knowledge and skill appropriate for someone of our standing and also refusing to undertake work, even at the patient's urgent behest, which the profession forbids as outside its legitimate scope, as was once the case for instance with abortion and still is as regards so-called euthanasia – even if apparently justified, since a potential patient, when he makes a contract or covenant with a medical doctor, relies on the latter's qualification as a guarantee of skill, learning and professional morals. The contract concerns the profession as a whole since a breach of it gets the whole profession into disrepute, making us less trustworthy and therefore less useful. This is the patient's best guarantee against malpractice, and it suggests that perhaps the defence societies should be run by the GMC and that the GMC in consultation with the colleges should be more actively concerned with defining the new ethical standards that are needed in the light of new technological developments in medicine and changes in public opinion as reflected by the law. The possibly desirable introduction of no-fault compensation will almost necessarily require some adjustment of this kind. Why should the colleges not handle complaints against their members on behalf of the GMC and in close collaboration with the defence societies, leaving the courts as a tribunal of last resort?

Where does that leave the role of the NHS? I suggest that it should have an enabling and facilitating role rather than a directive one and should be run by local authorities on local taxes and negotiated with the so-called caring professions (medicine, nursing, physiotherapists etc) as regards fees or salaries but with minimum standards laid down centrally.

What has all this to do with the case of Dr Savage? Everything, I believe, because what her case has made clear is the existence of structural faults in the organisation and running of the NHS.

But I have not yet dealt with the role of the academic departments – crucial in her case. Obviously the NHS ought, on behalf of patients, to pay the fees of medical academics to the university with their obligations specified at all levels as for NHS staff in relation to clinical duties. Would this lead to difficulties in recruitment as a result of generally lower rates of pay – since presumably academics would be paid at NHS rates for clinical work and at academic rates for academic work? Such anomalies could surely be covered by payment by the NHS to the Department of Education and Science (DES) in order to ensure adequate standards of medical education, undergraduate and postgraduate, and of research, which are essentially national rather than local responsibilities. There could also be a use for distinction awards here. But we should make sure that if a junior lecturer works for a senior academic in the relationship of registrar to consultant for patient care, the latter should have had the same influence on the appointment of the former as would an NHS consultant in the appointment of his or her clinical juniors – whatever the academic hierarchy, which is a different one: otherwise the essential loyalties may not inform their relationship. To return to the case of Dr Savage, anxieties about the clinical competence of someone in her position should surely in future be voiced confidentially through an appropriate college committee working in private with legal advice and after due warning to the person concerned; and colleges, not the NHS administration, should take responsibility for recommending suspension; the duty of the NHS being only to react appropriately to it.

My conclusions are:

1. that the role and function of the different elements providing medical care for our population needs clear and revised definition in accordance with the principle of separating responsibilities and relating to them the powers necessary for their exercise.
2. that there is a need for the colleges in consultation with the GMC to exercise what I see as their proper powers in relation to possible malpractice of any kind, including its definition in their brief.
3. that the profession should set its own house in order before others move in, and wreck it in the process, to the loss of our patients as well as ourselves. I believe that our ideals and standards are in practice and overall higher than those that obtain in any outside person or body, professional or statutory, that might be given a supervisory role in relation to the practice of medicine, and that we should resist any incursion on our autonomy by so ordering our affairs that they are beyond reproach.

*In this case a consultant obstetrician was suspended after compaints by the head of her department that she was incompetent to practise. Dr Savage vigorously defended her position. A judgement is awaited at the time of writing.

Reference

(1) Inch S. Professional incompetence. *Lancet* 1986; i: 864–865.

JOHN A DAVIS
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Support for Health Workers of South Africa

SIR

We have had an enthusiastic response to our letter, printed in the *British Medical Journal* of April this year, suggesting that a group of British health workers should support our colleagues in South Africa who are making a stand against apartheid.

We have formed the nucleus of a group, provisionally named Support Health Workers of South Africa (SHEWSA). We plan to have meetings on the second Wednesday of each month (except August) at 45 Anson Road, London N1, at 8.30 p.m.

We would welcome to these meetings any health worker interested in contributing to this endeavour.

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