Grey Turner, whose first assistant he had been at Hammersmith; and, lastly, probably his greatest friend and surgical hero among his seniors, Sir Gordon Gordon-Taylor.

Although his great knowledge of surgery combined with an original quality of mind made his opinions always worth hearing, yet he loved to quote the great masters of his craft in preference to stating views of his own.

No account of Lambert's life would be complete without reference to the guiding influence of his deep but simple religious faith; though tolerant of the failings of others he had the highest standards for his own conduct in all things. His last few years were clouded by an obscure malady about whose outcome he had no illusions. He fully realized that he "walked through the valley of the shadow of death" but like the Psalmist and for similar reasons he "feared no evil." He carried on as far as he was physically able up to the end. Although his many friends will deeply miss him and deplore his loss while still at the height of his intellectual powers, yet his life's work was virtually finished, and at least he was spared the prolongation of chronic illness and inevitable decline.

In a recent conversation with me concerning a mutual friend, Lambert summarized his opinion by simply stating, "He is a Christian gentleman." I can think of no more fitting description of Lambert Rogers himself.

Medico-Legal

OPERATING ON THE WRONG PATIENT OR WRONG PART OF A PATIENT

We print below a joint memorandum of the Medical Defence Union and the Royal College of Nursing on the steps that might be taken to obviate the risk of a surgeon performing an operation on the wrong patient, side, limb, or digit.

MEMORANDUM

The Medical Defence Union and the Royal College of Nursing have given consideration to the steps that might be taken to obviate the risk of an operation being performed on:

(*a*) the wrong patient,
(*b*) the wrong side,
(*c*) the wrong digit.

During the period October, 1959, to September, 1961, the Medical Defence Union dealt with no fewer than twenty-eight such cases and it is hardly necessary to say that these avoidable mistakes are quite indefensible.

The Councils of the Medical Defence Union and the Royal College of Nursing are firmly of the opinion that in order to minimise the risk of such occurrences, it is eminently desirable that wherever practicable the suggested safeguards as outlined below should be taken. It is appreciated that in certain out-lying or "cottage" hospitals there is no resident medical staff and that in some hospitals it may not always be possible to adopt these safeguards in their entirety.

(*a*) OPERATING ON THE WRONG PATIENT

Causes Predisposing to Error

(i) In hospitals which undertake a vast amount of casualty work where emergency patients are being admitted in quick succession, some of them unconscious, there is the possibility of the notes becoming attached to the wrong patient. Where it is the practice to attach the patient's name to the clothing which has been removed in the casualty department, this does not always provide an adequate check because the clothes may be detached from the patient before or on admission to the ward.

(ii) In respect of patients for non-emergency operations who have been in the ward for a day or two prior to operation, mistakes may arise if on the day of operation the beds are changed round. This situation is exacerbated if the day of operation coincides with a change in several of the nursing staff and could lead to the wrong patient being sent to the theatre if the routine did not provide adequate safeguards against error.

(iii) Mistakes may occur when changes are made in theatre lists following the commencement of the operating session, particularly if such changes have not been notified to the ward immediately they have been made.

Suggested Safeguards

(1) All unconscious patients admitted through the casualty department should be labelled before they are taken to the wards. The identity disc or label should bear the patient's name, initials and hospital number where possible. The labelling of the patient should be the responsibility of the casualty sister or her deputy, or by night, the nurse-in-charge or her deputy.

(2) Following the admission to hospital of a patient who is to undergo an operation, he should be seen in the ward by the surgeon who is to perform the operation. Prior to the operation the surgeon should examine the patient's records and make sure that the notes do in fact relate to that particular patient and that the entries contained therein are correct.

(3) All patients going to the operating theatre should be labelled by means of an identity disc or label attached to the wrist or ankle. The identity disc or label should bear the patient's name, initials and hospital number. The labelling should be carried out in the ward at the time the patient is prepared for the operating theatre and should be the responsibility of the ward sister or her deputy.

In rare cases where the patient goes direct from the casualty department to the operating theatre, the onus of correct labelling should rest on the casualty sister or her deputy. In either instance the labelling would constitute an additional check that the correct patient received the prescribed premedication and that the correct patient was sent to the theatre.

(4) In addition to the nature of the operation, the patient's name, initials and hospital number should also appear on the operation list. A copy of the operation list should be displayed in the anaesthetic room as well as in the operating theatre, thus enabling both the anaesthetist and the surgeon to check and ensure that the right patient is presented for operation. A copy of the operation list should also be made available to wards in which the patients who are to undergo operation are accommodated.

(5) Patients should be sent for from the operating theatre by name and number and never as "the patient from such and such a ward." Where it is the practice for a porter from the theatre to collect the patients from the ward he should bring with him a slip bearing the name of the patient and his hospital number. In hospitals where the procedure is to telephone the ward to ask that the patient concerned be sent to the theatre, the patient's hospital number, as well as the name, should be quoted. The ward sister or her deputy should be responsible for seeing that:

(*a*) the correct patient is sent to the operating theatre;
(*b*) the patient has already signed the appropriate consent to operation form;
(*c*) the patient has received the prescribed pre-operative preparation including premedication;
(*d*) where appropriate the side of operation has been marked (see Section (*b*) Clause (1));
(*e*) the correct case papers, *x*-rays, etc., accompany the patient to the theatre.

