consultants in the Faculty of Public Health Medicine. As some public health tasks cannot be accomplished in primary care, and if Hart is right, to make community oriented primary care a reality requires major changes in the work patterns in both primary care and public health medicine, and substantial funds.

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# Professional negligence

## Negligence cannot be decided by offending doctor

EDITOR,—As a doctor with some experience as an expert witness in writing reports on medicolegal cases I agree with the general thrust of the editorial by Jean Ritchie and Sally Davies: that doctors should be candid to patients and carers about the progress or otherwise of their patients.[1] However, the article continually mentioned the desirability of doctors disclosing to patients if they have been "negligent." That is wrong. Whether a doctor has or has not been negligent can only be decided by others (a court of law, the General Medical Council, an inquiry, etc).

As expert witnesses writing reports we conform to careful practice in coming to an opinion as to whether or not practitioners in the case under review were negligent or not. In coming to this opinion we have in mind various legal guidelines framed in famous judgments such as Bolam *v* Friern Hospital Management Committee, Whitehouse *v* Jordan, and Wilsher *v* Essex Area Health Authority.[2] As the judgment of Lord Fraser in Whitehouse *v* Jordan makes clear, there can be an error made by a skilled person acting with ordinary care that is not negligent.

I was interested to learn that lawyers are under constraint according to their code of ethics to inform their clients if they feel that they have handled their case negligently. It is strange how seldom one hears or reads of such conduct being spoken of or recorded.

Doctors should be candid to patients and carers when things go wrong and when the doctors feel things could have been done better, but that does not mean that they have a duty to apportion blame either on themselves or on colleagues. If they are involved in the case they are the last people who should be required to do this as they would not be able to apply the necessary objective approach that must accompany any matter of judgment. So, it should not be a duty for doctors to report their negligence to patients and carers. As the subtitle for the leading article says: doctors should explain in full when care has gone wrong.

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1 Ritchie JH, Davies SC. Professional negligence: a duty of candid disclosure? *BMJ* 1995;**310**:888-9. (8 April.)
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## Doctors may make mistakes that are less obvious than lawyers' mistakes

EDITOR,—The sentiments expressed by Jean Ritchie and Sally Davies are laudable but raise two important matters which were not addressed by the authors.[1]

The authors refer to "mistakes" and to care which has "gone wrong" as though these were invariably self evident. A lawyer's missed deadline for issuing a writ or a motorist's dented vehicle may easily be recognised as evidence of mistake. It will readily be conceded that amputation of the wrong limb or a gross overdose of a medicine through a misplaced decimal point are, similarly, easily recognisable mistakes. However, most allegations of medical negligence arise from therapeutic interventions or omissions which are not self evidently mistakes or evidence of care having gone wrong. Those whose professional judgments are to be called into question may be forgiven for failing to recognise as mistakes or evidence of care having gone wrong acts and omissions which, though criticised by some, unquestionably have the full support of responsible colleagues of similar training and experience. It would be helpful if the authors could translate the fine sentiments which they express into more tangible practical guidance for members of the medical profession who endeavour to serve the interests of their patients with commendable skill and integrity.

The concept of negligence is not without difficulty for most medical practitioners. The teaching of forensic medicine is no longer part of the medical curriculum and negligence as a civil tort is poorly understood. Our experience is that most doctors who are accused of it still equate it with neglect and do not understand the true legal meaning of the term. One of the principles of natural justice is that no man should be a judge in his own cause. Consequently it is not for the individual clinician to decide whether or not he or she has been negligent —that is a judgment to be made by others. On current tort principles, the allegedly negligent practitioner may well find that he or she has support from colleagues who have reviewed all the facts and the records in response to a formal request for an opinion.

By all means encourage clinicians to give full, honest, and objective information to patients at all times, and especially in response to adverse outcomes which follow therapeutic interventions. However, do not cloud the issue by reference to subjective considerations ("mistakes") and legal concepts ("professional negligence") which are imprecise and unclear to those at whom they are directed.

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1 Ritchie JH, Davies SC. Professional negligence: a duty of candid disclosure? *BMJ* 1995;**310**:888-9. (8 April.)

