Union itself has hinted at the possible draconian measures that may be necessary to reduce its current liability, a course of action that in itself will severely curtail clinical freedom. The present two thirds reimbursement arrangement is a mess, with many doctors still awaiting and indeed having to fight for reimbursement. It is also pernicious for the government to penalise doctors with part time contracts. This arrangement can be but a short term holding measure and illustrates how any compromise short of the government accepting liability for employees is going to generate more problems than it actually solves.

While there may be ancillary arguments about medical defence, such as no fault compensation, these can be debated later. The urgent necessity is for the British Medical Association and other professional bodies to urge the government to take over the liability for all doctors employed in the NHS. Unless this is done quickly the current uncertainty is going to cause unprecedented damage to the morale of, and recruitment to, the high risk specialties.

C W E REDMAN
E J BUXTON

Department of Obstetrics and Gynaecology,
Dudley Road Hospital,
Birmingham

1 Anonymous. MPS proposes differential defence rates. *Br Med J* 1988;297:1289. (19 November.)

SIR,—The prospect of commercial insurance companies entering the market for medical insurance seems to have triggered a price war between the Medical Defence Union and the Medical Protection Society.¹ Until now the two societies have indemnified all senior doctors at the same rate regardless of specialty.

Every doctor I have discussed the matter with feels it is an excellent principle to recognise that, though some specialties are at higher risk of expensive litigation, their practitioners are no less skilled than those in low risk specialties. It seems unfair to impose financial burdens on high risk careers and foolish for general professional standards if doctors are discouraged from taking up "risky" specialties or practise defensive medicine once in them.

My defence society, the Medical Protection Society, seems to have chosen to take the commercial road and is introducing differential charges which not only ignore the above principle but seem aimed at filching low risk practitioners. The Medical Defence Union will thus be left with smaller funds and higher payments, forcing it either to follow suit or to charge an impossibly high flat rate.

PAUL DIGGORY

London E1 5QZ

1 Anonymous. MPS proposes differential defence rates. *Br Med J* 1988;297:1289. (19 November.)

SIR,—The Medical Protection Society announced its intention to introduce differential subscription rates by specialty this year such that obstetricians may pay £5000, surgeons and anaesthetists £1800, and others £1000¹; it is proposed that the special concessionary rates for doctors who have been qualified for less than seven years will continue. Last year most doctors paid a basic rate of £1080 for defence subscriptions, with doctors who have been qualified for less than seven years paying on average 41% of the basic rate (assuming that there are roughly equal numbers in each year).

The Department of Health's manpower statistics for England and Wales show that of all doctors about 1.2% are obstetricians (consultants and senior registrars), 7.8% are surgeons or anaesthetists (consultants and senior registrars), and 26% have been qualified for less than seven years; the

remainder (general practitioners, other hospital doctors, and other doctors) constitute 65%.

A quick "back of the envelope" calculation shows that if the Medical Protection Society retained its existing system the basic rate would need to be increased by only 7% for the society to have the same overall income from subscriptions as is proposed. The basic rate would then be about £1160, and those who have been qualified for less than seven years would need to pay, on average, about £475. This basic rate is less than that proposed by the Medical Defence Union—that is, £1350. The above assumes that the specialty mix, etc., of doctors in the Medical Protection Society is not vastly different from national proportions. Other confounding variables such as the possibility that junior doctors may be charged pro rata concessionary rates based on specialty, that some registrars and senior house officers in obstetrics and surgery may have been qualified for more than seven years, and that some doctors are on concessionary scales based on their low salary make little difference to the above calculations as these groups constitute only a small proportion of all doctors.

The above calculations are based only on the proposed differential subscriptions as reported.¹ Any final figures from the Medical Protection Society may of course differ, but the main point is that as obstetricians are only a small proportion of all doctors even a fourfold or fivefold increase in subscriptions for this group will not significantly reduce subscriptions for all other doctors. At present, surely most doctors would be happy to continue on a flat rate basis rather than see some colleagues in certain specialties undergoing the hardship (albeit possibly temporary) of paying up to £5000 each?