(6) In the operating theatre one person should be made responsible for sending for patients. This should be the responsibility of the theatre superintendent but in large operating theatre suites it may be necessary for her to delegate this responsibility to some other person, e.g., the sister-in-charge of a particular theatre or the nurse taking the list in a particular theatre.

(7) When out-patients are admitted to the wards for the day for a minor operation, they should be labelled in the same way as in-patients before they are taken to the operating theatre.

(8) Patients who are to be operated on in the out-patient theatre under a general anaesthetic should be labelled in the same way as the in-patients.

(9) Patients should have one hospital number which should be quoted on all papers concerning the patient. Where it is the practice to have departmental numbers these may be used additionally on the appropriate papers but never exclusively.

(10) In so far as children are concerned, the labelling should be carried out when they are admitted to the ward. As the case histories must be taken from the patient's relatives (who may not be present immediately prior to the operation) it is vital that no error should occur in these notes in reference to the side, limb or digit on which the operation is to be performed.

(*b*) OPERATING ON THE WRONG SIDE OR LIMB

Causes Predisposing to Error

(i) Wrong information on the case papers of the patient, i.e., "right" instead of "left."

(ii) Abbreviation of the words "right" and "left."

(iii) Illegible writing on the case papers.

(iv) Failure to check immediately prior to commencing to operate the entry on the operation list with the notes taken to the operating theatre.

(v) The wrong case papers accompanying the patient, combined with (iv) above.

(vi) The preparation of the wrong side or limb, combined with (iv) above.

(vii) No routine procedure for marking the operation side.

Suggested Safeguards

(1) The side on which the operation is to be performed should be indelibly marked before the patient reaches the theatre, and in order to denote the side a mark should be made with an indelible skin pencil on the forehead of the patient. This should normally be made the responsibility of the house surgeon. In the case of "listed" patients already in the ward, it is usual for the house surgeon or a house officer to see the patient on the evening before the operation and this would give the practitioner concerned an opportunity of marking the operation side. In the case of emergency operations the surgeon generally sees the patient in the ward before he is taken to the operating theatre, thus providing him with an opportunity for marking the operation side. In the rare instance of a patient who is taken direct from the casualty department to the operating theatre, the practitioner who decides upon an immediate operation should be made responsible for marking the operation side.

In the event of the ward sister or her deputy, or exceptionally the casualty sister or her deputy, finding that the side of operation has not been marked when the patient is due to be sent to the operating theatre, she should see that the surgeon who is to operate is informed accordingly, but she should not herself undertake the marking.

(2) The words "right" and "left" should be written in full in the patient's notes and in the operation list.

(*c*) OPERATING ON THE WRONG DIGIT

Causes Predisposing to Error

(i) Fingers referred to by numbers instead of by name.

(ii) Wrong information on the case papers of the patient, i.e., "right" instead of "left."

(iii) Illegible writing on the case papers.

(iv) Failure to check immediately prior to commencing to operate the entry on the operation list with the notes taken to the operating theatre.

(v) The wrong case papers accompanying the patient, combined with (iv) above.

(vi) The preparation of the wrong digit combined with (iv) above.

(vii) No routine procedure for marking the side on which the operation is to be performed.

Suggested Safeguards

(1) In order to avoid the possibility of any ambiguity concerning the finger(s) on which the operation is to be performed, the finger(s) should always be described as thumb, index, middle, ring and little fingers and not as 1st, 2nd, 3rd, 4th and 5th. In so far as the toes are concerned, the accepted practice is to describe them as hallux (big), 2nd, 3rd, 4th and 5th (little) toes and this should always be adhered to.

(2) The words "right" and "left" should be written in full in the patient's notes and on the operation list.

In order to reach agreement on a routine procedure, incorporating as far as possible the safeguards put forward in this memorandum, to be adopted in a particular hospital or group of hospitals, it is suggested that joint committees of medical and nursing staff should be set up on a local basis. The committees should include, *inter alios*, the matron and a representative of the consultant surgical staff.

Medical Notes in Parliament

TOBACCO ADVERTISING

[FROM OUR PARLIAMENTARY CORRESPONDENT]

Mr. FRANCIS NOEL-BAKER, who sits as Labour M.P. for Swindon, is a persistent critic of what he regards as anti-social expenditure on advertising, and high on the list he places the tobacco firms' campaigns. He seized one of the three opportunities presented by the earlier recall of Parliament to mount another attack on October 18. This was based on recent work with the Advertising Inquiry Council, a non-political consumer organization, which has in preparation a long and documented report on tobacco advertising,

Cigarette-smoking and Health

Mr. Noel-Baker recalled the Medical Research Council's report of 1957 and the more recent surveys of smoking habits among secondary schoolboys, and asked the Government spokesman to restate the Government's general attitude to cigarette-smoking and its effect on health, and to smoking by young people. Teachers, parents, and relatives had a responsibility towards children and youngsters to do everything they could to prevent them getting into the habit of smoking cigarettes. Had not the Government a much wider responsibility for the health and lives of millions of young people who were being assailed by a £20m.-a-year campaign of commercial propaganda designed to make them start smoking and then keep on smoking? If the tobacco companies were not convinced that these enormous sums were having a substantial effect in increasing sales they would not be spending such sums. Statistics showed a substantial increase in spending on tobacco and cigarettes: for the calendar year 1960 it was £1,140m., of which £1,002m. was on cigarettes. From this the Government