligence made against doctors during the period studied.

(2) Hospital doctors are five to six times as likely to have allegations of negligence made against them as general practitioners.

(3) 64% of the allegations of negligence made against general practitioners and 46% of those made against hospital doctors had an outcome which was favourable to the doctor. This difference was significant ($P=0.05$).

(4) The proportion of hospital doctors in any grade corresponds closely with the proportion of allegations of negligence made against doctors in that grade. There is thus no reason to suppose that consultants, for example, are more likely to be threatened with legal action than junior staff.

(5) Doctors working in surgical and allied specialties (including anaesthetics and obstetrics) are approximately four times as likely to have allegations of negligence made against them as physicians and allied specialists.

(6) Only four out of every 100 allegations of negligence reported to the Society resulted in court action; nine out of 10 court cases were won by the doctor.—I am, etc.,

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Muscular Dystrophy in Young Girls

SIR,—Your leading article (27 June, p. 745) is a welcome reflection of the light shone into a dark corner of the genetics of muscle disease by the paper of Penn and colleagues.[1] Occasional autosomal recessive inheritance of Duchenne muscular dystrophy has been so difficult to prove or disprove that it has become a myth which has not been seriously challenged until now.

At the Newcastle General Hospital in a 4-year period 106 cases of muscular dystrophy have been examined. All had symptoms beginning before the age of 12 years, with equal or greater weakness of the legs than the arms, no myotonia, clear-cut progression, and biopsy evidence of muscular dystrophy in at least one member of the kindred. There were 52 males with pedigrees suggesting X-linked inheritance (group I), 47 males with only affected brothers or no affected relatives (group II), two males with milder muscular dystrophy never diagnosed as the Duchenne type (group III), and five females (group IV). The age at the onset of the disease was from birth to 7 years in all the males (median of 3 years in group I) and between 2 and 9 years in the females. The boys in groups I and II were unable to walk by 15 years except for two isolated cases who walked until age 18. They died before the age of 24 except for one isolated case aged 36. The girls were all alive at 17 and 24-28 years of age respectively and were ambulant at the age of 17 and 26 in two cases and until 12, 23, and 24 years in three others. The muscle weakness was similar in distribution in both sexes, but milder in degree in the females. Only one female had a raised serum creatine kinase level (208 i.u. at age 23), which contrasts strikingly with the high levels in males at the equivalent stages of the disease. The muscle biopsies in the females showed less fibre loss, necrosis, and regeneration than in the males. Q waves and abnormal R/S ratios in lead V_1 of the E.C.G. were absent in all the females whereas every male in groups I and II over 10 years of age who was tested showed one or other (and almost always both) of these features. Apart from the points mentioned there was no discernible difference between males in groups I and II. Those in group III more closely resembled the females in the clinical and pathological features. Two of the girls were sisters whose mildly affected brother had died in an accident. One adopted female's family history was unknown. The others and the boys in group III had no affected relatives; their parents were all unrelated.

It is tempting to equate groups I and II with the X-linked Duchenne disease and groups III and IV with a clinically distinct and probably autosomal recessive disease. On the basis of this study and the Philadelphia one, such a conclusion seems to be justified. If so the autosomal disease is not only perceptibly milder than the Duchenne type but is rare in relation to its mimics. The prevalence figures for the Newcastle Regional Hospital Board area (based on cases resident in September 1969) are Duchnene muscular dystrophy $2.8/10^5$, autosomal recessive muscular dystrophy $0.06/10^5$, and benign spinal muscular atrophy (with onset before age 12) $0.8/10^5$. Any autosomal cases which are indistinguishable from the Duchenne type must be even rarer if they exist at all.

There are several important consequences