Teleconsulancy has great potential but may expose the consulted party to liability. Unfortunately, legal systems vary throughout the world and there is little or no (international) legislation on the subject. The applicable law depends on the court which decided upon the dispute and the legal interpretation can differ significantly between courts. A contract containing certain clauses such as a governing law clause, may reduce the liability exposure. However, even a contract might not provide enough certainty. Therefore, the relevant authorities should address legal aspects of teleconsultancy, preferably on an international level. As long as (international) legislation is not available, guidelines must be developed.

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Shaking-impact syndrome and lucidity

Sir—There has been much debate on the differential contribution of impact and shaking to the intracranial pathology of shaking-impact syndrome.[1,2] The clinical presentation of this syndrome has also been closely examined, with great attention being given to the presence or absence of the lucid interval between the traumatic event and the onset of symptoms.

Definitive statements on conscious state are usually precluded by the lack, in most cases, of a reliable assessment of an infant immediately after injury. However, Duhaime and colleagues[3] deduced that a lucid interval does not follow serious head injury in children who subsequently die with subdural haematomas and cerebral swelling. Similar conclusions were reached by Willman and colleagues,[4] who studied accidental head trauma in children who did not have extradural haematomas. Reliable witnesses of significant infant shakings have also noted an immediate change in conscious state.[5]

Although these studies seem to have clarified matters, and while our own observations are that severe head trauma in infants is invariably associated with an immediate alteration in conscious state, there are still unanswered questions. Specifically, it is not clear what is meant by a lucid state in an infant, and who should verify whether this is present or not. Fluctuation of consciousness and altered mental state may be extremely difficult to identify in infancy. While a gold standard for the absence of lucidity in an infant would be an assessment by an experienced paediatrician immediately after trauma, this rarely occurs. Given that minor irritability and somnolence are common in uninjured infants, and that expert assessment of conscious state in the domestic setting is infrequent, comments on the presence or absence of lucidity by non-professionals on the basis of casual observation, often under suboptimal conditions, should not automatically be accepted as accurate. Indeed, even determination by professionals of what constitutes lucidity may be unreliable if there has not been specific training in paediatric evaluation.

Ascertainment of when an infant with a severe inflicted head injury was last neurologically normal may also not be possible when the history relies heavily on the veracity of a person who may be, or may be associated with, the perpetrator. It is important then, that reports of the presence or absence of lucid interval made by a non-independent witness of the events surrounding the episode of injury do not negate opinions based on clinical experience.

Unfortunately, the uncertainties that persist surrounding the issue of lucidity in infants with inflicted injury mean that we are still left with considerable difficulties when we attempt to plot a time course for events in these serious, complex, and highly emotive cases.

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Skull and crossbones

Sir—I see a large public teaching hospital in Australia in which the Chief Executive Officer was elected on the strength of having privatised critical hospital-based services.

I spy:
. . . ever decreasing funding negatively affecting . . .
. . . skewed distribution of services to the privately insured . . .
. . . awaiting elective . . .
. . . staffing and morale . . .
. . . where successful middle-managers . . .
. . . gradually eroding the service to the non- . . .
. . . disturbing trend on which . . .
. . . Kohlberg's moral dilemmas in action . . .

Such sightings give me cause to view such actions, not as privatisation, but as piratisation. I offer a contribution to the ever expanding medical lexicon. I offer the gerund, piratisation as a more descriptive, accurate, and colourful substitute.

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DEPARTMENT OF ERROR

Venous thromboembolism and cancer—In this Article by John A Baron and colleagues (Apr 11, 1998, p 1077), the first sentence of Findings in the summary (p 1077) should be, "At the time of thromboembolic admission or during the first year of follow-up, 2509 cancers were diagnosed (SIR 4·4, 95% CI 4·2–4·6)", and the third sentence of Results (p 1078) should be, "This risk was much higher than expected: the SIR for all cancers was 4·4 (95% CI 4·2–4·6)".

Infantile hypertrophic pyloric stenosis after pertussis prophylaxis with erythromycin: a case review and cohort study—In this Article by M A Honein and colleagues (Dec 18/25, 1999, p 2101), the fourth sentence of the third paragraph on page 2103 should read, "The prevalence of erythromycin use was 8·6% among infants born in January and 88·6% among infants born in February".

Malarial anaemia in African children associated with high oxygen-radical production—In this Research letter by P G Kremsner and colleagues (Jan 1, p 40), the first author should be B Greve.