LETTER FROM WESTMINSTER

Monitoring future activities of FPCS

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Two of the areas that the health service ombudsman is prevented from investigating under the terms of the 1977 National Health Service Act are matters concerning clinical judgment by doctors and actions taken by family practitioner committees in exercising their functions under the National Health Service (Service Committees and Tribunals) Regulations 1974.

The former has been a longstanding source of parliamentary debate, the latter less so. Mr Frank Dobson, Labour's health spokesman, during the committee stage of the Health and Social Services Bill, put down a probing amendment intended to lift the restraint that he claimed prevented the ombudsman from investigating virtually all the activities of family practitioner committees. He argued that on the strength of their operations to date most family practitioner committees had not devoted a great deal of time to looking into matters relating to the forward planning of the health service, and that the bulk of their activities had been dealing with complaints. He was not suggesting that they made a bad job of doing that, simply that it was an aspect of their work that was not subject to scrutiny by the ombudsman. There was no hierarchy of appeal against maladministration by a family practitioner committee, he argued. If parliament had decided that the ombudsman should look into the administrative activities of district health authorities and accepted that he could also look into the non-personal side of the activities of family practitioner committees then it seemed only reasonable that he should be able to review in any specific case put to him the exercise by a family practitioner committee of its function in looking into individual cases.

Mr Kenneth Clarke, the Health Minister, argued that what Mr Dobson was proposing would lead to duplication as service committee appeals handled by family practitioner committees were subject on their merits to appeals to the Secretary of State. Such procedures were subject to the Council on Tribunals, and he thought that that was the best place to ensure that they were correctly followed. In any case, he pointed out, the parliamentary commissioner for administration was an ex-officio member of the council and as he was also the health service ombudsman he was already properly empowered to look at such things.

But, of course, what Mr Dobson had in mind was to try to widen the ombudsman's role generally towards complaints by patients against a family practitioner in the National Health Service, and on this Mr Clarke said that he wanted to be as helpful and responsive as possible. It was essential that the complaints procedure be effective, open, and fair and that people should not have the feeling that any legitimate body was excluded from protecting the rights and interests of the public and patient, he added. At the same time, nobody wanted a complaints procedure so rigorous and onerous that it encouraged the growth of defensive medicine. This is the practice that has grown up in the United States, where nobody will exercise clinical judgment or take any considered and sensible risk in the interests of the patient because of the fear of facing endless tribunals or being dragged before the courts in pursuit of compensation in comparatively trivial cases.

Mr Clarke then outlined the steps that the government has taken to improve matters, although he emphasised that the service commission procedures were satisfactory in the government's view—

when they were followed properly. To start with, action had been taken to speed up appeals considered by service committees on whether a practitioner was in breach of his terms of service. The position of those who wished to speak on behalf of the complainant or the practitioner had also been clarified, he said.

At present the rules made clear that paid advocates were not allowed, but some family practitioner committees had taken the view that the secretary of the community health council was a paid advocate and so could not speak for patients. The government did not believe that that was a sensible interpretation of the regulations. But they were a little obscure and ambiguous and so they would be amended.

"When we set up our new arrangements for family practitioner committees and make them directly accountable to the Secretary of State we shall ask them to publish information about the incidence and outcome of the complaints they investigate so that they will become to that extent more publicly accountable for the way in which they handle complaints," he added. Work on a leaflet that would explain to patients how to complain was well advanced, and he hoped that it would help them find their way to the redress that they sought. Mr Dobson welcomed the improvements but threatened to return to the whole issue at the report stage of the Bill.

Priority for improving maternity services

The social services select committee, having pretty well told Mr Roy Griffiths to stick to selling groceries and leave the NHS alone for people who understood it to propose how it should be reformed, has now returned to have a look at how its report on perinatal and neonatal mortality issued four years ago has been implemented. The evidence for the Royal College of Obstetricians and Gynaecologists and from the British Paediatric Association was quite clear—there are not enough junior doctors, registrars, or nurses. Dr David Harvey, honorary secretary of the British Paediatric Association, told the committee that what was needed was extra staffing at every level—consultant, registrar, and senior house officer. He thought, however, that there were ways of using existing posts to "plug a lot of holes" without incurring extra costs.

Professor Malcolm McNaughton, of Glasgow Royal Infirmary, giving evidence on behalf of the royal college, was asked by Mrs Renée Short, Labour MP for Wolverhampton North East, what he would identify as the aspect of maternity care that should be given immediate priority of resources if he were Secretary of State. "I would have the staffing levels in England and Wales increased to the same level we have in Scotland," he replied. Professor Stuart Campbell, of King's College, London, said that his priority would be to pay midwives more and have more midwives. He also wanted to see neonatal intensive care units formed throughout the country. Mrs Short then reminded him about the question and he opted for more registrars for obstetric departments. The numbers should be "beefed up," he said. They needed at least four registrars. The committee seemed sympathetic, but quite clearly it all costs money and that is in the end going to be the government's excuse for whatever shortcomings that the report points out. But the royal college left no doubt that it felt that its specialty had so far had a Cinderella role in the affairs of the NHS. In written evidence Sir Rustam Feroze, president of the college, said that parliament must help to provide the resources and expressed concern at the fact that the necessary cash for the improvements that the college desired and that the committee had recommended seldom seemed to be forthcoming.

Part time training for senior registrars

At its meeting on 13 March the Hospital Junior Staff Committee agreed to support the proposals from the women in medicine working party, which is chaired by Dr Anne Blyth, for a new scheme to replace the existing one for part time training for senior registrars with domestic commitments.

