TALKING POINT

Clinical freedom, efficiency, and the Griffiths report

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The Griffiths report¹ has received a more muted response from the health service than might have been expected from the rumblings that surrounded the setting up of the National Health Service management inquiry in February 1983.² This low profile response could have several explanations. The contents of the report were fairly well known before it was published; there is little in the report that is new; the implications of any novel features are not spelt out; NHS cynicism in the face of yet another management upheaval; a belief that truly radical reforms (in NHS terms) will not be pursued. To sum up, it seems to be a case of "plus ça change, plus c'est la même chose."

Although the British Medical Association's council has criticised the Griffiths report, the low key reaction from individual doctors—as judged by the *BMJ*'s correspondence columns—may be because the report seems likely to have little impact on the role and responsibilities of the average clinician. The recommendation that clinicians should participate more closely in the management process is tempered by the clause "consistent with clinical freedom for clinical practice." We were struck, however, by the coincidence that this remark should be embodied in an official report in the same month that the *BMJ* published a leader entitled "The end of clinical freedom." A cardiologist, Professor J R Hampton, argued that "clinical freedom is dead" and, importantly, that "no one need regret its passing." While its death was accidental, Hampton suggested that "clinical freedom should . . . have been strangled long ago, for at best it was a cloak for ignorance and at worst an excuse for quackery." In welcoming its demise he concluded positively by suggesting that the profession should, in the post-burial period, "seize the opportunities now laid out before us."

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The vivid contrast between the views of Professor Hampton and those embodied in the Griffiths report point out the most serious weakness in this latest attempt to solve the problems of the NHS by reorganising them. As economists, we are much more in accord with Professor Hampton's view of the world, believing that he and other clinicians who share an interest in making the NHS efficient and effective should be disappointed with the Griffiths report.

Economics, as all avid readers of the *BMJ* series last autumn now know, "is about getting better value from the deployment of scarce resources"; it is about "meeting the objectives of health care within the resources available in the best possible way"; it is "about opportunity cost and about benefits . . . in other words, being efficient."⁴ Our view is that from the ashes of clinical freedom efficiency will arise. In a world where individual clinicians believe that their sole responsibility lies with their patients and where there are severe weaknesses in countering the medical values with other relevant values in deciding on priorities for care inefficiency will flourish. The aggregation of individual doctors' clinical freedoms leads to inefficiency.

Why is this? Is not the sum of all doctors doing good equal to society being well? In a sense, yes; but the removal of inefficiencies in health care, as economists have been saying for years, is about not settling for being well but about doing better.

Three essential elements

Essentially this means that three things are needed.

(1) Knowledge of how effective different forms of care and treatment are (and, note, not just whether treatment A is medically more effective than treatment B).

(2) Knowledge of the costs of different treatments and an understanding of the economist's concept of opportunity cost—that is, that using resources in one way means forgoing the opportunity of providing benefits in some other way—or as Hampton put it, "one man's provision is another man's deprivation."³

(3) Judgments about the relative values to be attached to effectiveness of care for different patients—in other words, value judgments about the relative weights to be attached to improvements in health status for the diabetic patient, the neonate, the geriatric patient, and so on.

Clinical freedom when it was alive meant freedom to be obsessed with (1), to attempt to ignore (2), and to be totally unaware of the need even to recognise the existence of (3). It is quite alarming to discover, for example, how frequently clinicians do not understand the concept of value judgments, assuming instead that all judgments they make are technical. Those who are aware too often do

not recognise the potential that exists for different individuals' or groups' value judgments to be appropriate in different circumstances; indeed, they often ignore the legitimate scope for conflict that exists between medical values and others—for example, the patients' values. McNeil *et al* suggested in the context of treating patients with lung cancer that "all clinicians should realise that failure to consider patient attitudes toward risks and differing time frames of survival may not permit optimal choice of therapy for some patients."⁵

