LEGAL RELATIONSHIPS

Anyone who renders a service to another will find that he has become related in a legal sense to that person. The common law is clear on this.

Criminal responsibility

Everyone knows what criminal law is about, yet, strangely, there is no adequate legal definition of crime. The accused knows that his adversary is usually the State in the form of a policeman. There are strict rules of evidence and the burden of proof is on the prosecution, who can obtain a conviction only on proof beyond all reasonable doubt. The outcome can be punishment of some kind and the convicted person is said to be repaying his debt to society. It might not be expected that this branch of the law should fall within the compass of this article, but it is to be remembered that simple assault and battery—the actual touching of a person—are both civil wrongs and criminal offences. Abortion, child destruction, sexual offences of various categories, indecency, misuse of controlled drugs and manslaughter are but a selection of crimes which have featured from time to time on the charge sheets of doctors in criminal proceedings. Aiding and abetting, as for example by assisting at an illegal operation by administering an anaesthetic, makes that person a principal offender.

There is a movement towards the creation of a new offence of mercy killing carrying a penalty of a maximum of 2 years of imprisonment. Some lawyers view this emotive proposal with alarm and suggest that the existing law governing homicide should be preserved.

Civil liability

It is in the field of civil law that doctors are more likely to become involved in their daily practice.

Contracts. Where the patient and his medical attendant have entered into a contract both parties will be bound by its expressed and implied terms, breach of which could provide a basis for recovery of damages.

It is conceivable that the practitioner might wish by means of an appropriate drafting of the contract to limit his liability; whilst, for his part, the patient could well seek to obtain more extensive or a more stringent standard of treatment than would exist in the absence of any contract. Subject to any statutory restriction as to what the law regards as unfair, mutually agreed terms are binding on both parties. A practitioner would thus place himself in an invidious position should he inadvertently guarantee a successful treatment which failed to materialize—cosmetic plastic surgery would provide a fertile field for such a contractual indiscretion.

Trusts.

In some relationships there will arise, in law, a presumption of undue influence: trustee and beneficiary, solicitor and client, parent and child, guardian and ward are examples. Doctor and patient is another. In the event of his purchasing land or property from a patient or of becoming a beneficiary under a patient's will then the law presumes that the doctor obtained a benefit as a result of exercising undue influence. If called upon to answer, the burden is on the doctor to prove that the patient acted with the unfettered exercise of independent will. This rule arises out of the implied trust created by their special fiduciary relationship. It is this position of trust which also imposes upon the doctor an obligation to preserve professional secrecy in confidential matters disclosed by the patient.

Torts. Assault, battery and conspiracy are crimes. They are also torts; therefore not only can the defendant be punished on conviction in a criminal court, but the victim may also obtain damages in a civil court. False imprisonment, deceit and conversion are torts—so are nuisance and trespass. A tort is a legal wrong which is quite independent of contract. Whereas a contract is created by voluntary agreement between the named parties, liability in tort is owed to people in general and is an obligation fixed by law. An aggrieved party who has suffered as a result of the...
tortious act or omission of another has a right to the award of damages against that other person.

In medical practice the common sources of legal proceedings are assault, defamation and negligence. Assault is considered later with consent to treatment. Defamation by colleagues, alas, is not uncommon. A patient may succeed in a libel suit if it can be shown that statements in a referral letter were actuated by malice. Injudicious remarks about patients within the hearing of others can amount to slander.

The bulk of legal problems, however, falls within the tort of negligence which commonly concerns health authorities, hospitals, clinics and their employees; this is the subject which concerns us in the remainder of this article.

For a negligence claim to succeed, the plaintiff must prove three elements: that the defendant owed him a duty of care; that there was a breach of that duty and that, as a result, the plaintiff suffered damage. The plaintiff must show that he suffered damage—breach of duty which does not result in damage does not constitute negligence. The burden of proof is on the plaintiff who must prove his case on a balance of probabilities—a standard, it will be noted, which is lower than that required in the criminal courts.

PARTIES IN LEGAL PROCEEDINGS

The writ
A civil action for recovery of damages ordinarily starts with the issue of a writ of summons endorsed with a statement of claim describing in detail the plaintiff’s allegations of negligence. The names of all the plaintiffs and defendants are set out at the head of the writ which must be served on each defendant either personally or on his solicitor within a prescribed period.

Mental patients
A person who by reason of mental disorder is incapable of managing his affairs suits by his next friend. In an action against him a mental patient defends by a guardian appointed by the court. The management of such affairs is ordinarily exercised by the Court of Protection.

