

companies," with negotiations "going on with the Department of Trade since last year over a Government plan for the medical defence societies to register as insurance companies under the Insurance Companies Act 1974." The *Lancet's* parliamentary correspondent also comments that "the Department is anxious that doctors insured with the societies should be adequately covered. Having to register as insurance companies would oblige the societies to meet one of the main requirements of the Act—that the income from premiums exceed the liabilities by one-fifth." Indeed, this article provides us with more information than has so far been forthcoming from the societies themselves, whose recent circular letter to their members, while full of criticism of the BMA's alleged intentions and capabilities, gives doctors little information on the defence bodies' own plans. With their recent annual reports carrying sombre warnings about the difficulties of providing medical indemnity, such a negative approach is both surprising and disappointing.

The defence societies' pique at the BMA's possible encroachment on their territory is understandable. But the threat in the letter that their "continued co-operation with the BMA would be difficult or impossible should the BMA divide the profession by introducing a scheme which is based on the American pattern of malpractice insurance" is not perhaps the best way of putting their case—which surely has sufficient merit by itself. The BMA's Representative Body is mature enough to debate and decide the issue on its merits.

Over the years the three defence societies have not only had close links between themselves—indeed, their subscription increases in step have had a whiff of monopolism about them—but advice and help have flowed in both directions between them and the BMA. How far in recent years the defence societies have displaced the Association in providing personal services to doctors is hard to judge, for the dividing line between their respective responsibilities is fuzzy. Certainly the defence societies have an advantage over the BMA in planning and expanding their services to the profession because they know that doctors must pay their subscriptions, whereas the BMA's voluntary membership is particularly vulnerable to subscription rises. A combination of inflation and pay restraint is bound to tempt some doctors to "make do" with their compulsory organisations, though such a course is against their real long-term interests. A more constructive approach is to arrange the profession's representative, advisory, and indemnity services as effectively and economically as possible, and doctors must decide whether and how they wish to do this.

Before deciding on this issue, however, the profession should consider the options. There are several questions to be asked:

How do doctors want to be protected against actions for professional error: by competitive mutual schemes (as at present); or by a single, monopoly mutual scheme; or by one or more commercial schemes; or should the State, as employer, provide the cover?

Whatever the choice, should the defence bodies be subject to the Insurance Companies Act, with its requirements of specified reserves and with members legally guaranteed financial cover up to a declared figure? (The defence bodies do not legally guarantee financial cover or set a ceiling on their liability.)

Are doctors prepared to pay whatever premiums may be necessary for complete cover, including a comprehensive advisory scheme? Or would they be content merely with protection against legal costs and damages?

Are differential premiums that reflect the risks of a particular branch of medicine acceptable or is the more simply administered flat-rate subscription preferable, with low risk doctors subsidising their high risk colleagues?

Should a defence organisation fight a case on an important professional principle even though it would be cheaper to settle?

Does the profession want more say in deciding the policy and the running of their defence societies, including, perhaps, postal elections of their Council members?

Should the defence societies collaborate more closely with the BMA, unite with it, or remain quite separate?

The defence societies are less accustomed than is the BMA to the rough and tumble, give and take, of the public market place. So who can blame them for feeling aggrieved at the BMA for jostling them into the limelight? Comparison with the GMC affair and the subsequent Merrison inquiry would be unfair but there is one common denominator: accountability. Doctors saw the GMC, for which they have to pay, as too remote and unaccountable. The profession, rightly, must fund its own protection: but when financial support is mandatory full representation is the *sine qua non*. Admittedly, the defence societies have a good record, and, given the profession's initial reactions to the Bowring proposals for indemnity insurance, they are unlikely to be faced with commercial competition yet. But events could alter the profession's mood: consumerism inside and outside the NHS is a trend which seems bound to lead to more litigation and to an increase in NHS inquiries; court awards are rising fast, as are legal costs; and the new contracts being negotiated in the NHS will mean more doctors wanting advice and support in dealing with their employers.

All these developments will cost doctors much more than their present defence society subscription of £40 a year, however indemnity is organised. Thus it is a matter for the whole profession to discuss—indeed, the community also has an interest—not merely a subject for argument between the BMA and the MDU, MPS, and the MDDUS. So should not the defence societies and the BMA turn their recent differences to the profession's advantage by joining with the British Dental Association and the royal colleges and faculties in sponsoring an independent, interprofessional assessment of defence needs for the '80s? Doctors would surely prefer such a constructive initiative to the present unproductive public fracas.

¹ *British Medical Journal*, 1886, 1, 323.

² Forbes, R, *Sixty Years of Medical Defence*. London, MDU, 1948.

³ *British Medical Journal*, 1977, 1, 1297.

⁴ Medical Protection Society, *Annual Report and Accounts 1976*.

⁵ *British Medical Journal*, 1977, 1, 385.

⁶ *Accountancy Age*, 1977, 1 (No 19), 6.

⁷ *Lancet*, 1977, 1, 1270.

Cataract management today

Patients with cataract occupy much of the ophthalmologist's working week. The growing proportion of the elderly in our population and the trend for patients to be better informed and more articulate than formerly mean that his reputation will rest to a large extent on his management of their problems. Gone are the days when a patient with bilateral cataracts, one mature and the other immature, would meekly accept advice to "go away and come back when you can't see out of the other eye."

