virtue of having taken the Hippocratic oath. When are the public going to be informed that doctors do not swear an oath and that if they did then that particular one would not be the most appropriate, in view of its ethos of elitism and self protectionism?

The professor would do well to read the Monopolies and Mergers Commission report on general practice advertising[2] to learn that the majority of the public do not choose their doctor when in a seriously ill state and are not particularly vulnerable. Most doctors easily fall into the paternalistic role and the public will have no difficulty finding such a relationship if they want it.

In fact I find the professor's arguments against the covenantal relationship stronger than those for it, as his particular arguments are based on an overemphasis of the unusual (vulnerability) and a failure to address the common (the desire for freedom and choice).

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Risks of prescribing on behalf of hospital doctors

Sir,

Family doctors are well aware of the short term financial implications on their PACT figures in agreeing to prescribe drugs on FP10s at the request of hospital doctors, with the aim of reducing the health authority budget. What might not be so obvious, but which could potentially have much graver implications for general practice, is that by complying with this request, the general practitioner takes on the long term professional liability for any deficiencies which may occur as a result of providing that treatment, even though his only input may be writing out the prescription for the hospital consultant.

Doctors may say that this has always been the case and that any liability resulting from the prescribing of a medication in such a case would be settled with the full cooperation of the hospital staff and without the need to apportion blame.

However on the 1 January 1990 so called 'Crown indemnity' was introduced into the hospital service, which effectively extended the vicarious liability of health authorities to cover negligent acts by doctors in their employ. This places a considerable new liability on already financially deficient health authorities, as they are now separately and collectively responsible for the first £300 000 arising from every claim, before central government will provide any assistance via the fund set up by the defence organizations.

Plainly a health authority faced with a claim relating to treatment which has been facilitated by the general practitioner helpfully providing the necessary medication will be under no obligation to accept liability, and indeed will be discouraged financially from entertaining it.

The question we must ask is whether the request for the prescribing of a drug is based on the inability of the health authority to pay for the treatment or on the potential risks of the treatment which the health authority is financially unwilling to accept as a liability.

This principle extends to all those requests for financially expensive treatments such as *in vitro* fertilization, which general practitioners increasingly find themselves asked to provide, even though the care is essentially still in the hospital sector. It would seem then, that the prudent doctor should decline to comply with the request, as it would be perverse to take on the liabilities of the hospital without any guarantee of their support if a problem occurred.

I would therefore suggest that the Crown indemnity system will further accelerate the already perceivable loss of intra-professional trust that has occurred since the white paper *Working for patients* and that this issue needs to be urgently addressed by the RCGP.

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Standardization of annual reports

Sir,

In his recent review of general practice reports[1] Dr Wilton argued for standardized information to be contained in practice reports to enable comparison between practices. He also comments on the absence of defined commonly used terms.

In Scotland an attempt has been made to standardize the core data required for inclusion in practice annual reports[2] and these defined terms, which were derived following negotiations with several interested parties, are now being used by a significant number of practices in the Grampian region. These same terms have also now been included on the G-PASS (General Practice Administration System for Scotland) software for use in the computerized practice annual report. The G-PASS software is currently used by over 300 practices in Scotland.

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Budget holding

Sir,

I agree with Dr Sykes that general practitioners should be united in their opposition to budget holding (April *Journal,* p.170). So far the new contract has been no more than an irritation to cope with. However, I believe that the introduction of general practitioner budgets would be the death knell of the altruistic paternalism that is at the heart of one of the best primary health care services in the world. Instead of being united in demanding the best for all patients in the NHS, we would be fighting among ourselves for a share of the ever-diminishing resources. This would of course take the political pressure off the secretary of state for health, and push it onto general practitioners, whose political power would be diminished by their divided state. A cynic might say that this is the driving force behind the department's desire to introduce budgets.

If a significant number of general practitioners take on budgets, there will be no need for them to become compulsory: budget-holders would take the lion's share of resources, forcing the rest of us to either join them or accept second best for our patients.

Unless general practitioners are united in their determination to reject budget holding, we will soon see British general practice degraded from the superb service that has been built up painstakingly with the encouragement of the College to a shambles that will provide second-class health care to our patients, and will not make the maximum use of our skills and experience.

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