The Medical Protection Society's rationale may be "tactical" to push forward the issue of compensation for babies who suffer brain damage. Unfortunately this is likely to fail as the Medical Defence Union is not acting in accordance. Next year all surgeons, anaesthetists, and obstetricians in the Medical Protection Society might transfer to the Medical Defence Union and all other doctors might move vice versa, or even be tempted to move elsewhere. This would leave differential defence organisations, the Medical Defence Union being the insurer for high risk specialties and the Medical Protection Society that for lower risk specialties.

R F COOPER

Department of Community Medicine,
Central Birmingham Health Authority,
Birmingham B15 2TZ

1 Anonymous. MPS proposes differential defence rates. *Br Med J* 1988;297:1289. (19 November.)

Use of hospital beds

SIR,—In their letter Mr Brian Birch and others advocated the use of a technique called "sedoanalgesia" as a method of providing greater utilisation of hospital beds in this time of financial cutbacks.¹ We agree that more rational use of our beds is necessary at this time, but we have grave doubts about the technique described. Day case surgery depends on the use of modern anaesthetic and analgesic agents to provide the best operating conditions for the procedure, along with the minimum of postoperative sequelae for the patient.

Midazolam given by oral, intramuscular, and intravenous routes has been used in outpatient surgery both as a sedative and as an induction agent, but it has not yet gained any widespread popularity as recovery has not been shown to be any faster than with diazepam for sedation or thiopentone for anaesthesia.² Furthermore, there have been reports that the sedation seen with midazolam is not mirrored by anxiolysis.³ One study of oral midazolam in 1987 said that it

prolonged the time to "home readiness" in patients undergoing general anaesthesia.⁴

Flumazenil has been introduced as an antagonist of the benzodiazepines, but it has been noted that, although there is quicker awakening, there is not complete reversal of all the effects of the benzodiazepines and cognitive and psychomotor performance is still reduced 15-420 minutes after the operation.⁵ The other problem noted is that the elimination half life of flumazenil is about an hour⁶ and that of midazolam about three hours, which accounts for the recurrence of sedation seen when flumazenil is used to reverse benzodiazepine sedation.⁷

From the above points we hope to show that in this time of increased medicolegal awareness increased patient turnover using new techniques can be justified only if these techniques are completely safe for the patients concerned.

P MCHUGH
K A MILLIGAN

Department of Anaesthesia,
University of Sheffield,
Sheffield S10 2RX

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Care of accident victims

SIR,—Mr D W Yates's editorial highlighting the inadequacies of British trauma management¹ is long overdue. The report of the Royal College of Surgeons' working party on the management of patients with major injuries suggests that there are many avoidable deaths after trauma. I recently completed a retrospective analysis of deaths after road traffic accidents in the Royal Infirmary of Edinburgh between 1983 and 1986 using the injury severity score system. All deaths occurred after admission from the casualty department. Early deaths were not examined.

The mean injury severity score was 25, the mean values for deaths related and not related to injuries to the central nervous system being 30 and 21, respectively. The table shows the effect of age on the score. Bull introduced the idea of the median lethal dose—that is, the injury severity score representing a lethal dose of trauma at which half of the population would die.² For patients aged between 15 and 44 the median lethal dose is 40, with values of 29 for those aged 45-64 and 20 for those over 64. Thus my figures make depressing reading. An accurate assessment of each patient's injury severity score compared with his or her age shows that 69.6% of our patients dying after road traffic accidents die with an injury severity score

Effect of age on injury severity score of deaths

Age (years)	No of deaths	Mean injury severity score
<i>From central nervous system injuries</i>		
15-44	22	29
45-64	4	29
>64	11	25
<i>Not from central nervous system injuries</i>		
15-44	14	27
45-64	13	23
>64	15	16