PRACTICE OBSERVED

Emergencies in the Home

What equipment is needed

B G STEGGLES

The articles in this series have dealt with various types of emergencies, and some have emphasised the importance of attempting to stabilise the patient before transfer from home to hospital, including keeping the airway open, and replacing fluid loss by infusion. This article is a review of the simple equipment available for dealing with emergencies in the home and is not intended to cover the comprehensive range that may be carried by doctors in immediate care schemes.

Maintaining the airway

BROOK AIRWAY

The Brook Airway (fig 1) is probably the simplest and cheapest method of ventilation after mouth-to-mouth and is

FIG 1—The Brook Airway.

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certainly easier and more hygienic than this. It has the advantage that it can be used effectively by an untrained bystander: inserting the airway displaces the tongue, and the position for blowing into the tube from behind the patient's head helps to keep the patient's chin up and the airway patent. The non-return valve prevents vomit from reaching the mouth of the operator.

BAG AND MASK

There are many different models of bag and mask available, probably the best known being Ambu and Laerdal. They need an experienced operator to be used well and have the disadvantage of cost against the Brook Airway. There are portable mechanical ventilators available, but these are expensive and cumbersome and probably of no great advantage in emergencies in the home. Oxygen may be a further useful addition, and there are a number of small portable sets available.

INTUBATION

The requirements for intubation are a series of endotracheal tubes of sizes appropriate from babies to adults, and a laryngoscope, which may be either a cheap plastic unit or a more robust metal one with interchangeable blades. Attempting intubation usually requires suction to the pharynx or down the endotracheal tube, and types of suckers are mentioned below. A suitable connector to the bag and mask is required, but will be dependent upon the other equipment being used although it should be standardised for simplicity in use.

OROPHARYNGEAL OBTURATOR AIRWAY

The oropharyngeal obturator airway (fig 2) is useful if intubation fails and relies on the cuff being inflated to obstruct the oesophagus and so permit positive pressure ventilation and also

FIG 2—The oropharyngeal obturator airway.

prevent vomit from ascending past the cuff. The earlier models without a tube for gastric aspiration proved dangerous on occasions when removal of the obturator could result in a large volume of stomach contents suddenly filling the pharynx. This may be easier to insert than an endotracheal tube for the doctor who does not often practise intubation.

TRACHEOTOMY

Fortunately, obstruction of the pharynx by a foreign body or acute oedema and acute epiglottitis are uncommon. They are life threatening, however, and require rapid action. In a patient with acute epiglottitis there is a risk of the manipulation pro-

FIG 3—Laerdal jet suction.

ducing laryngeal spasm, but if respiratory arrest has occurred then intubation may be possible but difficult. Tracheotomy is not to be recommended in the home, particularly in children, and the insertion of a wide-bore needle, such as the Medicut intravenous cannula is adequate as a first-aid measure. This may be inserted easily through the cricothyroid membrane with the neck extended: it is much easier to do this than to attempt to pierce the trachea itself. Various other instruments have been produced for emergency entry to the larynx and trachea, but none is really more satisfactory than a simple wide-bore needle.

Developments for the future

One item that needs to be improved is the equipment for emergency tracheotomy—such as a disposable plastic unit like a large intravenous cannula. Although this is not a common procedure, it is one for which there is no alternative should it be necessary. A cheap and simple unit would be most useful. The most important consideration about carrying and using such emergency equipment is that it must be simple, not too expensive, and easy and ready to use. One example of a complete kit is the Laerdal Modulaid (fig 5), but a useful addition to the large range of equipment available would be a simple case containing a good sucker, a Brook Airway, intravenous cannulae, a giving set, and infusion fluid. Although this may

FIG 5—The Laerdal Modulaid kit, complete and ready to use.

be made up by the individual, a ready-made kit would be more convenient to buy. Many ambulances now carry intubation and infusion kits, and it is pleasing that an increasing number of our ambulance colleagues are becoming trained up to intu-

bation and infusion standards. It is often the general practitioner, however, who is first on the scene and carrying some simple equipment might be life-saving. It would be ideal if such emergency equipment were standardised for general practitioners, the ambulance service, and hospitals, and for the facilities to exist for the replacement of equipment used.

Various types and ranges of equipment have been mentioned, but if only one piece is to be carried then probably the Brook Airway is the most useful single simple device.

Suppliers of the equipment:

F W Equipment Company Ltd, Ambu (International) (UK) Ltd,
Harrow Road, London W9 1JH, 10 Station Road West,
Cardiff CF12 9AN.
West Yorkshire BD12 0SG.
Kerr Medical Engineering (Laerdal)
Proctor Road,
Barnsley, South Yorkshire S19 6NP.