Minors
A minor also sues by his next friend and defends by a guardian appointed by the court. Any damages recovered by a minor must be paid into court and no settlement can be agreed except by approval of the court.

Death
Many causes of action which are vested in or subsist against a person who dies survive for or against his estate. Thus the estate of a deceased person will be represented either by the executor of the will or the administrator appointed by the court.

The defendant
Obviously, the defendant should be the one who caused the mischief, but if that person happens to be a porter or an impecunious medical student the likelihood of recovering damages would be remote. It is customary in such cases for the proprietor of the hospital to be named as the defendant.

Employer’s vicarious liability
Where the plaintiff is unable to name individuals in the writ, the vicarious liability of the proprietor will entitle him to obtain a contribution or indemnity from those employees who were themselves responsible.

Everyone who holds himself out to have a particular skill is obliged to exercise it. Thus, a nurse must exercise her skills at the level which the law demands of the particular individual from student nurse to matron. This principle raises two issues: delegation and training.

Delegation. The general rule is that any task may be delegated provided it lies within the competence and experience of the person required to carry it out. Taking blood from a vein does not necessarily require the services of a doctor or even a nurse. On the other hand, injecting a drug into a vein is entirely different: the standard now requires a higher level of competence on the part of the operator. For example, he must consider the possible sequelae of extravasation and of the effects of a too rapid injection, and the possibility of anaphylaxis. Given that a task has been properly delegated, then the responsibility falls fairly upon him who accepts it—no-one can escape from a duty which has been properly imposed.

Personnel in training. Similar principles apply to those in training, but it is necessary to distinguish a gradation in the levels of trainees. Medical students, for example, are liable for their errors but the question of delegation must be viewed more critically than in the case of qualified practitioners. The pre-registration year is regarded by the General Medical Council as an extension of the undergraduate training period: supervision, especially in accident departments, must be direct and it is not sufficient for a registrar to be available in bed a mile away. Staff in middle-grade
posts sometimes find themselves in difficulty because of their inability to judge their own limitations. Attempts to administer a general anaesthetic to a patient with oedema of the larynx or pharynx have been known to lead to disaster because of failure to assess that tracheotomy under local analgesia was mandatory in that particular case.

Emergency obstetric anaesthetics are a common source of avoidable morbidity in the hands of inexperienced junior anaesthetists. Matters of this kind raise the question upon whom should responsibility fall. Although the consultant is in overall charge, clearly he cannot exercise continuous and direct supervision—such a condition is simply not practicable and he must be allowed to rely on a measure of delegation where appropriate.

**Employer's direct liability**

Mention has already been made of the employer's vicarious liability for his employees. It would be wrong to imagine that the employer's liability is limited in any way by this rule of law. Of equal importance is his direct or personal liability, and it is necessary to emphasize this aspect otherwise there is a danger that it may be assumed, incorrectly, that a health authority, for example, can shelve its responsibilities on to the shoulders of its staff. Thus, although an operating department assistant may be responsible for putting a diathermy electrode in place, the hospital proprietor has a personal responsibility to provide suitable equipment and to maintain it properly. It is the duty of the proprietor of a hospital or clinic to establish and maintain a safe system by the provision of adequate accommodation, staff, facilities and equipment.

A further illustration of an employer's personal liability is to be seen in the control which he must exercise over the organization of his establishment, including the determination of policies which define the limits of the service which it is aimed to provide.

In private practice, of course, the doctor can exercise as much control over his daily case load as he wishes. Although, in contrast, the practitioner in hospital employment does not have the same control, nevertheless he is obliged to draw his employer's attention to any avoidable situation which could place a patient at risk. Operating in theatre suites which are overheated or contaminated is seldom excusable, and a surgeon who continues to accept such dangerous conditions must expect to carry some of the responsibility. Failure to provide adequate postoperative recovery facilities is a fault for which the hospital proprietor must bear the legal burden. An anaesthetist who knowingly acquiesces in maintaining such poor standards will be answerable if the patient should suffer harm as a result and will be responsible if he hands over patients to inexperienced staff or to a situation in which the facilities are inadequate.

**THE DUTY OF CARE**

It is in the judicial setting that the duty of care is determined, taking into account the extent of the duty, the standard of care and the possible risks. Both sides in the legal battle may produce expert witnesses, but it will be the judge who decides upon the issues. He may reject expert evidence in its entirety if the matter before him can be determined without the assistance of expert testimony.

