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Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

When things go wrong

SIR,—I was glad that Dr Richard Smith pointed out that the United Kingdom already has a degree of support for victims of medical accidents in the form of medical care and social security payments towards the burden of injury (23 August, p 461).

It seems that the defence bodies are reluctant to contribute more details about case groups and their costs because that would raise the level of demand for specialty related premiums. The low risk end (community medicine) has already been the source of suggestions for such differentials. There has also been the more general suggestion that the NHS should bear the costs of insuring its medical employees. I think this could lead to the insurer defining and decreeing the areas of risk and introducing some control of practice methods.

Defensive practices have certainly altered obstetrics and contributed, if only a little, to higher caesarean section rates. But until the issue is resolved I do not see defensive practice as wrong. Action for Victims of Medical Accidents says that if an apology and explanation were given, as recommended by the Patient's Association in its report to the Health Commissioner's Inquiry in 1977, some litigation could be forestalled. Although I was glad that the Medical Defence Union reminded its members that this is a proper feature of good manners and necessary compassion, I doubt whether it will diminish the number of litigants among the injured: rather, it serves to illuminate the targets.

It would be interesting to know how much the resort to litigation results from the patient's own dissatisfaction and how much from that of a close relative or spouse. The latter is something especially encountered in obstetrics and gynaecology. The lesson, of course, is that the specialist must involve more fully, and equally, both partners in the same way that the general practitioner must always concern himself with family ties. It is worth noting that the NHS complaints system gives equal weight to complaints from patients and those from close relatives.

Do working conditions in the NHS really permit the standards of good communication described in courts, committees, and wherever feet are resting under comfortable tables? Perhaps the diligent doctor should be defending his position more strongly by taking on only that which he can do well. At last the NHS hospital service has found a form of management which should relieve doctors of accountability for what they cannot do, provided they fulfil reasonably the hours and applications of their contracts.

The general criticism that doctors do not have the time to sit down and talk to their patients suggests that either their priorities are wrong or they are overburdened by the "striving" ethos which the profession seems to enjoy. I believe that the open endedness of doctors' contracts with the hospital service has become a major cause of patient's dissatisfaction, and this may bear more heavily on the trainee than on the consultant since the trainee is less free to be articulate about the conditions of work. The recent clarification of the liability of a doctor in training (23 August, p 497) will have helped to remind us all of the balance between standards and service levels of provision.

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SIR,—Dr Richard Smith's leading article (23 August, p 461) highlights the consequences of increasing medical litigation and higher awards being made by the courts. Dr Smith suggests that an accident compensation scheme similar to that which has operated in New Zealand since 1974 may help to discourage the possibility of "defensive medicine" being practised in Britain. I agree.

Unfortunately, all is not well with the New Zealand Accident Compensation Scheme. Earlier this month the first part of a review by an officials committee of the Accident Compensation Scheme was released. The introduction to the report states (inter alia): "This particular review was prompted by inequities in treatment of illness and accident disabled and concern about escalating costs of the present Accident Compensation Scheme."

Among a wide range of options and recommendations in the officials committee's report are suggestions that the accident victim should contribute up to NZ $250 towards the medical costs either each year or for each accident and that the lump sum payments for permanent loss or impairment of bodily function or the lump sum payments for other non-economic loss (pain and mental suffering and loss of enjoyment of life), or both, should be dropped. The suggestion to drop lump sum payments raises the spectre of a return to a situation where doctors in New Zealand may be sued for negligence.

The current review of the Accident Compensation Scheme is a prelude to a Royal Commission of Inquiry on Social Policy currently being established and which is due to report by June 1988.

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SIR,—The Medical Defence Union's sales package designed to make this year's massive increase in premiums more palatable contains the information that of 7698 respondents to a questionnaire, 43% were in favour of specialty related premiums and 49% were against. These statistics are meaningless unless the various medical specialties were equally