LETTERS

Medical indemnity

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TO THE EDITOR: Recent astronomic awards for medical mishaps, and the follow-on medical indemnity crisis, bring back memories of an earlier editorial I wrote for the Journal dealing with some aspects of this problem. Its message is worth repeating.

In 1990, a letter by Armstrong was published in the Journal, which enclosed a newspaper advertisement for a firm of solicitors, Messrs Stern, Stern & Tanner, inviting custom from anyone who may have been a victim of "obstetric negligence", "even if your child was born as long ago as 1965 or even earlier. Initial consultation free". The Journal's then editor invited me to write an accompanying editorial.

The editorial, published simultaneously with Armstrong's letter and accompanying advertisement, was headed "No hawkers, canvassers or solicitors".[2] It began with a quotation from United States Chief Justice Burger: "Never, never, never under any circumstances hire an advertising lawyer!".[3] It noted that some solicitors claimed to possess special expertise in asbestos-related diseases, others claimed to know all about defoliants. I suggested, in those innocent days, that "obstetric negligence" was a new subspecialty which should henceforth be known as Stern–Tanner disease. (If Drs Guillain and Barré were to be forever enshrined in medicine's Hall of Fame, why not Messrs Stern and Tanner?)

My editorial suggested a remedial response, stating that "the law permits parties to any contract to abrogate, limit or qualify their legal rights, duties, liabilities and remedies which might otherwise arise. Thus, while the courts — both here and in the United Kingdom — tend to lean against total exclusion from liability, they are, surprisingly, more benevolent towards clauses which limit liability, however contemptuous the specified amount."

I adhere to that view. I can see no reason why doctors — save in an emergency — cannot demand that patients enter into a written "contract of treatment" which limits the treating doctor's liability to a specified amount. And while such contracts will not be valid against children born impaired as a result of "obstetric negligence", I can see no reason why the courts should deny the validity of such contracts as a matter of public policy. Why should "contracts of treatment", entered into between consenting adults, be any different from those entered into with lawyers or dry cleaners? It may seem a trifle offensive, but then the practice of medicine is treated in law as a business, much the same as touting lawyers or dry cleaners. If doctors were once put on a pedestal, this pedestal has been effectively knocked down by astronomic awards of damages freely awarded by the courts — whether by judge or jury — largely as a result of the freely expanded constituent elements of the tort of negligence.

I researched the law relating to "limitation of liability" clauses, which was published in the *Australian Law Journal*[4] and quoted in the *MJA* editorial:

> "Why the courts should be more benevolent to clauses of limitation than to clauses of exemption is not easy to comprehend. . . . The principle, it seems to the present writer, is much the same: Exclusion clauses save a party from having to pay anything, whilst a limitation saves him from having to pay as much as he would otherwise have to pay. [. . .] Alas, the last word on this seems to have been spoken for some time to come."

As far as I am aware, the law has not changed since the publication of my earlier research.

1. Armstrong M. Claims for obstetrical negligence [letter]. *Med J Aust* 1990; 152: 52.
2. Gerber P. No hawkers, canvassers or solicitors! [editorial]. *Med J Aust* 1990; 152: 3-4.
3. Burger CJ. Address to the American Bar Association Commission on advertising. *Nat Law J* 1985; 22: 18.
4. Gerber P. Limitation of liability. *ALJ* 1984; 58: 418-420. ❑

Chronic fatigue syndrome clinical practice guidelines

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TO THE EDITOR: The ME/Chronic Fatigue Syndrome Association of Australia Limited. has expressed its concern over the content of the Royal Australasian College of Physicians' clinical practice guidelines on chronic fatigue syndrome, published as a recent supplement to the Journal.[1] Recognising a shared objective to overcome the challenges of chronic fatigue syndrome (CFS), neither the Association nor the College believes that conflict will provide a useful path to future answers. Accordingly, as the Chairman of the ME/Chronic Fatigue Syndrome Association of Australia and the President (at the time the guidelines were published) of the Royal Australasian College of Physicians, we would like to document the common ground we have identified.

- We acknowledge, as do the guidelines, that CFS is a serious, disabling illness.
- There is no evidence that the illness is primarily psychological in origin.
- There is significant evidence of a range of biological abnormalities occurring in people with CFS. It remains unclear whether these are primary or secondary.
- Treatment should be personalised according to the symptoms and circumstances of the individual patient. Treatment plans should be worked out by the patient together with a healthcare professional and designed to be within the capabilities of the patient.
- Scientific evidence on aetiology, pathophysiology and treatment is, at this stage, grossly deficient. More research is required to understand the biological mechanisms involved and to clarify the role that genetic, environmental and infectious agents might have in the aetiology and pathophysiology of this complex and debilitating illness.
- The medical community, other health professionals and patients and their families should work together to encourage increased funding and research into the epidemiology, aetiology and pathophysiology of CFS so that we may find more effective treatments for this condition (or these conditions).

All clinical guidelines should be viewed as documents that will, in time, require refinement, rewriting and replacement. Doctors must be cognisant of the limita-

Correspondents

Letters must be no longer than 400 words and must include a word count. All letters are subject to editing. Proofs will not normally be supplied. There should be no more than 4 authors per letter. Each author should provide current qualifications and position. Contact telephone and facsimile numbers should be supplied. Letters from a single author may be submitted by email (editorial@ampco.com.au), but must include full details of postal address and telephone number. There should be no more than 5 references. The reference list should not include anything that has not been published or accepted for publication. Reference details must be complete, including: names and initials for up to 4 authors, or 3 authors, et al. if there are more than 4; places and dates for conferences and publishers, places and year of publication for their proceedings; publishers, places, year of publication and page numbers for monographs; volume numbers and page numbers for journal articles.

tions of all such guidelines and be aware that the investigation and management of a patient's condition must be determined with the assistance of the best and latest information as it emerges and, in all instances, be tailored to the needs of the individual patient.