Equipment list and approximate cost (excluding VAT)

Brook Airway	£ 6
Compact Ambu bag and mask	47
Laerdal bag and mask	25
Oropharyngeal obturator airway	25
Laryngoscope—metal blade plastic	25
Laerdal jet suction	44
Ambu mini-pump suction	24
Laerdal Modulaid (basic)	170
Complete	240
Rechargeable oxygen cylinder with adaptor	90

I am grateful to Mr I Stewart, consultant in accident and emergency to Plymouth General Hospital, for his assistance with this article, and to F W Equipment Co Ltd, Harrow Road, Low Moor, Bradford, West Yorkshire BD12 0SG, for their kind loan of equipment for evaluation.

Law and the General Practitioner

Confidentiality

ROBERT D FRANCE

Confidentiality is such an emotive subject that discussion tends to confuse rather than clarify the issues, notwithstanding broad agreement on the basic principles. A doctor acquires much information from and about his patients, but although he is under a moral obligation to respect these confidences this duty is not established in common law or enshrined in statute. The patient therefore has no certain legal remedy whereby he can obtain damages if there is a breach of confidentiality. It has been suggested that in accepting a patient for treatment a doctor enters into an unwritten contract, an implied term of which is that strict confidentiality shall be maintained; but this proposition has not been put to the test in a court of law and must remain

of uncertain validity. In any event it could hardly apply in the case of a patient in the National Health Service, where the "contract" is not strictly between doctor and patient only and where the records are the property of the Secretary of State for Health and Social Services. Equally, since there is no statutory duty to preserve secrecy, a breach of confidentiality does not raise the risk of criminal proceedings. Nevertheless, there are several legal aspects that require consideration.

Legal aspects

Firstly, there are circumstances in which a doctor is positively required by law to provide information regarding a patient to the appropriate authority. Certain infectious diseases must be notified under the Public Health Acts, industrial poisonings under the Factories Acts, terminations of pregnancy under the Abortion Act, and addition to some of the controlled drugs

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SUCTION

The simple rubber bulb sucker is usually inadequate to clear the pharynx of mucus or vomit, and either the Laerdal jet suck (fig 3) or the Ambu mini-pump (fig 4) are necessary. The Laerdal jet suck has the advantage that it may be used single-handed in any position, while the Ambu mini-pump is foot-operated and really needs a firm flat surface. Such continuity as the battery-operated Laerdal is rarely needed in the sort of emergencies considered in this series.

FIG 4—The Ambu foot-operated mini-pump.

Infusion

The use of intravenous infusion has been mentioned in several of the articles, and the equipment needed is simple and cheap: a selection of intravenous cannulae of the user's choice, a giving set, and Haemacel or normal saline. Haemacel is an excellent plasma expander and has really replaced the earlier ones because of its shelf-life of eight years and the fact that it is not necessary to take blood for cross-match before use. The normal saline is a useful addition for the patient who may not need a rapid restoration of blood volume but who may benefit from having an intravenous line open. It is always easier to take a drip down than put one up on a collapsed patient, and it should be remembered that on an ambulance journey the volume of blood loss is often increased because of the motion of the vehicle.

Developments for the future

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under the Misuse of Drugs Act. Failure to comply with these requirements could render the doctor liable to criminal proceedings, although prosecution will seldom result unless he is also being charged with more serious related offences. Claiming that notification was not made because the patient did not wish it is not an adequate answer.

Secondly, a doctor cannot necessarily claim exemption from the duties of citizens in general under common or statute law. For example, the Road Traffic Act places a duty on any person, if so requested by the police, to give any information that he is able to give and that might lead to the identification of a person who is believed to have committed certain offences under the Act. In the case of *Hunter v Mann* a general practitioner who had treated two patients injured in a road accident was approached by the police, who believed that one of them was the driver of a stolen car that had been in an accident. The doctor refused to disclose the identities of the patients and was duly charged and convicted in the magistrates court. On appeal to the divisional court the conviction and fine of £5 were upheld. The law is clear on this point but not on crime in general. While every citizen may have a moral duty to help the police in preventing and detecting crime and in apprehending the criminal, this is not a statutory duty, and even if it were upheld as a principle of common law, it is doubtful if there would be any effective sanctions against its breach. It therefore remains a matter of conscience whether a doctor volunteers, or provides on request, information to the police concerning a crime.

