3. The College does not argue for any retention or extension of the referral system beyond what is indispensable to attain these objectives.
4. The maintenance of the referral system does not eliminate true competition. The dismantling of the referral system would set up quasi-competition between non-equals. This paper does not argue that general practitioners should not compete in quality and cost effectiveness with one another, or that cardiologists should not compete with one another, or general surgeons — only that there can be no true competition between 'suppliers' of totally different 'goods'.

Legislation to remove restrictive trade practices, to limit monopolies and regulate mergers are means by which any government, however committed to the benefits of a free market, seeks to regulate the market for the good of society. In this instance, what makes sense in a market, makes no sense whatsoever in medicine.

MARSHALL MARINKER
Director, MSD Foundation, London

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Medical indemnity — a collective responsibility?

THE advertisements in the medical press offering professional indemnity to general practitioners are enticing. These new schemes offer cover to general practitioners at rates which are likely to undercut substantially the subscriptions to the traditional medical defence organizations. These developments seem to be in the spirit of the age which encourages competition as the most effective method of reducing costs giving direct benefit to the general practitioner and indirect benefit to the government through a reduction in overall practice expenses.

It is probably too late to stop the fragmentation of arrangements for providing medical indemnity in this country but serious thought must be given to the consequences. For over a century the medical profession itself has assumed responsibility for covering the costs of legal actions and settlements. The new schemes are able to offer insurance cover at relatively low rates because they only offer policies to those doctors who are considered to be at low risk of litigation. They are thus divisive both in their intent and in their operation. In comparison with surgeons and obstetricians, general practitioners are considered to form a low risk group. However, many general practitioners deliver babies and many work in anaesthetics. In future, is the range of activities undertaken by general practitioners to be determined by insurance considerations rather than the needs of patients?

If the new schemes are successful in recruiting low risk doctors, the traditional defence organizations will have to adopt similar selective policies or be left with only high risk members. The Medical Protection Society is already reported to be replacing the present flat-rate subscriptions with differential rates.

The virtues of the existing defence organizations are in danger of being over-looked as some general practitioners pursue short term financial gain. The new schemes provide cover on a short-term basis and there is no guarantee for the individual doctor that cover will continue to be provided at the same attractive rates. In contrast, the defence organizations have demonstrated that they can provide cover on a long-term basis for generations of doctors. They provide legal advice as well as insurance cover and have built up a wealth of experience and expertise in defending doctors. They have regard for the need to defend the reputation of doctors and decisions to defend legal actions rest on the merits of the case and not on purely financial expediency.

The defence organizations can be criticized for not making more use of their experience to help doctors avoid the pitfalls in practice which result in legal actions. Even here, welcome developments have taken place in recent years, with publications from defence organizations drawing attention to trends in litigation and areas in which clinical practice should improve.

The widening gap between the subscriptions for the Medical Defence Union of Scotland and the other two defence organizations, the Medical Protection Society and the Medical Defence Union, is of interest. Membership of the Scottish society is limited to medical and dental graduates of Scottish universities and doctors who complete at least one of their preregistration house officer posts in Scotland. Scotland has a long tradition of exporting doctors to the rest of the United Kingdom. The separate legal system in Scotland is unlikely to account for the increasing discrepancy in subscription rates. The selection and education of undergraduates in Scotland would seem to be the major factors responsible for the relatively low number of claims made against Scottish graduates. It is important that this difference in claims experience is analysed in detail so that the lessons for medical education can be learned.

Changes in the arrangements for medical indemnity cannot be seen in isolation from the general picture of medical litigation. The number of cases brought against doctors has doubled over the past three years and major individual awards made against doctors can now be expected to exceed one million pounds. This rapid rise in the number of actions may be good news for lawyers but it is not necessarily in the best interest of patients. In legal contests lasting several years both the patient and the doctor are likely to be the losers. Patients and their relatives may have to endure a series of hearings with awards made by lower courts rescinded by higher courts on appeal. The initial injury which stimulated the action is compounded by the anguish and uncertainty of prolonged legal proceedings even if the case is ultimately successful. For the doctor similar anxiety and anguish will be experienced during the years of court hearings.

Changes are necessary in the way in which compensation for medical accidents is awarded. Sweden has shown that a system of 'no fault' compensation can work satisfactorily. There is widespread support for the creation of such a scheme in the UK but the present government has shown no interest. Without radical reform of this kind the number of legal actions against doctors is likely to increase further and subscriptions to the defence societies or insurance premiums will continue to rise.

'No fault' compensation is often misunderstood. An excellent analysis of existing schemes is given in the booklet *Medical negligence: compensation and accountability.*[1] 'No fault' compensation does not remove a patient's right to sue a doctor for medical negligence but is a separate procedure whereby a patient can apply to a board for injuries resulting from a medical accident. In Sweden there are two boards. One determines the amount of compensation to be awarded and the other investigates the background of the accident and any avoidable factors. The prime role of the second board is educational. Whether or not the medical profession continues to be collectively responsible for medical indemnity, for a system of 'no fault' compensation to have any chance of implementation we need to be united in campaigning for it.

E.G. BUCKLEY

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