Medicolegal

The Savage case: disciplining consultants

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Three weeks ago Mrs Wendy Savage, consultant obstetrician to Tower Hamlets District Health Authority and a senior lecturer at the London Hospital, Mile End, was awarded the fellowship of the Royal College of Obstetricians and Gynaecologists. Yet for the past two months she has been unable to practise obstetrics. On 24 April she was suspended on full pay from her consultancy and teaching duties pending the outcome of a health authority inquiry into five complaints of alleged malpractice.

The furore over the suspension of a consultant popular with general practitioners and patients—68 of the 84 local general practitioners have signed a petition calling for her reinstatement, a 1000 strong protest march over her suspension took place last week, and several Labour MPs have signed an early day motion supporting her—has focused unprecedented attention on the NHS procedure for handling serious disciplinary charges against hospital doctors. Mrs Savage's supporters say that the inquiry procedure, intended to deal with serious allegations involving professional conduct or competence, is being used to wage a battle between the high tech, interventionist, hospital based school of obstetric practice and the community based, woman centred approach that she favours.

The investigation was instigated by the professor of obstetrics at the London Hospital, J G Grudzinskas, and two consultant colleagues, Trevor Beedham and John Hartgill. All the allegations concern obstetric care. In only one of the cases did a patient complain, and that complaint was disposed of at the time with no disciplinary action. In two of the cases the baby died. In neither of those cases was Mrs Savage present at the time. Four of the five complaints centre around caesarean deliveries that her colleagues allege were done too late. Three involve breech births. Mrs Savage has the lowest rate of caesarean deliveries at the London Hospital—7.5%, as against an overall rate of 10% at the hospital's Mile End site and 15% at the Whitechapel site. (A recent survey by the Maternity Alliance put the national average at 11%.)

In setting the investigation in train Tower Hamlets health authority followed the procedure set out in HM (61) 112, a Ministry of Health circular published in 1961. In cases involving complaints about professional conduct or competence the authority must make preliminary inquiries to decide whether there is a *prima facie* case that, if well founded, could result in serious disciplinary action, such as dismissal. The circular does not lay down what form the preliminary inquiries should take. In deciding whether there was a *prima facie* case against Mrs Savage the health authority approached Mr Gordon Bourne, now retired but at the time the regional obstetric assessor and a senior consultant at St Bartholomew's Hospital. Barts and the London Hospital share a joint department of obstetrics and gynaecology. Professor Grudzinskas was a lecturer at Barts and worked under Mr Bourne.

Once a *prima facie* case is established the next stage is a formal inquiry. Before the chairman of the health authority decides whether an inquiry is necessary he must warn the doctor of the nature of the complaint and the possibility of an inquiry that might lead to serious disciplinary action, and send him copies of all relevant correspondence. The doctor should be given reasonable time to take advice and to make representations before a decision on whether to hold an inquiry is taken. An inquiry is unnecessary when there is no dispute over the facts or when the doctor has been found guilty of a criminal charge in a court of law.

The chairman of Tower Hamlets health authority, Mr Francis Cumberlege, announced on 9 May that an inquiry was to take place in Mrs Savage's case, though (according to her solicitor) the district medical officer had given her until 22 May to comment on the allegations against her. Last week, however, the authority acceded to her solicitor's request to send reports on the five cases to an outside expert. Professor John Dennis, professor of human reproduction and obstetrics, University of Southampton, and consultant obstetrician and gynaecologist at the Princess Anne Hospital, Southampton, is expected to report within the next two weeks.

If the authority decides to go ahead with the inquiry it is unlikely to convene before the autumn. Inquiries are chaired by a lawyer chosen from a panel kept by the Lord Chancellor, flanked by two consultants chosen in consultation with the Joint Consultants Committee. Neither consultant must be connected with the hospital concerned. The inquiry hears evidence from witnesses for both sides, who are subject to cross examination. Should a doctor be cleared after an inquiry the health authority is not liable for his costs. The defence societies will advise and assist doctors involved in disciplinary proceedings and refer those who need legal assistance to the societies' solicitors. Doctors who prefer to choose their own solicitors—Mrs Savage is being advised by Brian Raymond, whose other clients include Clive Ponting—will usually have to find their own funds.