Thirdly, the doctor cannot claim special privilege as a witness before a court or tribunal. Whether he attends voluntarily or in response to a subpoena or witness summons he may be required to answer questions of fact, even though his knowledge was acquired in professional confidence. He may appeal to the judge or chairman, but if he is directed to answer he must do so, or risk being held in contempt of court. Nevertheless, Lord Denning has said, "The judge will respect the confidences which each member of these honourable professions receives in the course of it, and will not direct him to answer unless not only is it relevant but also it is a proper and, indeed, necessary question in the course of justice to be put and answered."

Fourthly, there is the matter of disclosure of medical records. A general practitioner is the owner of the records of his private patients and is in a lawful position of refusing his NHS duties. These records comprise not only his own case notes but also notes made by colleagues, hospital summaries, reports, and correspondence. These are not privileged documents and may be subject to an order for production in respect of the wishes of doctor or patient. Section 31 of the Administration of Justice Act 1970 provides that a person who is likely to bring high court proceedings in respect of personal injury or death may apply for an order requiring the production of documents which are relevant documents in his possession, custody, or power. Thus a patient or relative who is exploring a claim for damages against a doctor may be able to obtain the relevant medical records from the doctor, and the doctor has no real control over whether the records are released to the patient or relative in person or to their legal representative. Similarly, section 32 of the same Act provides for any party to proceedings for personal injury or death to apply for an order compelling a person who is not a party to the proceedings to disclose what relevant documents are in his possession and to produce them to the applicant. Here the applicant may be the patient, his next-of-kin, his employer, the driver of a vehicle that caused the injury, or some other person—for example, the victim of an accident for which the patient was thought responsible. Again, the doctor holding the relevant records may be compelled to yield them up for inspection. As to what is relevant, Lord Diplock has stated that "any irrelevant parts of a document that is subject to disclosure can be covered up when the document is produced." This raises questions of who is to decide what is irrelevant and whether that decision is likely to prove acceptable. Whatever the mechanism of the procedure medical records may have to be handed over

by the doctor and may come under the scrutiny of the patient, a relative, or some other person, and this could result in hurt or embarrassment.

Defamation

Clearly, then, the doctor has no legal obligation to maintain absolute privacy in respect of all information obtained about his patient; but there remains the matter of defamation. If in revealing information, for whatever reason, a doctor utters statements that might be construed as defamatory—that is, holding him up to ridicule, hatred, or contempt—then he may be held liable for damages in libel or slander. Of the defences that might be open to him, qualified privilege is the most likely in that the doctor might claim that he has a proper interest in making the statement to a person or body who has a proper interest in receiving it. This would apply to communications between professional colleagues, to medical reports to appropriate authorities, and to statements made, for example, to administrators investigating complaints. The defence of privilege might fail, however, if there were evidence that the doctor had acted out of malice or did not care whether the statements were true or false. In the case of *Kisson v Playfair* the doctor had attended a patient for a miscarriage and, since her husband had been abroad at the probable time of conception, inferred adultery. The doctor, being related to the husband, discussed the matter with members of the family with a view to having her allowance stopped. The patient brought proceedings against the doctor and was awarded £12 000 damages, the jury finding malice on the part of the doctor. Although sometimes quoted in support of the argument for a contractual basis of a duty of confidentiality, this action was in fact in defamation.

Ethical aspects

Although there are several more or less clearly defined circumstances in which a doctor is legally obliged to may be compelled to disclose information about a patient, he may be asked for information in various circumstances where there are no ready answers. Some of these requests may safely and properly be complied with; others may and should be resisted. In reaching a decision it may be helpful to consider the following points:

- (1) Does the patient consent?
 - (2) Who is seeking information and what is his standing in the matter?
 - (3) For what purpose is the information required?
 - (4) What information is in the doctor's possession?
 - (5) What part of that information is relevant to the matter in hand?
 - (6) To what extent is the information already known to other parties?
 - (7) What is the likely effect of disclosure on the patient?
 - (8) Is there any overriding duty in the public interest?
- Doctors may fail to give adequate attention to these points but, perhaps more important, may also fail to distinguish between information that is sensitive and better kept secret and that which will cause no harm or embarrassment if revealed. Usually the background history to the illness or accident should give rise to more concern than the plain facts of diagnosis and treatment. There is little likelihood that a patient will suffer ridicule or contempt if he is known to have had an attack of pneumonia and to have been treated with antibiotics, but his suicidal ulcer may have developed as a result of the stress of an adulterous relationship or the embarrassment of his employers' funds. Perhaps, therefore, as much care should be devoted to the selection of information to be disclosed as to the protection of the records from improper disclosure.

The Hippocratic Oath clearly implies that the ethical duty of