**Extent of duty**

The duty must be owed to the plaintiff himself; not to others. It may be an act, or an omission to act, but in the latter instance there cannot be liability unless some existing duty can be shown—the failure to warn the plaintiff of danger for example. Where the patient is known to be abnormally sensitive to a drug even when given in a normal dose or less, the doctor will be held to have been negligent if damage results as a consequence of its administration.

**Standard of care**

The required standard is that of the reasonable man. Such a person has been described in legal textbooks as the man on the Clapham omnibus, but in medical practice the passengers on that particular vehicle must be selected with care and caution: the defendant should have behaved as a reasonable man would have behaved in his position being neither over-apprehensive nor over-confident. The test is that of a practitioner who professes to have a special skill and exercises it. The fact that the particular defendant is forgetful, foolish, myopic or deaf is irrelevant. The general rule is that there is only one standard of care applicable to the particular defendant—that of the fictitious reasonable man in the same circumstances.

**The risks**

In deciding whether a defendant has shown the requisite standard of care, the courts tend to refer to the concept of risk: they balance the extent of the risk against the importance of the object and the cost of precautionary measures in time, money or trouble.
Performing cardio-thoracic surgery with inadequate monitoring equipment is an example; as is the administration of a general anaesthetic to a patient undergoing an emergency Caesarean section without an available suction line.

Assessment of the standard of care

It would be impossible to cover every eventuality that is met in clinical practice, but there are basic principles which a court is likely to apply to any particular set of circumstances.

History

The patient must be identified and, depending on the circumstances, may need to be labelled: in the case of a baby or an unconscious adult labelling is mandatory. Then follows the routine, hallowed by a century of medical education: taking a history covering symptoms, previous diseases, allergies and any current drug treatment; surgical operations and anaesthetic histories.

Examination

In addition to the obvious need to establish or confirm a diagnosis, physical examination must be sufficient to expose any foreseeable anaesthetic hazards. The state of dentition including the presence of fixed or removable prostheses; limitation of movement of the neck and mandible; suitability for extradural or hypotensive techniques—these are simple illustrations of the many points which may demand attention. Marking the skin to indicate the affected limb or side of the body may be done routinely by a nurse, but it is the surgeon who will carry the ultimate responsibility if the wrong part is removed. The anaesthetist is often the last to see such a patient whilst still conscious and must have some responsibility. Certainly he should be aware of anything which will affect his work, for example, where the resection of a lung is contemplated.

Investigations

Some pathologists and radiologists complain about unnecessary investigations which are said to be in inverse ratio to the status of the doctor requesting them. Clearly, investigations must be selected on clinical grounds which alone will determine the need. There is a direct implication for senior medical staff to supervise their juniors in these matters. Fluid balance, serum electrolytes, cardio-respiratory reserve, radiographs of the chest and thoracic inlet spring to mind, but each case will create its own specific demand. Failure to screen a person suffering from sickle cell anaemia will not invite criticism provided, of course, that the case had been managed on the assumption that screening would have revealed a positive result!

Blood

In many cases the blood group will be determined as a routine and serum held for subsequent cross-matching. Blood transfusion procedures are now so strictly practised that it is surprising to learn that the transfusion of wrong blood still happens. In almost every reported case the blood has been correctly grouped, cross-matched and labelled, but there has been a failure at the bedside to check the blood unit label with the identity of the patient.

Nutrition

Nursing staff will need clear instructions on feeding patients where normal ingestion of a standard diet is impossible or contraindicated; i.v. treatment implies an automatic need for monitoring to avoid circulatory overload and electrolyte imbalance.

Diabetic management may require the intervention of a physician specializing in this field. The point to be recognized is that the medical attendant is under an obligation to seek advice or assistance when he knows or should know that the matter no longer lies within his own field of competence.

Contraceptives

Before undertaking elective major surgery on patients who are taking the contraceptive pill, a surgeon will be expected to have considered the question of postponing the operation until the patient had discontinued taking the pill for at least one complete cycle. Some authorities insist on the pill being discontinued for a period of two or even three cycles.

Thrombo-embolic complications occurring in a patient who had undergone elective surgery whilst taking oral contraceptives would present difficulties to the defendant doctor, not least that of finding an expert witness who would be prepared to enter the witness box to testify on his behalf.