## Candid disclosure is right

EDITOR,—At first reading we thought the editorial by Jean Ritchie and Sally Davies[1] was in response to the wave of antilawyer jokes that has swept North America—for example, "What would you call 100 dead lawyers at the bottom of the sea?" "A good start"; the new version presumably is: "What would you call 100 lawyers owning up to the truth?" "A new beginning, or perhaps a miracle." Nevertheless, better late than never. It was, after all, medical defence lawyers who, until recently, wanted to treat medical accidents like motor vehicle accidents and impressed on all concerned that they should not admit any liability.[2]

Ritchie and Davies reiterate most of the points that were in our 1986 guidelines as to what to do if things go wrong,[3] but they have missed one crucial item. The main reason for candid disclosure is because it is right. Doctors should provide "full disclosure of facts."[4] Patients and families want and need that, as well as some "reassurance that a similar accident will not happen to someone else."[5] The avoidance or mitigation of lawsuits is a secondary consideration.[4]

In our experience it is essential that a doctor (regardless of seniority) involved in an incident discusses the matter with other colleagues.[3] This should be done, if possible, before meeting with the patient or relatives. Reasons for this include the difficulty the doctor affected may have in deciding alone what is the truth of the matter; that the doctor cannot conduct any necessary investigation of the case in an unbiased fashion; and, if the event has an adverse outcome, the issue of counselling for the doctor.[5]

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# Ethics and economics of health care

## Prognosis, a traditional alternative to futility

EDITOR,—The editorial by Charles Weijer and Carl Elliott and by Richard Smith raised important questions about the ethics and economics of health care.[1,2] Weijer and Elliott drew attention to the shortcomings of the new and fashionable concept of futility.[1] Medicine, however, is a venerable profession and doctors already have suitable concepts in our traditional toolkit—namely, an awareness of the importance of establishing a precise diagnosis and prognosis. A decision about appropriate treatment can then by taken, after discussion with the patient or a child's parents. It is neither necessary nor appropriate to invoke the issue of rationing limited resources at that stage.

I think that it was here that the arguments about B, the child with leukaemia, became confused.[3] The doctors looking after B had come to a diagnosis and prognosis. Cambridge Health Authority muddled the issue by invoking two separate arguments for not funding further treatment. Firstly, that treatment would cause B suffering that would be unjustified when set against a 10% chance of success. Secondly, that the treatment would not have been "an effective use of resources." Regrettably the Appeal Court did not clarify the issue. How much better it would have been if the Appeal Court's judgment had reaffirmed the views of the House of Lords Select Committee on Medical Ethics, which stated that "health-care teams should not be put in a position of having to make such decisions in the course of their day-to-day clinical practice. Their concern must be for the welfare of the individual patient."

The challenge to clinicians, when dealing with an individual patient, is to derive as precise a prognosis as possible on the basis of the available scientific evidence, and then to act in the best

interests of that person. The issue of resource allocation is an important but separate one which should be debated in a separate forum.

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## British medicine has lessons for North American medicine

EDITOR,—The editorial on futility by Charles Weijer and Carl Elliott had a distinctly North American flavour, which will limit its relevance to British clinicians.[1] We do not agree that withdrawing life supporting care from a patient in a persistent vegetative state presents a dilemma; it is common sense to us that such care is futile.

The context in which such decisions are made in North America, or in the United States at least, is very different from that in the United Kingdom. As J Bion pointed out in the preceding editorial, in the United Kingdom only 1-2% of the small health care budget is spent on intensive care whereas in the United States 15% of a much larger budget is spent on it.[2] In the United States "elaborate and uncomfortable therapies of dubious advantage or none to the frail elderly are deployed on a scale unimaginable in Britain."[3] Doctors and hospitals get well paid for this, and medicolegal considerations encourage physicians to do more rather than less.[3] It is against this background that American physicians promote patient autonomy and scorn paternalism.

In the United Kingdom doctors get paid a salary, not fees for services, and are less likely to be victims of litigation.[3] In English law the doctors of incompetent patients rather than relatives have responsibility for making decisions on their behalf. This has led British doctors to behave in an "indefensibly paternalistic"[4] way in the past, although this is now changing to accommodate a greater degree of patient autonomy. Doctors are realistic enough, however, to accept that medical decisions are never going to be completely objective even if this was desirable; there is always going to be some subjectivity.[4]

Recognising that some interventions are inappropriate because they are futile often requires a simple combination of clinical experience and common sense, not elaborate protocols. In 1990 the editor of the *Journal of the American Geriatrics Society* discussed the use of cardiopulmonary resuscitation in nursing homes: "at long last, we seem to be paying some attention to the winds of common sense blowing eastwards across the Atlantic."[5] Perhaps in this case British doctors should be exporting ideas to rather than importing them from their North American colleagues.