The doctor need not be suspended, but the authority has a right to suspend from duty where required "in cases of a very serious nature." HM (61) 112 is not as rarely used as press reports of the Savage case suggest. Defence society sources reckon that possibly as many as a dozen consultants a year are involved in a preliminary investigation under the procedure, though only some two or three such investigations go to a full inquiry. Complaints may be initiated by patients, colleagues, nurses, or non-medical staff. Cases in which the procedure has been invoked are a mixed bag, including cases of alcoholism, addiction, and psychiatric disorder (though there is a separate procedure, HM (82) 13, designed to help prevent harm to patients that results from physical or mental disability—including addiction—of medical staff, which is more likely to be used where the doctor admits his problem) and cases in which a consultant is simply impossible to get on with and quarrels constantly with colleagues.

If the doctor is found to be at fault and is dismissed he has the right, under paragraph 190 of the Terms and Conditions of Service of Hospital Medical and Dental Staff ("the red book") to appeal to the Secretary of State, who will put the case before a professional committee of civil servants and doctors. Having had their advice,

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the Secretary of State may confirm the dismissal, reinstate the doctor, or arrange a compromise solution (such as re-employment in a different post).

A consultant who thinks that he has been unfairly treated by health authority disciplinary or disputes procedures may decide to take the authority to court. Mr Tony Bliss, a consultant orthopaedic surgeon, won damages of £106 000 for breach of contract in the Court of Appeal two months ago. A feud developed between Mr Bliss and Mr Robert Hay, a colleague at the Medway Hospital, Gillingham. Mr Hay asked the authority to consider suspending Mr Bliss. Under the procedure laid down by HM (60) 45 (now HM (82) 13), the procedure for preventing harm to patients resulting from doctors' disabilities, a subcommittee of the medical staff committee—the "three wise men"—met and decided that Mr Bliss should undergo a psychiatric examination. He refused and was suspended. Disciplinary charges were brought against him but were dismissed. The authority lifted his suspension and withdrew the requirement to undergo a psychiatric examination. But Mr Bliss did not return to work at the hospital. He was given study leave and continued to accept his salary until his solicitors wrote to the authority asserting that its actions amounted to a repudiation of his contract of employment. The court decided that the authority had no reasonable grounds for requiring Mr Bliss to submit to an examination to confirm that there was no illness but merely a severe

breakdown of personal relationships. The requirement and subsequent suspension were a breach of contract which repudiated the contract, and Mr Bliss was not affirming the contract by continuing to accept his salary. A doctor who accepts reinstatement can still sue for breach of contract, but the damages, if he wins, will be considerably smaller.

Disciplinary procedures can drag on for years, leaving a doctor in a seemingly open ended limbo. Dr Charles Entwistle has now entered his fifth year of suspension on full pay from his post as consultant psychiatrist at Rubery Hill Hospital, a psychiatric hospital with a secure unit, over allegations about the treatment of 16 patients. Suspended in May 1981, he was dismissed without an HM (61) 112 inquiry in September 1983. He appealed to the Secretary of State under paragraph 190 of the red book and also won leave to apply for judicial review in the high court of the decision by the West Midlands Regional Health Authority to dismiss him. The application for judicial review was adjourned pending the outcome of the appeal to the Secretary of State. Last February the Secretary of State instructed the health authority not to operate the dismissal but to hold an inquiry. The inquiry is not expected to convene until the autumn. Two consultant pathologists from the same authority, Dr Terry Marshall and Dr Peter Fletcher, are to appeal to the Secretary of State after their dismissal last week for failing to pay private fees over to the health authority.

How common is it for ovarian cysts to contain a fetus?

Ectopic pregnancy in a normal ovary is unusual, and primary ovarian implantation is said to occur in only 1% of ectopic pregnancies.^{1,2} The true incidence, however, is difficult to assess because the condition generally ends early in haemorrhage,² and it has recently been suggested that ovarian pregnancy accounts for almost 3% of ectopic pregnancies, or 1 in 7000 pregnancies.¹ Ovarian pregnancy may be misdiagnosed as a bleeding corpus luteum or a tubal pregnancy, and strict criteria have been laid down for its diagnosis.^{1,3} Histological examination usually shows decidual and trophoblasts with occasional chorionic villi,¹ and an embryo was identified in only 12% of cases in one series,² though in another series of 24 cases two reached the second trimester.¹ The condition is presumably caused by the fertilised ovum adhering to the ovary.² In an abnormal ovary ovulation may still occur, and a few cases have been reported of pregnancy in a pathological ovarian cyst—for example, an endometriotic cyst or a cystic teratoma.¹ Such cases are extremely rare.—JAMES OWEN DRIFF, senior lecturer in obstetrics and gynaecology, Leicester.