Drugs

Treatment cards and instructions to nurses invite criticism if they are illegible or slovenly written and as a result the patient receives the wrong drug or an incorrect dose. It is unfortunate that drugs with names that are engagingly similar can be quite dissimilar in
their properties: a scribbled word which looks something like papaveretum, papaverine or Pavulon can present a harassed nurse in a moment of stress with an easy error of choice with disastrous consequences. Minims, milligrams and millilitres continue to be confused by nurses. Inadvertent use of potassium chloride instead of sodium chloride for i.v. injections produces the inevitable and tragic result. Spelling and clarity in the writing on a treatment card can become quite an important issue.

In an emergency a nurse may be obliged to act on a verbal prescription for a controlled drug, but such a practice is unsafe and illegal.

Those who do not favour pre-medication before general anaesthesia must be prepared to submit to cross-examination in court at the hands of counsel who has been briefed by an expert witness of the opposite school of thought if the patient should suffer harm and the question of pre-medication becomes an issue.

**Emergencies**

It is in vitally urgent surgery where clinical judgement is paramount. Confronting the surgeon and anaesthetist is the agonizing choice whether to undertake immediate surgery to secure arterial bleeding in a viscus or to attempt prior resuscitation. Perhaps this is an occasion when the doctor would expect to be immune from criticism and certainly free from guilt, but one cannot depend upon this assumption; armed with knowledge derived from hindsight a surviving husband may prove to be a determined adversary following the death of his wife as a result of a ruptured ectopic pregnancy.

Many emergencies are dealt with by junior doctors, often at night when the department is denuded of experienced ward sisters and the operating theatre inadequately staffed. This is fertile ground for the litigant and it behoves senior medical staff to maintain a continuous supervision of their emergency arrangements.

Emergencies in obstetrics are often distinguished by the associated triad of difficulties: the patient is unprepared for surgery, she has a full stomach and the emergencies are frequently handled by junior medical staff. Confidential enquiries into maternal deaths reveal each year an unchanging incidence of avoidable mortality arising from the unsuccessful efforts of inexperienced anaesthetists. Repeated oral doses of antacids are claimed to reduce the incidence of the acid-aspiration syndrome, but this form of prophylaxis alone is insufficient if other measures are ignored, such as reducing the gastric volume by suction and using a rapid endotracheal intubation technique with cricoid pressure preceded by a period of oxygenation by mask.

Increasing enthusiasm for extradural analgesia raises the question of delegating to midwives the task of administering incremental doses of analgesic for continuous extradural blockade. Obviously, to be satisfied as to the safety of such delegation a consultant would need to be certain that the individual midwife was properly trained in recognizing abnormal reactions and signs of overdose.

In countries where termination of pregnancy has been legalized the operator, the anaesthetist and theatre staff actively engaged in the procedure must ensure that all the necessary formalities required by regulation have been fulfilled before the start of the operation. Failure to do so could lead to a prosecution for illegal abortion.

**Day surgery**

Careful administration is an essential requisite in the organization of a day surgical unit. The late arrival is a particular source of trouble since he can dislocate the routine of questioning about recent meals and dentures and may fail to complete the consent form properly after an explanation of the proposed treatment.

Giving clear warning against driving and other hazards after a general anaesthetic is mandatory.

The use of topical analgesia to the pharynx or larynx requires a warning to avoid oral ingestion of fluid or solid food until the recovery of sensation.

**Electroplexy**

Candidates for electroplexy are often managed as day patients with the attendant difficulties already described, particularly the hazard of a full stomach in an unreliable patient unsupervised by any relatives. The anaesthetic may even be given by a junior psychiatrist with only limited knowledge and experience of the procedure. The employment of such personnel can lead to potentially hazardous conditions. For example, the doctor giving the anaesthetic may fail to appreciate the necessity to have immediately available adequate resuscitation facilities or to possess the ability to use them effectively.

**Mental subnormality**

Mentally subnormal patients of any age may not be able to comprehend the nature and purpose of an investigation or surgical operation and, therefore, cannot give a valid consent. Such patients may only be
subjected to an operation or other procedure where it is rendered necessary to save life or limb. No elective operation can be performed, regardless of its apparent desirability, except on the ground of necessity.

A practical question which frequently arises is the desirability of performing a vasectomy or tubal resection for contraceptive purposes on social grounds. Where the patient’s mentality prevents him from giving a valid consent then such an operation would be illegal.

