that my ethical judgments were based on prejudice rather than sound reasoning. We would all condemn doctors who have no knowledge of the pharmacology of the drugs they prescribe, but I think we tend to be more lax about our need for a critical awareness of how we make decisions on what is right. It is easy to dismiss philosophy in relation to medicine as either a matter of common sense which is too obvious to be interesting or as a hopeless jumble of contradictory ideas divorced from reality. The brief glimpse of moral philosophy I snatched on this course, however, has greatly helped me to recognise the defects in my education and has helped to sharpen the criticism of my own ethical values.

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Blunt injury of the heart

SIR,—The leading article on blunt injury of the heart (12 February, p 497), while accurately reporting on the range of cardiac injuries resulting from non-penetrating thoracic trauma, failed to quantify this obscure but important clinical condition. It further omitted to comment on the value of acute thoracic radiology in predicting those patients in whom cardiac injury is likely to be present.

It has recently been reported that 20% of patients sustaining crushing injuries of the chest will have some degree of cardiac injury.[1] Furthermore, the commonest unsuspected visceral injury responsible for death in fatally injured accident victims is blunt cardiac trauma.

With regard to the predictive value of the initial chest radiographs in the patient with trauma the individual presence of a sternal fracture, a first rib fracture,[2] fractures of seven or more ribs,[3] or a traumatic rupture of the diaphragm[4] should alert the doctor to the high probability of a concomitant cardiac injury since each of these injuries evolves from the sudden application of a severe crushing force to the thorax. These points are of practical relevance to the junior accident doctor.

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[1] Jones KW. Thoracic trauma. *Surg Clin North Am* 1980;**60**:957-81.
[2] Richardson JD, McElvein RB, Trinkle JK. First rib fracture. A hallmark of severe trauma. *Ann Surg* 1975;**181**:251-4.
[3] Wilson RF, Murray C, Antonenko DR. Non penetrating thoracic injuries. *Surg Clin North Am* 1977;**57**:17-36.
[4] Wise L, Connors J, Hwang YH, *et al.* Traumatic injuries to the diaphragm. *J Trauma* 1973;**13**:946-50.

Method of healing diabetic foot ulcers

SIR,—Professor Paul Brand advocated the use of below knee walking plasters with rubber rockers for healing diabetic forefoot ulcers (5 February, p 436) in South India in the 1950s, and since then they have been used for treating forefoot ulcers in patients with leprosy throughout the whole of the country. In Mysore, where I worked, part of the routine during our regular visits to village leprosy control and treatment centres was to saucerise forefoot ulcers and then to apply such plasters. If they lived nearby patients went home with the plaster; others were accommodated on makeshift mattresses and fed on the clinic verandah until the next visit. The plasters were changed every two or three weeks. The smell of the discharge was often offensive, but this was minimised by the open air life of the verandah. Most of the ulcers healed if they were on the forefoot, but patients with heel ulcers did not do well and their feet needed to be totally off weight bearing.

When I returned from India in 1967 I tried using this technique with diabetic forefoot ulcers but became discouraged largely because of the unpleasantness of the discharge and its odour, which could pervade the small rooms of our British houses. Many forefoot ulcers were not easily accessible to regular dressing from in front as suggested in your article. Many patients too were elderly and did not take kindly to plasters. Obviously, however, we do need to reconsider using the technique where it is practicable and where access for dressings from in front is not difficult.

We have been disappointed in the use of medium and light density Plastazote insoles once the ulcer is healed to prevent further ulcers. These quickly lose their resilience so that the area of insole under a pressure point can become compressed and as solid as the sole of the shoe itself. After years of trials with different materials we have evolved an insole which incorporates a high density Plastazote cradle moulded to the shape of the foot. This has windows cut out under the pressure points, which can be filled in with 6 mm Neoprene. Neoprene has been the most resilient of cushioning materials, maintaining its recovery and, provided it is thick enough, never "bottoming out" under pressure. With these insoles the recurrence rate of ulcers has been negligible.

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Out of court settlements by defence organisations

SIR,—I write to correct the erroneous impression created by your correspondents Dr John Galway (22 January, p 307) and Drs E Besterman and J M Gate (19 February, p 644). The conclusion that Dr Galway sets down about the case he quotes can only have been reached through ignorance of all the facts.

So far as The Medical Protection Society is concerned, there is no trend whatsoever towards "easy" out of court settlements. Whatever trend there may be is related to increased public knowledge and awareness of legal remedies. The tip of the iceberg is that much more visible and the skeletons in the cupboard to which every clinician of humility and insight admits are not as securely hidden from view as they were.

Out of court settlements are entertained only when, on a careful review of all the facts and evidence, the prospect of a successful defence is not good. The decision is reached by a body of practising clinicians who invariably consider whether there is a principle of professional practice at stake. Many an otherwise good defence has been spoiled by the lack of adequate legible notes and the witness potential of the member, to mention but two factors. If the decision is to negotiate an out of court settlement, this usually results in a sensible agreement on quantum and a considerable saving in legal costs, and, because frequently the settlement is achieved while maintaining a denial of liability, the member's professional reputation remains intact.

No effort is spared to reach a just and realistic decision which accords with the state of the law, and the society spares no trouble or expense in searching out expert advice. Easy, or expeditious, out of court settlements form no part of the Medical Protection Society's philosophy. I trust these comments, pious sounding but true, will reassure your correspondents.

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SIR,—Dr J Galway (22 January, p 307) thinks that the defence societies make out of court settlements in cases which could be successfully defended. In support of his argument he quotes the case of a colleague. I understand that the case was handled by the Medical Protection Society, which cannot reveal the reasons for settling the claim without the consent of the member concerned, but the society has stated that the facts of that case do not support Dr Galway's contentions. I can assure him that he is absolutely wrong in thinking there is a "trend" to easy settlements by the Medical Defence Union.

Dr E Besterman and Mr J M Gate (19 February, p 644) assume that Dr Galway is correct in saying there is a disturbing trend to make out of court settlements. Dr Gate thinks: "Recent out of court settlements by the defence organisations suggest that there is a growing tendency to sacrifice reputations if money can be saved." The Medical Defence Union has no evidence of this whatsoever.

It is the policy of the union to defend every claim and make out of court settlements only when factual and expert evidence suggest there is a serious risk that the case would not be won in court. The decisions on the handling of cases are made by the council of the union, which consists of doctors and dentists. The lawyers report to the council on the legal aspects of the case but do not make the decisions. The union puts a member's reputation before all other considerations.

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No objection to proper training

SIR,—What a profoundly depressing heading (29 January, p 410) highlighting the extraordinary position taken by the General Medical Services Committee on dental anaesthesia. It gives a new meaning to the phrase, "the zero option." Alone among the interested parties, the GMSC seems to believe that we do not need driving tests or penalties for incompetence, just government support for schools of motoring to make the roads safe.

This field, in which as many fit individuals are killed unnecessarily as in obstetric anaesthesia, has reached the level of a public scandal. The first thing to tackle is the single handed operator anaesthetist. There is no such thing as a dental emergency which could justify a dentist giving his own general anaesthetic. Yet despite condemnation by the president of the General Dental Council, the practice persists. Or does it? For, by a fine irony, the only way a dentist can claim any