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- *No letter should be more than 400 words.*
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- *Because we receive many more letters than we can publish we may shorten those we do print, particularly when we receive several on the same subject.*

Struggling with malpractice and medical defence subscriptions

SIR,—Dr John Havard's article (15 August, p 399) seems extraordinary in its complacency. He writes that "our judges are well aware of the dangers of encouraging defensive medicine," yet in the light of recent six figure awards this is hard to sustain. As to the "healthy reputation" of British defence bodies and the health service complaints machinery being effective, such anecdotal stuff can come only from someone immured inside the system.

Instead of discussing the American situation, surely the BMA should be hammering at the current British crisis. Subscriptions for medical defence are due to rise by some 80%, a major burden for those of us who reject private practice. No differential payment is required of those in high risk professions, of those earning substantial private incomes, or even of those who have incurred previous damages for negligence. Why should private negligence be subsidised by public service? Furthermore, why has no one pointed out to our judges that the NHS provides free care for the chronically disabled—unlike in America—which should be reflected in the form (revenue or capital) and amount of awards.

Finally, is it not time that we tried to learn from American practice and insist on stricter peer review and compulsory continuing education? Keeping up with changes in therapeutics, diagnostic technology, and clinical research is too important to be left to our spare time. Registration should be withdrawn from practitioners who do not attend appropriate refresher courses, which could also provide a forum for debate, communication, and the development of a professional ethos.

The sheer amateurism of the medical establishment, as revealed in the tone of Dr Havard's article, will be easy pickings for the lawyers unless we act urgently. We should introduce no fault compensation or insist on changes in the present award system, but unless, like the Americans, we actually struggle with malpractice, there is unlikely to be a sympathetic response from those empowered to enact such changes.

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SIR,—I read with dismay though not surprise that next year's medical defence premium is to rise by nearly 100%.

Even the most rapidly promoted house officer will after seven years be only a first year senior registrar on a salary of £13 250 (gross). Is it fair that he or she will pay the same premium as a consultant whose starting salary is £23 500? This ignores the fact that junior doctors may be obliged to work overtime at 30-37% of their basic hourly rate and that consultants may choose to supplement their income with private practice. Few members of the medical profession in the United States pay the same percentage of their annual income in insurance as junior hospital doctors will be expected to pay in 1988.

It is not realistic to compare medical insurance premiums with those of other professional bodies (as in the booklet accompanying the announcement last year). Junior members and those in training positions in firms of solicitors, accountants, and architects do not pay their own premiums. Their firms pay the cost, even if the sum is taken into account when negotiating the individual's salary.

Should litigation arising from private practice be covered by the same premium or should those members of the medical profession choosing to carry out private practice pay an extra or different premium?

It is time to reconsider the matter of differential rates for different specialties and perhaps also to raise the question of whether doctors should be