The working party has proposed that a quota of present full time senior registrar posts in each specialty and area should be split to form two part time senior registrar posts.

(1) These posts would be under central manpower control.

(2) They would be equal in educational content and conditions of service to a full time senior registrar post.

(3) They would be half time posts and, therefore, last for double the period of the original senior registrar post.

(4) They would be advertised as part time.

(5) There would be no flexibility in the number of weekly sessions.

(6) Each quota would be agreed in consultation with regional manpower committees and regional college advisers. It might take some time to build up to the full quota, which would roughly be in the area of 25%, taking into account that half of medical graduates would be women by the end of the decade.

(7) An absolute upper and lower limit of these posts would be set, which would vary between specialties and areas.

(8) Normal standards of incumbents to these posts would be maintained by the senior registrar selection committee.

(9) The actual distribution of the sessions would be agreed with the consultants involved and the postgraduate committee to accommodate good training and service needs.

(10) The educational content of the post would be reviewed annually by the appointments committee.

(11) If an incumbent wished to return to full time senior registrar training he would have to resign and reapply for a full time post.

Preregistration house officers

It was reported to the Hospital Junior Staff Committee on 13 March that according to the Department of Health and Social Security seven graduates were still seeking preregistration house officer posts at 23 February—four were seeking medical posts and three a first post. Four vacant posts were known to the DHSS—three surgical and one medical. The HJSC chairman, Mr Stephen Brearley, said that he believed that the DHSS was embarrassed by the failure to allocate all new graduates and had been tough with authorities who had appointed people to preregistration posts who were not new graduates.

Mr C J Ingoldby reported that in Wales the postgraduate dean of the Welsh National School of Medicine had said that hospitals should not make appointments until all Welsh graduates had been placed. Most consultants opposed this despite the fact that there were more graduates than posts available. Some

hospitals in Wales had links with non-Welsh medical schools, and some consultants wanted to keep places for graduates trained outside Wales. Mr Ingoldby and the Welsh HJSC were assured of the committee's support in opposing this action.

General practice

Computer confidentiality

The attention of the General Medical Services Committee has been drawn to circumstances in which possible breaches of confidentiality may have occurred in respect of computerised information held by general practitioners. The committee has suggested the following safeguards to local medical committees to avoid such breaches.

In order to determine the nature of faults in software, some maintenance engineers have been using, as test material, floppy disks containing confidential information from other practices. The committee is anxious to ensure that when software containing patient information is referred to manufacturers for inspection the confidentiality of the data is respected. The GMSC has endorsed the action taken by the project manager of the micros for general practitioners scheme, following representations from the profession, who has written to all companies supplying or servicing computer systems in general medical practice advising them that they will be required to sign an undertaking on confidentiality. Doctors will be aware that it is their responsibility to ensure that the confidentiality of their medical records is observed. The committee therefore commends the undertaking to general practitioners as an appropriate way of ensuring this. It is important that general practitioners take steps to ascertain whether the companies with which they have maintenance contracts have signed such an undertaking. It is also important that when service engineers are called to a practice to undertake maintenance they are accompanied by a general practitioner during the maintenance.

Market research

Several market research companies have approached general practitioners asking, in return for a fee, that the practitioner supplies them with prescribing information. As independent contractors, general practitioners are expected to come to their own decisions about this matter, but the GMSC is concerned about the way in which such information should be supplied. Examples have been produced of doctors being asked to provide copies of their data on to either floppy disks or tapes for subsequent analysis by the market research company. The company supplies the programme to extract the data with an assurance that only prescribing data will be readable and that the other information will be "scrambled."

The committee is not convinced about the safety of this practice in terms of guarding confidentiality and has suggested the following code of practice:

"Any information leaving a practice for market research should not be on a tape or floppy disk, nor should it be in machine language. It should be in a printed form which can be read and checked for confidentiality by the doctor before being handed over."

Training receptionists

The General Medical Services Committee has considered the revised version of a report *Receptionist Training for General Practice*. This has been prepared by the Association of Medical Secretaries, Practice Administrators, and Receptionists and the Royal College of General Practitioners. The committee has not accepted the planned syllabus for training, which it considers too detailed, but it has, nevertheless, welcomed the report and the establishment of receptionist training courses. The GMSC has agreed to participate with the association and the college to set up a small central body to collect and disseminate information about educational courses for receptionists. It believes that the initiative for setting up such courses should be taken locally and the committee has suggested that local medical committees should be encouraged to establish joint committees with faculties of the Royal College of General Practitioners, local branches of the Association of Medical Secretaries, the organisers of existing courses, and other relevant professional organisations, with the aim of coordinating training courses. A list of the branch secretaries of the Association of Medical Secretaries may be obtained from the association's head office, Tavistock House (South), Tavistock Square, London WC1H 9JH.

Notifiable diseases

A working party of the board of science and education has been looking at the present system of notification of disease in the United Kingdom and the value of notification and has made recommendations about how methods of notification might be made more efficient and which diseases should be subject to statutory notification. The working party, chaired by Dr W W Fulton, has reported and made the following recommendations:

Statutory notification of infectious diseases should be retained.

The system should be flexible to allow for change to meet changing situations. It should be based on enabling legislation with subordinate regulations capable of relatively easy amendment.

The criteria for inclusion in the list of notifiable diseases should be:

To provide immediate information to the appropriate community physician so that quick preventive measures may be taken in the control of communicable diseases.

To provide statistical information to help to plan health care facilities and longer term