MEDICINE AND THE LAW

Unwanted hysterectomies

Except in an emergency, a patient about to undergo a surgical procedure will be asked to sign a consent form. Where this form includes permission for such further surgery as the surgeon thinks necessary there should, in my view, have been a discussion with the patient about those further options that might arise during the agreed procedure. Otherwise a catch-all form may not constitute consent and a dissatisfied patient may seek remedy via the police or by civil proceedings against the surgeon for compensation.

In the UK several claims arising from unwanted hysterectomies are being investigated by the Crown Prosecution Service (CPS). The latest complainant is a 75-year-old woman who, in October, 1991, went into hospital in the north of England for non-emergency treatment for bladder prolapse, having made it clear to the consultant that she did not want a hysterectomy. In the event a hysterectomy was done because the surgeon (not a consultant) believed it to be the best course of action. The hospital accepts that the hysterectomy was unwanted but is reportedly[1] defending the claim on the grounds that it appeared medically indicated to the surgeon.

The patient alleges that, when asked on the day after surgery how the hysterectomy was, she responded, "You must be talking to the wrong person"; that the doctor then revealed that she was the surgeon and had done a hysterectomy; that a request to see somebody in authority was refused; and that she was invited to sign a paper to confirm that she had had the operation, a paper she later realised to have been a consent form with the previous day's date on it. An independent consultant who has reviewed the case records considers a hysterectomy to have been unnecessary and unwanted and that a repair without hysterectomy would have been possible. A consultant at the hospital has denied the allegation that the patient was invited to sign a consent form after the operation.

The CPS still has under consideration papers relating to a woman in her early '50s who went to the police after an unwanted hysterectomy at a London hospital last year.

In medicolegal practice, civil claims arising from unwanted surgery—ie, procedures going well beyond what had been discussed with and agreed to by the patient—are not that unusual. I myself have handled three in the past 12 months. The damages recoverable in the UK are usually modest, however, and neither assuage the hurt felt by the complainant nor attract the sort of publicity that would prompt surgeons to think collectively about the matter.

The CPS and civil action apart, another route is the National Health Service complaints procedure. In 1982, a woman in her late 20s, happily married and hoping to have a family in due course, was admitted to hospital for an emergency appendicectomy. At operation the surgeon discovered severe endometriosis and called in a gynaecologist, who felt that the best option would be to remove the affected tubes and ovaries. It transpired that the patient had had a bilateral ovarian cystectomy for endometriosis in 1979, but had not been told that this was likely to be a serious problem in future.

The patient was devastated to discover that she had lost the ability to conceive normally. She became depressed, her marriage broke down, and she lost all faith in the medical profession.

In 1992, the hospital agreed to her request for a review of her complaint and case-history. The review[2] found that the gynaecologist had been in a very difficult position when called in by a consultant general surgeon because he had no chance to talk to the patient. "It is clear that he performed the surgery in a way which he felt to be in the patient's best interests", and this the patient has accepted. The endometriosis had caused such damage that natural conception would have been impossible; both ovaries were largely replaced by endometriotic cysts and "no other treatment short of excision of the affected areas would be sufficient to cope with the disease process".

The review acknowledged that the patient was upset that she had had no choice and noted that new consent forms have a space in which patients can designate procedures which they do not wish to be done. However, what happened to this patient during the appendicectomy is not something that she could have been expected to need to refuse. As she herself has told me, ". . . it would not occur to me to state that I did not want my ovaries, fallopian tubes etc removed any more than I would say I do not want my left leg or right arm removed. To me they are totally unrelated organs and I find this part of their report ridiculous".

Women who awake from an anaesthetic to find that, totally unprepared, they have lost womb, ovaries, or fallopian tubes, see what has happened to them as "worse than rape" or as "castration". Often, but not always it seems, the further procedures will indeed have been medically well justified, but not emergencies. So there may be a choice—namely, a delayed procedure with renewed consent, albeit with the risks and inconveniences attached to a second operation. Surgeons should neither underestimate the devastating effect on patients presented with an unwanted *fait accompli* nor confuse expediency with the genuine emergency that brooks no delay and provides little opportunity for preoperative discussions.