In the last three decades real advances have been made in the science and art of cataract surgery, so that nowadays if a cataract is causing appreciable visual loss it should be

extracted as soon as arrangements can be made. Not only have there been refinements in the development of instruments and suture materials, but new concepts of treatment have been developed—including enzymatic zonulolysis with alpha-chymotrypsin and techniques for lifting the whole lens out of the eye (the intracapsular or total lens extraction) without rupturing the lens capsule. The cryoprobe and the operating microscope have transformed surgical methods. More and more surgeons are extracting both cataracts at one sitting if the patient is a poor anaesthetic or medical risk. Early mobilisation is the order of the day, and so is the provision of temporary aphakic spectacles. With these changes, patients with cataracts may now expect to be up and about and watching television two days after the operation. General practitioners may justifiably assure their patients with cataracts that operation is no longer the ordeal it used to be and that they can forget the old wives' tales.

The specific advantage of the Kelman¹ technique of cataract emulsification and aspiration is that the tiny incision (only 3 mm long) permits very early mobilisation, discharge from hospital, and resumption of a normal life. The drawbacks include the expense of the equipment, which must be carefully maintained by a team trained in its use, and the technical difficulty of the operation, which requires special training and use of an operating microscope. Advocates of the Kelman technique believe that extracapsular extraction is superior to intracapsular or total removal of the lens; not every surgeon would agree. In fact, probably for the ordinary senile cataract (which makes up the bulk of cataract surgery) an intracapsular extraction by an ordinarily competent surgeon without access to costly equipment is more satisfactory and is likely to remain so for the foreseeable future.

At present the sad reality is that there are only three Kelman machines in the United Kingdom. Two are in the new Charing Cross Hospital, one presented by a grateful patient and the other purchased by the surgeon who pioneered its use.² The remaining machine—and the only one financed by NHS funds—is in Aberdeen. This is hardly the way to evaluate an important new technique: ophthalmic teaching hospitals should surely hire the equipment and train surgeons and technicians in its use and so make their own assessment.

Equally important are recent advances in the visual rehabilitation of the newly aphakic patient. Spectacles can provide only a magnified, topsy-turvy and confusing world, which takes weeks or months to become accepted by the patient. Some degree of limitation of the visual field is unavoidable. Nor are contact lenses (for the aphakic) living up to their early promise: use of the new, so-called permanent-wear lenses is fraught with danger.³ There seems a strong case for offering permanent intraocular artificial lens implants to selected aphakics. With few exceptions patients with unilateral cataracts benefit greatly.⁴ Implants may also be justified for some patients with bilateral cataracts, especially those wishing to drive public service or heavy goods vehicles and those facing the public in politics or entertainment.

What are the future prospects for intraocular lens implantation? There has been a rapid growth of specialised societies and clubs to promote understanding of the techniques and to help would-be lens implant surgeons and manufacturers. The senior body, the International Intraocular Implant Club, was founded in 1966 with Harold Ridley as its first president, and the United Kingdom Intraocular Implant Society was set up in 1976. National implant societies also exist in America, Japan, France, and Holland. The manufacture and sterilisation of lens implants present special

problems, which have attracted the attention of the American FDA and our own DHSS. Indeed, with characteristic thoroughness the Americans have founded their own Association of Intraocular Lens Manufacturers to establish standards and controls over these devices, which contribute so greatly to the quality of life of sufferers from one of the most common ocular disorders.

¹ Kelman, C D, *Transactions of the Ophthalmological Societies of the United Kingdom*, 1970, **90**, 13.

² Arnott, E J, *Transactions of the Ophthalmological Societies of the United Kingdom*, 1973, **93**, 33.

³ *British Journal of Ophthalmology*, 1977, **61**, 249.

⁴ Choyce, D P, *British Medical Journal*, 1959, **2**, 609.

Polio vaccines and polioviruses

Living virus strains provide the most effective vaccines against virus diseases. They have two advantages over their inactivated counterparts: the quantity required is smaller because the host produces further virus from the inoculated vaccine, and the immunity lasts longer. Nevertheless, there are disadvantages, too. Storage is a more delicate matter, and the process of infection may take the form of a febrile illness, not always mild. There is yet another cloud on the horizon. Theoretically, since it is capable of multiplication, the vaccine virus may be shed and infect other, susceptible, individuals. In practice, most of the live virus vaccines in use in human preventive medicine do not behave in this way. Vaccinia virus occasionally spreads—for example, to children with eczema—but this is a rare event and is controllable. Other live vaccines in common use, such as rubella and measles (and in the United States mumps), are known not to be disseminated to household contacts and into the environment. Live polio vaccine is the striking exception. This virus multiplies in the wall of the gut and is excreted in the faeces, whence at least some other persons are infected. Even with good hygiene dissemination is inevitable. Many millions of doses of live (Sabin) vaccine have been given in countries all over the world, and the apparently innocent sugar lump with its drop of oral polio vaccine, is, in fact, a virological Pandora's box.

This week (at p 1621) we publish an examination by Dr Y E Cossart of the characteristics of polioviruses isolated by the Public Health Laboratory Service laboratories from the small numbers of cases of poliomyelitis seen in Britain. The pattern emerging is interesting. Type 1, previously by far the most common poliovirus, is giving place to types 2 and 3; there are fewer cases of paralysis in those with neurological disease; and many of the recently isolated strains lack the ability to grow at temperatures above 37°C, betraying their similarity to vaccine strains. This all suggests that at least some and perhaps most of the poliovirus strains causing disease in Britain today are vaccine strains that have reverted to some degree of virulence. The old, classic, virulent, wild strains may be on the way out, but they are being replaced by a new regiment apparently derived from vaccine strains. The numbers of new isolates are small compared with 20 years ago, and it will be of great interest to see how the trend continues.