**General dental practice**

Chairside dentistry poses certain problems when a general anaesthetic is required. Clearly the anaesthetic should never be given by a single-handed operator. Unless the anaesthetist has had specialist training and adequate facilities are available, patients at risk should be screened and considered for hospital treatment under full theatre conditions. Young unstable diabetics, patients with myocardial disease and those of restricted respiratory reserve are typical high risk groups.

**Organ transplantation**

The volunteer donor merits special interest within the context of this article. Of vital importance is the question of consent. There must be no doubt in the donor’s mind as to the risks which he faces when he undergoes hazardous investigations and a major operation under general anaesthesia which is undertaken for no beneficial objective so far as the donor is concerned. Interview and explanation must be in the hands of a senior member of the medical staff.

A minor cannot give consent to act as a donor. The moribund donor presents several different aspects. Professional bodies such as the Royal Colleges in the United Kingdom have proposed a procedure by which the determination of death should be reached by the consultant in charge and one other doctor. The procedure is easily followed and its application should remove any difficulty over the declaration of death based, as it is, upon clinical measurement. To maintain public support and trust it is advisable to keep close liaison with the Coroner who should be provided with full clinical details of the patient’s terminal condition. Written agreement must be obtained from the person in possession of the body giving authority for removal of organs or tissues *post mortem*.

**Radiology**

Modern radiological developments have led to sophisticated investigations which are themselves hazardous and this is relevant to the question of consent. Air encephalography and computerized axial tomography in a restless patient both require general anaesthesia which also must be taken into account in the overall assessment. Some contrast media are known to have toxic effects or to produce an anaphylactic reaction which could be fatal. Intravascular catheterization for angiography is not without risk of vascular damage and embolism. Patients are entitled to know the risks and indeed must be told of them where the frequency is high.

The 10-day rule must be observed in order to reduce the likelihood of irradiation of a foetus. The responsibility for checking the date of the last normal menstrual period is a shared one between the practitioner requesting the investigation, the radiologist responsible for organizing his department, the receptionist in the radiology department and the radiographer who takes the film.

**CONSENT TO TREATMENT**

Assault and battery are both civil wrongs and criminal offences. An assault occurs when a person is put in immediate fear of being touched intentionally or negligently by another person. When actual physical contact occurs then a battery has been committed and the victim has a legal remedy without the need to prove that he has suffered any harm. Is further emphasis required to underline the importance of obtaining consent before a doctor undertakes an examination, investigation or treatment?

Consent may be implied by the patient’s conduct, for example, when he opens his mouth whilst sitting in the dental chair. It may be given expressly in conversation. Either form is effective, but consent given expressly in writing is preferable because it can be retained as a record in the event of subsequent dispute. A patient, seated in the dental chair with his mouth pointing motionless to the ceiling, cannot deny his implied consent to something, but if the dental surgeon is contemplating the extraction of the upper incisors it is wise to have such an intention approved by written consent.

To be valid the consent must be informed; that is, the nature and purpose of the proposed operation must be explained to the patient and consent must have been fully and freely given. The explanation should be given by a medical or dental practitioner, who, as a general rule, should disclose any special risks, but on occasion the doctor may be justified in minimizing or not revealing the risks involved if it is necessary to do so in the interests of the patient. If the
full extent of the operation cannot be determined beforehand, the consent should be drawn up to include any further or alternative procedure that may be found to be necessary in the course of the operation.

Where a patient is under the influence of alcohol or drugs, including premedication, he may claim later that he was unaware at the time that he was giving his consent which may thus be declared invalid. On attaining the age of 16 years a minor can give effective consent to treatment and in such cases it is not necessary to obtain consent from the parent or guardian.

The consent of a mentally subnormal person over the age of 16 years will only be valid provided he is capable of understanding the nature and purpose of the treatment. From this it follows that a severely subnormal woman cannot consent to an operation for sterilization whether or not there are medical or psychiatric grounds to support such a procedure—the wishes of parents or anyone else are irrelevant. Sterilization of a normal person can be done with the consent of the individual whether or not there are medical grounds, but where the operation is to be carried out simply as a convenient form of contraception then, if the couple are living together, it would be advisable to obtain the concurrent agreement of the spouse in order to forestall any future dispute on the subject.

Persons suffering from mental illness may be capable of giving valid consent depending on their particular condition. Where a mental patient is compulsorily admitted to hospital any statutory provision for compulsory treatment only applies to the mental condition itself—it does not, for example, enable a surgeon to perform an orchidectomy or hysterectomy without the patient’s consent.