Diana Brahams

1 Nelson D. Patient, 75, sues over emergency removal of womb. *Observer* July 11, 1993.
2 Complaints Procedure: annexe B to HC(88) 37. Held at Wessex Health Authority, Winchester, March 23, 1992.

William McBride's penalty

Almost six months after being found guilty of scientific fraud (see *Lancet* Feb 27, p 550), celebrity obstetrician Dr William McBride has been deregistered by the New South Wales Medical Tribunal. "Dr McBride's character mirrors the classic tragic character—the person of eminence in public life whose good deeds and interest in human welfare command respect and admiration, but who is brought down by a fatal flaw in his character . . . His [fraud] was not the honest mistake of a naive man, ignorant of the ways of true science; it was not an error of judgement caused by an excess of zeal because of concern to get out an early warning to the public." He had not acted in haste, nor was he in poor physical or mental health, the tribunal said. "His acts demonstrated a course of premeditated deception in the field of medical research and indicate a serious flaw or defect in his character, a trait of dishonesty."

In February McBride was found guilty

on 14 counts of scientific fraud after a hearing of the NSW Medical Tribunal lasting 22 months, with 198 sitting days and costing A$ 5–7 million. The charges related to an experiment published in the *Australian Journal of Biological Sciences* on hyoscine, an anticholinergic agent related to one of the components of the anti-nausea drug Debendox. In the experiment conducted there were six rabbits, one deformity, and no controls. The published study had eight subjects, with three deformities and eight normal controls. It was now statistically significant. McBride used the experiment as part of his warning that Debenox was teratogenic. It followed earlier warnings from McBride about the teratogenicity of thalidomide (subsequently proved true) and imipramine (a claim he was forced to withdraw for lack of evidence). During the 1980s, McBride frequently gave expert testimony in US courts on claims for compensation following birth defects. His recollections of experiments he described as the basis for his testimony were dismissed by the tribunal as faulty.

67-year-old McBride, who was overseas at the time of the decision, was quoted in local newspapers as being ". . . shattered. The whole thing is terrible, devastating. It is a bloody awful thing to do to someone at the end of a career. Whatever the medical tribunal thought of me as a scientific researcher, I thought they might give me no more than a reprimand on the basis of the whole hearing". But the tribunal disagreed, with a majority conclusion that McBride could no longer be trusted and was not of good enough character to practise medicine.

Mark Ragg

Measuring quality of life

"What's your Euroqol index today?" is unlikely to be a question much put to patients in follow-up visits, at least not in the near future. For one thing, the reliability and validity to this index is still being evaluated. For another, a single global score of well-being based on a standardised questionnaire is unlikely to indicate which areas of life are adversely affected by the health state or the extent of the impact. Some researchers are thus assessing patient-generated measures—single-figure indexes derived from questions about areas of life nominated by the patient. Another approach is the development of health profiles, some illness-specific, others genetic. But even health profiles cannot be expected to be used in isolation.

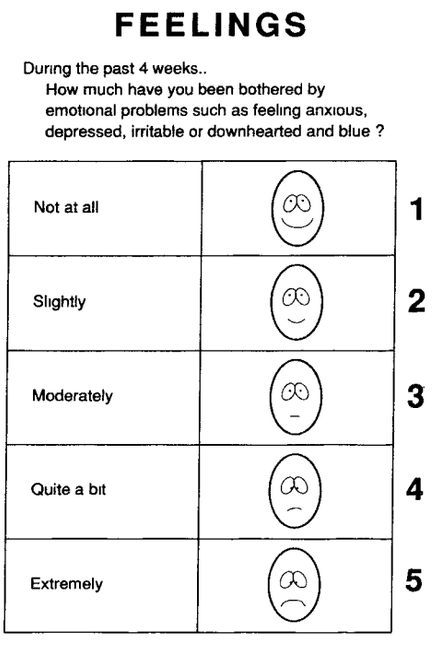

Figure: **A COOP chart**
Reproduced with permission from The Dartmouth COOP project.