1. Chronic fatigue syndrome. Clinical practice guidelines — 2002. *Med J Aust* 2002; 176 (6 May Suppl): S17-S56. ❑

Howard Florey, Alexander Fleming and the fairy tale of penicillin

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TO THE EDITOR: I read with interest the article by Goldsworthy and McFarlane on Howard Florey, Alexander Fleming and penicillin.[1] With regard to the cause of Florey's "famous pinched smile", which allegedly hid tooth erosion caused by his drinking dilute hydrochloric acid prescribed for achlorhydria, a more prosaic yet interesting explanation is found in the memoirs of Raymond Valentine Hennessy. Hennessy was Senior Ear, Nose And Throat Surgeon at St Vincent's Hospital, Melbourne, between 1928 and 1951.[2]

In August 1936, Florey, who was then Professor of Pathology at Oxford, visited his dying mother in Melbourne. He and his family stayed with his sister, Dr Hilda Gardner. Florey had a supply of sulfanilamide, probably the first in Melbourne, to treat his daughter, who was convalescing from a recent mastoid operation. During his stay, Florey attended a local dentist for treatment of a painful lateral incisor tooth. Some days later (on a Saturday evening), his face had become swollen and he began having rigors. His sister, a medical graduate who was then working as a clinical pathologist and microbiologist at the Melbourne Hospital, appreciated the danger — an abscess of a lateral incisor tooth can produce a cavernous sinus thrombosis — and quickly contacted Raymond Hennessy, who lived nearby. Hennessy had graduated as a dentist before pursuing a career as an ear, nose and throat surgeon and had written about the dangers of a lateral incisor dental abscess.[3] After examining Florey, Hennessy told him that the offending tooth required extraction that night. Initially, Florey refused to heed his advice, preferring to see his own dentist the following Monday. Fortunately for Florey, he was persuaded by his sister to have the extraction.

Howard Florey in the late 1930s

Hennessy then telephoned a dentist colleague, and they all met at the latter's surgery in Collins Street, where Hennessy gave Florey a gas–oxygen anaesthetic, and the nervous dentist proceeded to extract the incisor. However, he extracted the normal central incisor, not the offending lateral! On realising his mistake, the dentist "went to water", but Hennessy immediately rose to the occasion and extracted the correct tooth. When Florey woke from the anaesthetic, as Hennessy well remembered, he was not amused. Later, he had a dental plate made but did not like wearing it. Whether he took the sulfanilamide is not known.

This episode is not mentioned in Gwyn Macfarlane's biography of Florey.[4] However, the photograph of Florey in the frontispiece of this book shows the gap in his upper incisors (pictured). I believe this is the explanation for Florey's "famous pinched smile".

1. Goldsworthy PD, McFarlane AC. Howard Florey, Alexander Fleming and the fairy tale of penicillin. *Med J Aust* 2002; 176: 176-178.
2. Hennessy R. Memoirs [typescript]. St Vincent's Hospital Archives, Fitzroy, VIC, Aug 1970.
3. Hennessy R. Acute inflammatory conditions of the mouth and pharynx. *Med J Aust* 1926; 2: 469-472.
4. Macfarlane G. Howard Florey: the making of a great scientist. London: The Scientific Book Club, 1980: 268-270. ❑

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TO THE EDITOR: The patronising article by Goldsworthy and McFarlane on the discovery of penicillin[1] depicts the popular heroic view of Alexander Fleming as a myth, but also promulgates myths of its own.

Their description of the Fleming saga is historically accurate. Fleming searched for an answer to the riddle of infection, and, to paraphrase Pasteur, chance in the form of a spore of a rare subtype of *Penicillium* favoured his prepared mind. Whether or not the spore came through an open window is irrelevant, but the windows in Fleming's laboratory — now preserved as a museum (pictured on opposite page) — could be opened[3] and probably were on occasion, as Fleming was a heavy smoker.

Fleming perceived the significance of inhibition (or, more correctly, lysis) of staphylococcal colonies, named the active agent "penicillin" and studied its effect on animals. Goldsworthy and McFarlane are "astonished" that he failed to inject it into infected animals to investigate its therapeutic effect, but the reason is simple: Fleming discovered that penicillin was rapidly inactivated by serum, dashing his hopes for its use as a systemic agent.[3] Although he met opposition from his chief, Almroth Wright (known to his students as "Almost Right"), who rejected the view that penicillin might be a useful therapeutic agent, it is absurd to say that Fleming was "a victim of the pessimistic mind-set against toxic chemical antimicrobials". His confidence in its lack of toxicity led him, in 1929, to use penicillin to treat pneumococcal conjunctivitis in one of his assistants, with dramatic success.[2]

To say that "Fleming had little idea what to do with his mould apart from dabbing it on infected wounds" unfairly trivialises his actions after the discovery. In addition to clinical and animal studies, he had the mould identified, deposited a culture with the collection held by the Medical Research Council and published his observations. He set two researchers to work purifying the active principle of the mould broth, and established that penicillin was soluble in alcohol and that its stability was pH-dependent. He also developed an assay for penicillin and defined the range of organisms that were sensitive to it. He sent cultures of the penicillin-producing strain to many laboratories, including Oxford, where that very culture later provided the starting point for Chain and Florey's work.