From the CCHMS

Audit, manpower, and private practice

Mr David Bolt chaired the meeting of the Central Committee for Hospital Medical Services on 6 December. Subject to the agreement of the Joint Consultants Committee the principles set out in the Secretary of State's letter on private practice (p 1605) were approved. The main debates were on the report of the Medical Audit Working Party and on the Council's Working Party on Medical Manpower, Staffing, and Training Requirements.

Medical audit working party's report

Continuing education

The 1978 Conference of Senior Hospital Staff passed the following resolution:

"That the CCHMS should explore actively methods of medical audit which should be of practical value and also be acceptable to the profession."

A working party was set up with Dr W D Linsell, a consultant pathologist, in the chair. Presenting the report to the CCHMS Dr Linsell explained that his working party had collaborated with the Board of Science, which was also examining audit. The final report was in three sections, all of which were interrelated: continuing education, medical audit or peer review, and the revised "three wise men" procedure. In the section on continuing education the working party had recommended that all senior hospital medical staff should be entitled to 15 days' annual study leave and to sabbatical study leave on the basis of one week for every year over a 12-year period in which the doctor averaged 10-15 days' study leave a year.

Mr A P J Ross pointed out that it would be difficult for doctors in district general hospitals to take 15 days. Moreover, professional conference attenders would be able to build up entitlement to sabbatical leave. The person who took only five days a year was the one who really needed a sabbatical every few years. In the view of Dr C L Smith it was a retrograde step to link study and sabbatical leave. If mandatory continuing education was introduced doctors would have to "sign up" and this would eventually be tied to remuneration.

The working party had emphasised that participation in study and sabbatical leave schemes should be voluntary but Dr W D Dolton warned that failure to participate could be used against doctors as evidence of lack of professional competence—a form of negative audit. Doctors could go on as many study leave courses as they liked, Dr D H Kenward told the committee; but it was impossible to practise up-to-date medicine in outmoded hospitals.

The committee agreed that the section of the report on continuing education should be considered and revised by the General Purposes Subcommittee.

Audit

Dr Mary White warned that the presentation of any report on audit would need a careful public relations exercise; otherwise it would seem that doctors had been doing nothing to audit their activities. On the contrary, senior hospital staff were constantly monitoring their work. The working party report had set out the action already being taken to maintain standards—for example, ethical committees (clinical research and surveillance), clinicopathological conferences, and control of infection committees.

The proposals were innocuous, according to Dr G H Hall, and would not satisfy the hawks who wanted to impose a compulsory supervisory system. If audit meant assessment of clinical performance, how would it be done and who would do it? There were assurances that participation would be voluntary; this meant that people who needed assessing would not take part. Audit did not work in the USA; it was not true that the feedback of information was helpful; if a bad doctor was told he was doing something wrong he would not change his ways. Consultants were entrusted with complete responsibility only when they had been subjected to a rigorous selection procedure and this was the best form of audit. Dr Hall thought that it would damage the CCHMS in the eyes of the profession if it was seen to endorse audit. He challenged the protagonists to provide evidence that it made any difference to patient care.

Mr Julian Elkington, on the other hand, believed that it would be good for hospital practice and for staff morale to take several topics each year, department by department, and see whether better results were achieved.

But quality control was not the same as audit, Dr Jeremy Lee Potter said. Audit was a matter of opinion; it could work in laboratories but many things could not be audited.

Dr Clifford Astley was appalled at the recommendation that members of medical audit committees, which the report suggested should be set up, should be paid. He wanted the section referred to regional committees. If a vote was taken it might be lost, which would imply that the CCHMS was opposed to any form of peer review. The consultants in Mr J R Chawner's area did not want the kind of formal monitoring that the report recommended; he was in favour of audit but in an informal way. The confidential inquiry into perinatal and maternal mortality had been invaluable, he said.

Dr Astley's suggestion that this part of the report should, after modification, be referred to the regional committees for hospital medical services was adopted. The comments will be reported to the next meeting of the CCHMS.

Three Wise Men procedure

The committee decided to defer a debate on the section of the report dealing with the revised "three wise men" procedure when it was told that the JCC would shortly be seeing a draft revised DHSS circular on the subject. Furthermore, the General Medical Council was consulting the profession on the constitution and working of its new Health Committee and this would be debated at the same time.

Medical audit working party

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"That the CCHMS should explore actively methods of medical audit which should be of practical value and also be acceptable to the profession."

A working party was set up with Dr W D Linsell, a consultant pathologist, in the chair. The other members were: Mr David Bolt,* Mr R T Booth,* Dr J M Cundy, Mr R K Greenwood (resigned), Mr J R Harper, Mr P R J Vickers, Dr W J Appleyard (observer), Mr James Kyle (observer), and Dr J Sarginson (CCCM observer).

*Appointed in May 1979.

Revised contract and pensions

A new booklet, which explains how a consultant's pension will be affected by the kind of contract he chooses and how he can use non-NHS income to provide a private pension, is available from the secretary of the Superannuation Committee, BMA, 7 Drumsheugh Gardens, Edinburgh EH3 7QP. BMA members should quote their membership number when applying for a copy.