The authors of the Griffiths report cannot have failed to recognise the problem that exists. They comment in their general observations that clinical evaluation of particular practices is by no means common and economic evaluation of those practices extremely rare. Nor can the NHS display a ready assessment of the effectiveness with which it is meeting the needs and expectations of the people it serves. Yet the "Griffiths" reads "clinical freedom rules, OK." The Griffiths team has failed to recognise the link between the circumstances that exist and the position of the medical profession within the NHS. It is all the more surprising that a report that was supposed to cast a commercial eye over the running of the NHS should endorse the continuation of a professional freedom of action that would not be tolerated anywhere in the private sector.

Fatal flaw of Griffiths

Given this fatal flaw, the Griffiths report is unlikely to have much impact on the NHS in the sense of improving the delivery of patient care. Most of the recommendations are merely putting right the defects in previous reorganisations, many of which were pointed out by NHS managers at the time. For example, it was always going to be difficult for districts to delegate to units without giving them control over their budgets (recommendations 8.4 and 8.5). As for the introduction of general managers, we favour the end of consensus management but do not see it as a panacea. The Griffiths team failed to see that the first requirement for the NHS is better setting of objectives rather than better management performance in achieving them (recommendation 6.2). The recommendation (9.2) for reviewing the remuneration system and conditions of service "so as to overcome the lack of incentive in the present system and the inability of chairmen to reward merit or take action on ineffective performance" would have our support if it was extended beyond management, or if clinicians were recognised as managers.

This last point is just one where the Griffiths report has missed the opportunity to be truly radical in its approach to NHS management. Clinical merit awards are substantial. Yet there is no system of rewards or penalties to induce clinicians to behave in

an efficient manner in the sense that we would advocate—that is, maximising the value of improvements in health status. Laudable recommendations on output measurements, clinical budgeting, and clinical and economic evaluation of medical practice will continue to be hampered by the lack of will to tackle those elements of the medical establishment who fail to recognise the truth of Professor Hampton's comments. Clinical freedom may be dead but it has not been finally laid to rest in the minds of many practitioners.

References

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- ³ Hampton JR. The end of clinical freedom. *Br Med J* 1983;287:1237-8.
- ⁴ Mooney GH, Drummond MF. Essentials of health economics. *Br Med J* 1982;285:949-50.
- ⁵ McNeil BJ, Weichselbaum R, Pauker SG. Fallacy of the five-year survival in lung cancer. *N Engl J Med* 1978;299:1397-401.

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Quality of out of hours care

RCGP calls for working party

The Royal College of General Practitioners has circulated a document on out of hours care to all its members. When the comments are considered by the college council on 10 March a formal response will be made to the Department of Health's draft circular on deputising services which was issued in December.¹

At a press conference called to launch the document on 25 January the college's honorary press secretary, Dr Bill Styles, emphasised that the college was not opposed to deputising services, which it saw as making a contribution to out of hours care in general practice. The RCGP's main concern, however, was on the quality of care. Terms and conditions of service were a matter for the BMA. The college shares the concern of the BMA and the General Medical Services Committee at the way that the draft circular was issued without prior consultation and believes that there would be more effective ways of monitoring the frequency of use than the random method proposed in the circular, which smacked of snooping.

In the document the RCGP explains that it interpreted paragraph 4 of the circular on the frequency of use differently from the GMSC. The latter had suggested that interpractice rotas would not be permitted and that larger practices would not be allowed to use commercial deputising services.