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## WHO in Cambodia

EDITOR,—In one of her articles on the World Health Organisation Fiona Godlee refers positively to the organisation's work in Cambodia, saying that it is "one country programme [that] shows what WHO can achieve at its best."[1] She implies that the success of this programme is at least partly due to the fact that "the project suffered little interference from the regional office in Manila."

As the first three WHO programme managers in Cambodia since the re-establishment of the organisation's office there early in 1991, we take strong exception to this statement. Whatever has been accomplished by the WHO in Cambodia has largely been due to the strong technical and moral support that we and our staff in the country have received from the regional office for the western Pacific; our colleagues in Manila deserve a major share of the credit.

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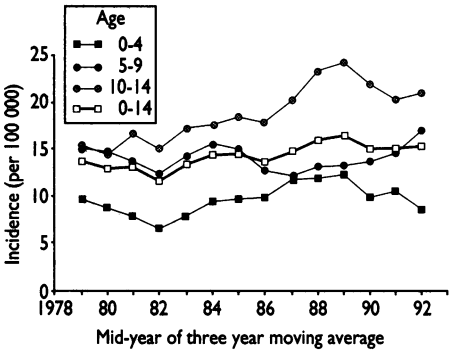
1 Godlee F. WHO at country level—a little impact, no strategy. *BMJ* 1995;309:1636-9. (17 December.)

## Incidence of diabetes in children

EDITOR,—Emma Wadsworth and colleagues report the incidence of insulin dependent diabetes in children under 5 years in the British Isles.[1] Their data suggest that the incidence remained stable over four years. The use of "snapshot" years to address the question of potentially increasing incidence must have limited value, even over a large geographical area, when random variation substantially affects annual numbers.

The population based Yorkshire children's diabetes register includes 1650 children and for the years 1978-90 is 97% complete.[2] A time span of 16 years is likely to reflect true changes in incidence, and data from the Yorkshire register were used to calculate age specific incidences (per 100 000 per year) for 1978-93. The figure shows smoothed rates (three year moving average) for ages 0-4, 5-9, 10-14, and 0-14. Testing for a significant rise in incidence ($\chi^2$ test for trend) showed no evidence of an increase in the youngest age group ($\chi^2=1{\cdot}23$, $P=0{\cdot}27$), which supports the observations of Wadsworth and colleagues. A similar non-significant trend was seen in the 5-9 year olds ($\chi^2=1{\cdot}22$, $P=0{\cdot}27$). However, a significant increase was observed in the 10-14 age group ($\chi^2=17{\cdot}8$, $P<0{\cdot}001$), which accounted for the increase in all ages combined ($\chi^2=15{\cdot}29$, $P<0{\cdot}001$). The incidence over 16 years for the 0-4 year olds is 9·46/100 000/year, which closely matches the rates from national surveys.[1] An underlying constant base rate should not mask the importance of looking at geographical and temporal heterogeneity, which may provide clues to the aetiology of a disease.




*Age specific incidence of diabetes in children aged 0-14 in Yorkshire, 1978-93*

Temporal trends in Yorkshire show roughly four yearly cycles of high incidence, with the rates for the 0-4 year olds ranging from a high of 15·40/100 000/year in 1988 to a low of 5·34/100 000/year in 1982. If this was a feature of patterns of incidence on a larger geographical scale then figures from two years separated by a period of four years could be misrepresentative, showing unusually high or low rates.

An interesting finding of the national studies was the significant geographical heterogeneity among British regions, although rates were not consistently high or low in the same areas in 1988 and 1992. These features indicate widespread environmental factors influencing the onset of disease; one candidate might be cyclical variation in infections, which are known to vary geographically. The importance of investigating localised differences in occurrence should not be minimised.

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## Specialists in the United States

EDITOR,—I was trained in general surgery in Britain and then spent 10 years training surgical residents in the United States. Having observed the results of this method for the past 15 years in private surgical practice, I can vouch for the fact that it is possible to train bright medical graduates to a high standard of specialist competence in a defined period.[1]

In my opinion, the main difference between the British and American systems is that the British method relies heavily on the old apprentice system, which leads to a long, slow, gradual approach to learning. Its final product is excellent, but it is time consuming. The American system, in contrast, is very concentrated practically and theoretically. It is much more labour intensive for the trainers and trainees but produces a similar result in a much shorter time.

To train the "new" British consultants to current standards in a defined period major changes will be necessary. These will include a great increase in full time teaching staff, which will have major consequences for the government and the NHS. The advantage for NHS patients will be that, in future, most will be seen by an appropriately and fully trained specialist. The advantage for trainees will be that training will last for a