Manpower and staffing structure: Council report discussed

The Council's Working Party Report on Medical Manpower, Staffing, and Training Requirements was published in May (19 May, p 1356). Regional committees had been circularised with a commentary on the report and asked to base their comments on 11 questions (see below). The views of the CCHMS, in its debate last week, mirrored closely those of the regional committees. There was a majority in favour of questions (*a*), (*b*), (*c*), (*g*), (*h*), and (*i*). The committee, however, did not agree that specialty choice should take place at the SHO/first year registrar stage (that is, about three years after registration), further progress being restricted to those in approved training posts in the particular specialty (question (*d*)). Like the regional committees, the CCHMS was divided on the remaining questions.

Mr R K Greenwood considered that the subject was the most important—for the future of the profession and for patient care—with which the committee had had to deal since he had become a member. It was more important than money, contracts, or private practice. The Council's report lacked credibility; the chairman had been a GP and there were too many junior hospital doctors. The report had ignored the increased number of medical students, which would inevitably lead to unemployment, and had taken no account of the financial implications of the recommendations. If more consultants were to be appointed they had to be paid but there would be no more money. The important thing, so far as Mr Greenwood was concerned, was to persuade young doctors who were not going to make the grade in a particular specialty to shift sideways. The only contentious issue was the working party's proposal to introduce a new training grade, broadly at registrar level. This, the report said, would mean "the recognition of certain posts for training purposes and the linking of the number of these posts to the established senior registrar grade." There must be some selection, he said. The document was a passport to mediocrity as it eliminated competition.

If people were to move sideways, Dr J R Harper said, the system had to be flexible enough to allow them to do so. He knew that the subconsultant grade was an emotive subject but the Oxford RCHMS had suggested a closer look at incorporating a specialist grade into the career structure. The arguments against a subconsultant grade became less cogent each time he heard them.

Mr Julian Elkington wanted to see registrars treated fairly. Young doctors wanted security, a certainty of being promoted, and the promise of a genuine consultant grade at the end. They could not have all three at once and had to say which one or two they wanted.

A member of the working party, Dr Mary White, had wanted more emphasis put on the numbers aspect of manpower in the report but she had been in a minority. The report was, she emphasised, a discussion document and it had never been envisaged that the proposal for a new training grade would be a straight passport to a consultancy.

Mr A P J Ross agreed with the suggestion that there should be more consultant posts where sufficient work and facilities existed to justify them. So long as junior staff were not reduced they would be giving more of a consultant service instead of practising battery-type medicine as at present.

Dr C L Smith pointed out that honorary contract holders were not included in the manpower figures. Half of the honorary contract senior registrars would move to the NHS as consultants. Any suggestion that they were second rate was untrue.

"Immature" and "shortsighted" were the comments on the report from the Trent RCHMS, Dr G F Cohen reported. It took no account of the supporting staff and services needed or of the people who fell off the career ladder.

The chairman of the Joint Consultants Committee, Dr J D N Nabarro, emphasised how important it was to get the views of the members of regional committees and of consultants who worked in district general hospitals to arrive at a satisfactory career structure. The questions which had to be answered were to what extent consultants would be prepared to cover the work of an SHO rather than insist on a registrar living in and how the intermediate cover between house officer and consultant would be organised. Would young consultants be prepared to do more emergency work, for instance? The proposed hospital practitioner grade mark II would also be an important factor. He envisaged departments where originally there might be three consultants and three registrars. The consultant establishment might be increased to four with two registrars and two SHOs.

A proposal from South-west Thames RCHMS that the CCHMS should set up its own manpower working party was defeated by 23 votes to 15.

Questions to regions on manpower and staffing

(*a*) Do you agree that a body to monitor the overall medical manpower situation should be set up?

(*b*) Should the number of overseas doctors entering this country in the future seeking a permanent career be controlled?

(*c*) Should overseas doctors coming here in the future specifically for postgraduate training be subject to a strict time limit on training?

(*d*) Do you agree that, usually, specialty choice should take place at the SHO/first year registrar stage (that is, about three years after full registration), further progress being restricted to those in approved training posts in the particular specialty?

(*e*) Do you agree that comparable training posts should be set up specifically for overseas doctors?

(*f*) If so, do you agree that such posts should be excluded from the training ladder for UK consultants?

(*g*) Do you agree that manpower control should be exercised over the grant of honorary NHS status to academic posts at training level?

(*h*) Should there be an increase in the number of consultant posts in those hospitals where sufficient work and facilities exist to justify them?

(*i*) Do you favour the concept of early retirement with pension protection for consultants, on a voluntary basis, to improve promotion prospects for junior staff?

(*j*) Should the posts in the new training grades, both UK and overseas, be distributed equally between teaching hospitals and district general hospitals?

(*k*) Has your committee any suggestions for other ways of achieving better career prospects for doctors in training in popular specialties?

Handling industrial disputes

Government guidance to management

The DHSS has issued detailed guidelines to health authorities on handling industrial disputes in the Health Service. At the same time the General Whitley Council is discussing a draft agreement on procedures for handling local disputes. The DHSS circular (HC(79)20) advises management how to respond to industrial action: it states that voluntary help may be used during a dispute and that authorities are free to use agency staff or contractors. Contingency planning should be given high priority; authorities should identify services which are susceptible to disruption and assess with doctors and nurses the extent to which services need to be maintained to provide basic essential clinical and support services.

In an annex the circular spells out the various forms of management response. Pay should be stopped for the period of the strike. If performance is affected by industrial action bonus schemes should be adjusted. In the case of guaranteed or regular overtime, shift allowances, units of medical time, and other allowances, where employees do not carry out the duties to which the allowances relate pay should be stopped for the appropriate period. If staff report for duty normally but refuse to carry out their normal duties by working to

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