The officers of the college assumed that interpractice rotas of any size, including non-commercial town rotas and cooperatives, were not covered by the circular. Furthermore, they thought that the proposal carried considerable flexibility, in that the minister seemed to want to encourage family practitioner

committees to define the selective use that any practice, large or small, might make of deputising services. Such selective use on an occasional basis might arise, for example, when a partner was disabled through illness. The chairman of the college council invited Mr Kenneth Clarke to clarify the position. In his reply Mr Clarke confirmed that the deputising services that the draft circular was intended to cover were those for which family practitioner committees had granted consent of use under paragraph 19 of the terms of service for doctors. Local rota arrangements with neighbouring practices would therefore not normally be affected, although some large cooperatives that had been established on a commercial or a quasi-commercial basis had been adjudged to require consent. He continued:

"Your [the officers'] interpretation of paragraph 4 is quite correct. The form of consent suggested would be subject to modification as necessary to take account both of particular local circumstances and of the problems of individual doctors and practices. It was certainly my intention that this would introduce sufficient flexibility into the system of control to accommodate the sort of case that you describe in your letter and others which, as you rightly say, would be local and could not be predicted in guidelines. There is in any case, as I am sure you will appreciate, a danger in spelling out a list of examples in the circular, since this might then be taken as exclusive. That is something which I should certainly not want."

It is the college's view that out of hours care at any time of the day or night is an integral part of general practice and that it is therefore a function of all principals to play their part in maintaining the service by seeing patients on a regular basis in out of hours periods.

Within the framework of the independent contractor status using rotas, cooperatives, and principal based deputising services there is sufficient scope, given local flexibility, the college believes, to cater for the differing needs of patients in, for example, the deprived parts of inner cities and in country areas. Equally, such a framework should ensure that arrangements could be made to take care, for instance, of the sick or frail doctor, holidays, study leave, and other local circumstances.

Wider issues in out of hours work

The RCGP concludes its document by pointing out the wider issues involved in out of hours care.

"It is essential that the broader issues involved in out of hours care in general practice should be examined urgently. There is a new generation of doctors, changing expectations in patients, and modern practice management methods—these are all new factors which need time and a period of calm to think through. The general purposes committee strongly recommends the setting up of a working party which should bring together the government, patients, and the profession through the GMSC and the college.

"The working party will need to consider fundamental questions such as what doctors really want, what patients really want, and how the potential for more sophisticated

practice management, including the use of new technology, can help.

"Finally, a considerable number of college members have made the point that, if out of hours care was made more financially attractive, the true need for commercial deputising services would soon become clearer. They hold that the remuneration of general practitioners providing their own care in their own partnerships or in association with local colleagues should more closely reflect the time spent and the skill made available to patients. The committee agrees. Quality, exemplified by committed doctors who know their patients well, should not be a cheap commodity. Other members have expressed concern that the profit element inevitable in a commercial deputising service must necessarily affect the whole nature of patient care."

Recommendations

- Out of hours care at any time of the day or night is an integral part of general practice. It is a function of all principals to play their part in the maintenance of the service by being available to and by seeing patients on a regular basis in out of hours periods. Given such a commitment, the independent contractor must be free to decide when and to whom he will subcontract some of his overall responsibilities.

- Out of hours care in general practice must be of a high standard, however it is provided. The general purposes committee's preference is for a personal service that uses experienced practitioners with local knowledge, which should be well organised, and which should be founded on local practice rotas, including non-commercial cooperatives. Where arrangements of this kind are not possible, only properly supervised commercial deputising services should be used.

- Deputies working for commercial deputising services must be principals, or must be eligible to be principals, in general practice.

- The government and the profession through the GMSC and RCGP should form a working party on which patients are well represented, to examine and report on the issues which we have highlighted.

- The minister's proposals for the supervision of commercial deputising services through family practitioner committees, modified in the way we have suggested, should now be implemented.

- The remuneration of general practitioners providing their own care in their own partnerships or in association with neighbours should more closely reflect the time spent and the skill made available to patients.

¹ Department of Health and Social Security. *Health service development. General practitioner deputising services*. HC(FP)(84). London: DHSS, 1984.

Cost rent scheme

The Department of Health and Social Security has notified family practitioner committees that the practice unit cost allowances of the cost rent scheme and the minimum and maximum cost limits of the improvement grant