- 1 Grimes HG, Nosal RA, Gallagher JC. Ovarian pregnancy: a series of 24 cases. *Obstet Gynecol* 1983;61:174-80.
- 2 Hallatt JG. Primary ovarian pregnancy: a report of twenty-five cases. *Am J Obstet Gynecol* 1982;143:55-60.
- 3 Yu TJ, Iwasaki I, Teratani T, Tanaka T, Aoki M. Primary ovarian pregnancy in a cystic teratoma. *Obstet Gynecol* 1984;64:52S-4S.

Can the use of dichlorvos in clothes' cupboards in a relatively unventilated bedroom cause nocturnal cough and mild respiratory distress possibly due to bronchospasm? If so can persistence of the symptoms after removal of the dichlorvos be due to residual insecticide in the clothing? Can a safer alternative be suggested for eradicating clothes' moths?

Dichlorvos (DDVP; 0,0-dimethyl-0-(2,2-dichlorovinyl) phosphate) is an organophosphorus insecticide. According to WHO it is a highly toxic compound,¹ and, being highly volatile and only slightly soluble in water, may be absorbed through the respiratory tract as well as the skin. It acts by causing functional disorders of the central and autonomic nervous systems, consequent on cholinesterase inhibition; its toxicity may be enhanced by the concomitant administration of phenothiazines.² Because it is highly volatile, it is commonly used in proprietary fly killing devices and flea collars for pets. Cough and dyspnoea with bronchospasm and enhanced bronchial secretion are known to accompany organophosphorus poisoning. Absence of other evidence—headache, sweating, visual blurring, hypersalivation, abdominal cramps—does not exclude this diagnosis as inhalation of the vapour of an organophosphorus insecticide may cause respiratory symptoms in the absence of systemic poisoning.³ Bronchial asthma has been reported after accidental inhalation of Phosdrin, a chemically related organophosphorus insecticide,⁴ and after exposure during crop spraying with similar chemicals.⁵ These reports, however, do not indicate whether bronchospasm was due to a

true allergic reaction or to a pharmacological action of the inhaled insecticide on the lung.

If casual domestic exposure to dichlorvos resulted in respiratory sensitisation (and this is questionable) then residual insecticide in clothing might account for persistence of symptoms. Otherwise, contamination of clothing is unlikely to be relevant. It is inadvisable to use dichlorvos in confined spaces or in poorly ventilated rooms, and clothing should be thoroughly aired after treatment. Furthermore, such chemicals should be used only for the purposes specified by the manufacturer and in accordance with his instructions. Advice on alternative methods for the eradication of clothes moths should be obtained from WIRA (formerly Wool Industries Research Association) in Leeds.—W R LEE, professor, and A R SCOTT, lecturer, in occupational health, Manchester.

- 1 World Health Organisation. Recommended classification of pesticides by hazard. *WHO Chronicle* 1975;29:387-401.
- 2 Finkel AJ. *Hamilton and Hardy's industrial toxicology*. 4th ed. London: John Wright, 1983:288.
- 3 Finkel AJ. *Hamilton and Hardy's industrial toxicology*. 4th ed. London: John Wright, 1983:291.
- 4 Winer A. Bronchial asthma due to the organophosphate insecticides: a case report. *Ann Allergy* 1961;19:397-401.
- 5 Wittich FW. Respiratory tract allergic effects from chemical air pollution. *Archives of Industrial Hygiene and Occupational Medicine* 1950;2:329-34.

What diseases might be transmitted during group first aid instruction of mouth to mouth resuscitation? What precautions should be taken to minimise the risk of disease transmitted during such instruction? In what situation should the risk of contracting acquired immune deficiency syndrome deter a would be resuscitator confronted with a real patient?

There is a risk of catching any infectious disease carried in or around the mouth, in the sputum, or in droplet form in the expired air. This may vary from a simple common cold, to herpetic infections, to the more serious hepatitis. It is necessary to add that the risk is probably no greater than casual oral to oral contact. Direct oral contact with other trainees should be minimised and all equipment, including resuscitation mannequins, properly disinfected. Adequate instructions are provided with most commercial mannequins. Any infected trainee should be isolated from using equipment in common use. Autoimmune deficiency syndrome is believed to be caused by human T lymphotropic virus III. Experience from the United States leads us to believe that although the virus is found in the saliva of infected patients, there have been no reported incidents of infection resulting from mouth to mouth resuscitation. The high risk "unknowns" include haemophilias, intravenous drug abusers, and homosexuals. When dealing with any of these groups it would, despite the above, seem sensible to take precautions to avoid direct contact with saliva or blood. Thus a "Brook airway" may seem a sensible precaution. It should be emphasised that if resuscitation is delayed the victim may die as a result of the supposition of a rescuer.—D A ZIDEMAN, consultant anaesthetist and honorary senior lecturer, London.