A report from the Health Services Research Unit in Oxford provides a review of some of the most widely used generic profiles. The Dartmouth COOP profile, for instance, is based on nine illustrated charts covering physical, social, and role functioning, emotional status (figure), social support, pain, quality of life, overall health, and health change. It gives reasonably high levels of test-retest reliability for single-item measures, though perhaps less so for elderly patients and those in lower socioeconomic classes. The Short-Form (SF) 36 (a 36-item questionnaire covering eight dimensions) has been derived from two large-scale North American studies—the Health Insurance Experiment and the Medical Outcomes Study, both of which collected data on patient-assessed outcomes. The SF-36 has been extensively used in the US. Studies in the UK indicate that it is easy to complete, that there are high levels of internal reliability for the eight items, and that comparison of responses from different socioeconomic groups, from males and females, and from those who reported long-term chronic illness and those who had recently consulted a medical practitioner give the expected differences in profiles. However, there are few data on the extent to which SF-36 is sensitive to clinically important change.

The report includes UK population norms for SF-36. The slight differences between the Oxford and Sheffield samples probably reflect better health in the south.

Vivien Choo

1 Jenkinson C, Wright L, Coulter A. Quality of life measurement in health care. A review of measures, and population norms for the UK SF-36. Oxford: Health Services Research Unit, University of Oxford, Oxford OX2 6HE. 1993. Pp 66. £8.50. ISBN 1-974551-04-9.

Agent Orange

During the Vietnam War, US forces sprayed millions of gallons of the herbicide Agent Orange and other defoliants in order to deny cover to the Viet Cong guerrillas and North Vietnamese regulars. More than 40 000 Vietnam veterans have now filed Agent-Orange-related claims. But only a few have received compensation from the Department of Veteran Affairs, which has disputed the connection between most complaints and herbicide exposure. To end the debate, Congress asked the National Academy of Sciences' Institute of Medicine to evaluate scientific publications on herbicide exposure, but the committee's conclusions [1] are unlikely to put the matter to rest. The panel found:

- sufficient evidence for a statistical association between exposure to herbicides or dioxin, which is found in these herbicides, and soft-tissue sarcomas, Hodgkin's disease, non-Hodgkin lymphoma, chloracne, and porphyria cutanea tarda;
- limited or suggestive evidence of an assocation between herbicide exposure and respiratory cancers, prostate cancer, and multiple myeloma;
- inadequate evidence to demonstrate an association for most other cancers and disorders, and
- for a small group of cancers—those of the skin, gastrointestinal system, bladder, and brain—a sufficient number of well-designed studies to provide suggestive evidence that *no* association between the disease and herbicide exposure existed.

But most of the studies reviewed looked at the health of industrial and agricultural workers who were exposed to much higher levels of herbicides for much longer periods of time than the average soldier in Vietnam. Hence the committee recommended that an independent agency be established to determine the amount of herbicide exposure experienced by US servicemen by reconstructing the history of herbicide use by different units during the war.

Michael McCarthy

1 Veterans and Agent Orange: health effects of herbicides used in Vietnam. Washington DC: National Academy Press, 1993.

Aldosteronism

An International Registry for Glucocorticoid-Remediable Aldosteronism (GRA) has been set up at the Brigham and Women's Hospital, Harvard Medical School, Boston, Massachusetts, USA. The finding reported last year that GRA results from a chimeric 11-β hydroxylase/aldosterone synthetase gene (*Nature* 1992; **335:** 262–65) has since been confirmed in 15 additional families. The registry will provide a screening service for GRA and a scientific database.