The faith and wishes of religious sects are entitled to be respected. The need to administer blood or blood products to Jehovah’s Witnesses can lead to difficult problems. Sometimes an explanation of the clinical picture will persuade the patient or, in the case of a child, the parent or guardian to agree to a transfusion should the necessity arise. If such an approach should fail then, as far as children are concerned, the doctor must base his decision upon clinical need whether to transfuse in order to preserve the child’s life or limb. Where a child is in hospital some health authorities favour the procedure whereby a court order is obtained for removal of the child from the custody of the parents so that the necessary consent can be given by the person to whom the court entrusts the custody. Although this may be administratively expedient, it is not a satisfactory solution and is not recommended because the decision remains to be determined on clinical grounds by the practitioner directly concerned. Where the patient is an adult he should be required to sign a statement relieving the hospital authority and staff of all liability from damage resulting from the restrictions placed upon them. If the patient refuses to sign the statement of release the doctor must proceed according to his professional conscience, but he is under no obligation to treat that person.

In emergencies affecting children where time is of the essence it may not be possible to obtain consent from parents or guardians, in which case the doctor must take whatever course is dictated by clinical necessity: the decision is his and cannot be transferred to an attendant schoolmaster or scout leader. The health or life of a minor must not be put in jeopardy by waiting for formal parental consent. In these circumstances the doctor should render all such treatment as is reasonable and necessary.

**PREPARATION FOR INDUCTION OF ANAESTHESIA**

For some patients this is a critical period because of the regrettable absence of an earlier outpatient examination or ward visit by the anaesthetist, and this is the first time they will be seen by him. For others, equally regrettable, it will be the first time they will have the opportunity of being seen by the surgeon before he starts the operation. It is a period when much ground may need to be covered quickly because of the timing of the operating schedule. To simplify the exercise the reader is invited to imagine himself, with all his knowledge and professional experience, as the patient but with the same loss of control over his immediate destiny as any other patient.

On arrival in the theatre suite you should be wearing an identity bracelet and accompanied by your own case-notes including a signed consent form describing the proposed operation or investigation. There should be a mark on your skin to indicate which limb or side of the body is the affected side. It is your hope that the anaesthetist will have visited you before, but in any case will read your notes to acquaint himself with your physical condition and the identity of any drugs you may be taking; that he will look into your mouth for dental prostheses and generally satisfy himself that there are no foreseeable difficulties in the way of a successful induction of a general anaesthetic or the performance of an extradural analgesic. Finally, it would be reassuring to be able to acknowledge that you have not had a recent meal or developed an upper respiratory tract infection since admission—assuming,
of course, that you are sufficiently awake to understand the question.
Following this introduction you play a less active part in the proceedings and, depending on your level of awareness, simply become an impotent observer. A battery of charged syringes are arranged correctly labelled with the contents which have been drawn from ampoules read by the anaesthetist. The machines are ready for use, having been checked by the anaesthetist, found to be in safe working order and delivering volatile agents and gases in accordance with the labelled cylinders and pipe-lines. Your last hope as your sleep deepens is that you will remain in skilled and careful hands until your return to consciousness, placed in a position that will make peripheral nerve damage impossible.

RECORDS
An inaccurate or incomplete record which leads to damage becomes an ingredient of the act of negligence and, moreover, is evidence of it. The legal importance of good record keeping for the protection of medical and nursing staff is probably equal to its clinical importance for the patient.

The aptitude to write legibly with clarity of expression is a gift which seems to have been bestowed sparingly upon many whose business it is to write notes in clinical records. A careless, illegible script may be full of meaning to the author, but is of limited use to others who are called upon subsequently to continue treating the patient. Typewritten notes have much to commend them, but additional errors can easily be introduced, rendering careful cross-checking essential.

Case notes should contain all essential and relevant details. Many hospitals keep an operating theatre book containing details of operations and anaesthetics. There appears to be no known reason for this practice, but it may possibly have some administrative or statistical purpose. The disadvantage of maintaining such a book is that the essential details entered therein often are omitted from the individual case notes.

The quality of the medical records often assumes crucial significance in legal proceedings and a doctor’s defence may be severely prejudiced by the absence of written records. Inadequate notes often present a real handicap in court: not only is the contemporaneous record of the precise treatment insufficient to support the oral testimony of the doctor, but the very fact that it was not recorded tends to throw doubt upon his credibility—perhaps even his creditability, thus dealing the fatal blow to an already weakened defence.