appreciable number of senior house officers enter general practice and therefore there will be many departments with a two day shortfall in senior house officers.

The NHS executive must be reminded that senior house officers do not rotate endlessly within the NHS hospitals, but follow a career path. Any plans for changing the start dates of house officers must take into account the end points of these career paths, which may lie outside NHS hospitals.

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1 Winyard G. New start dates for medical posts. *BMJ* 1994;**309**:56. (2 July.)
2 NHS Management Executive. *Introduction of compulsory induction courses and changing the starting day for hospital medical and dental staff.* Leeds: NHSME, 1994. (EL(94)1.)

Problem doctors

EDITOR,—Liam J Donaldson discusses dealing with problem doctors in a region.[1] Regional responses to medical disciplinary problems have often been remote, cosy, and ineffective, lacking in urgency and understanding of local situations; regions have not inspired confidence in hospital managers and clinicians who wish to bring forward serious allegations. Local knowledge of the personal and professional conduct of individual doctors should enable medical directors of hospital trusts to assess problems more rapidly and deal with them more effectively at an earlier stage. NHS trusts are less likely to tolerate personal and professional misconduct in any groups of staff, including doctors.

A tiny minority of staff consistently abuse privileges afforded through medical professional self regulation. New and more flexible procedures are needed, but existing disciplinary procedures need to be enforced, as would apply in the case of any other NHS employees. Disciplinary action has become a commercial consideration. The short term financial interests of the trust—the costs of disciplinary action and the salary of a suspended consultant—are set against the benefit to the trust, and the NHS, of a properly convened disciplinary process, which sees justice done in the presenting case and prevents future misconduct or incompetence for the protection of patients and taxpayers.

Appeal to the secretary of state over alleged professional misconduct and incompetence is an anachronism that must be abolished. Furthermore, it is ludicrous that a ministerial review can be invoked in respect of personal misconduct if a doctor appeals that alleged misconduct is professional and not personal.

Prospective audit of medical disciplinary processes is needed, involving trusts' medical directors and directors of public health. This should be regional, but the new regional offices may not have the wherewithal to organise it. This is the only way to test the effectiveness of trusts' medical directors in operating medical disciplinary procedures. Until these medical directors have gained sufficient experience, those who are experienced in medical discipline should be involved, from the region and district. An "override" facility should remain so that the chief medical officer, or regional medical officers, can investigate serious untoward incidents and allegations about medical conduct in trusts.

The General Medical Council could function as a national surveillance and response unit for professional misconduct and incompetence, akin to communicable disease surveillance units. A poorly performing doctor functions as a carrier of communicable illness does. Clinical accidents should be "notifiable," with information collated across Britain to identify "outbreaks" associated with a single doctor, or trends, related to long hours, failures in training, or substance misuse. An effective mechanism to monitor and control medical accidents can be implemented for the protection of patients and staff but requires greater medicopolitical will. The public and the profession must have confidence that medical disciplinary matters are dealt with effectively and appropriately.

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Master's degree in general practice

EDITOR,—Lindsey Smith writes about the provision of master's degree courses in general practice. She points out the low uptake of the higher degrees provided by university departments of general practice and suggests a possible curriculum.[1]

There are providers of master's degrees for general practitioners other than departments of general practice. I am just finishing a master's degree in medical ethics and law at King's College, London. This course was not put on by a department of general practice yet it was highly relevant to general practitioners and there were several other general practitioners on the course with me. Before deciding on this particular course I found several available which were suitable for general practitioners—for example, the history of medicine MPhil course in Cambridge. There is, however, a need for an up to date list of appropriate courses.

My second point is about the content of master's degrees. Smith's list was quite comprehensive but I was left asking whether the purpose of a master's degree is to make you a more educated generalist or is this the time when general practitioners should start to look at a smaller area which they find particularly interesting? My answer would be the latter.

Bruce Charlton thinks that a doctor should have at least one other way of thinking than that of the doctor, one other system of mental discipline than that of medicine.[2] It may be impractical for us to acquire this as undergraduates but it would be a shame if we missed the chance as postgraduates.

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2 Charlton BG. Holistic medicine or the humane doctor. *Br J Gen Pract* 1993;3:475-6.

Informal complaints procedure in general practice

EDITOR,—P C Pietroni and S de Uray-Ura describe an important development in general practice—namely, an informal complaints procedure.[1] Their experience shows that a need for a practice based complaints procedure exists and that a viable protocol can be devised. Their use of the procedure for complaints by staff as well as complaints by patients is welcome.

The Medical Defence Union supports the concept of practice based complaints procedures, but such procedures are unlikely to reduce the number of general practitioners who are found in breach of their terms of service for serious complaints such as failure to visit when necessary. They should, however, reduce the number of complaints to the family health services authorities that do not concern terms of service.

The authors do not describe how they dealt with patients' "grumbles" before their practice complaints procedure was set up. Many such grumbles can be dealt with by unstructured discussion at the time that they are voiced. Not all complaints will fit into the neat categories devised by a protocol. Speed, sympathy, and a willingness to listen may be all that is necessary to resolve a complaint.[2] It would be a retrograde step to refer all patients' complaints to a procedure run by a third person.

In their introduction the authors confuse complaints to family health services authorities with litigation and quote my figures incorrectly.[3] It is not complaints to family health services authorities but claims for damages against general practitioners that have increased 10-fold over 12 years. Complaints to family health services authorities have increased threefold in 12 years. Similarly, the differential rates of complaint against male and female general practitioners relate not to claims for damages but to complaints to family health services authorities.

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2 Beresford D, Green S. *Practice complaints procedure.* London: Medical Defence Union, 1994.
3 Schütte P. Introduction. In: Schütte P, Nesbitt M-L, eds. *Coping with patient complaints in general practice.* London: Medical Defence Union and Pulse, 1993:2-5.

Taking away hope

EDITOR,—No matter how humanely and sympathetically a death sentence is given, it is a rare patient who is not deeply and adversely affected by the news that she will, within a relatively brief time, inexorably die. Additionally, she must be told that there is nothing that modern medicine can do to help her. In their article S M Downer and colleagues make the point that "for many cancer patients hope is an important issue."[1]

Are we so inhuman or suprahuman that we must blindly follow the modern dictate that "the patient must know"? During my days in general practice I knew my patients and their families, and between us we were usually able to decide those who must know and those who need not. Almost always the patient conspired, when appropriate, to maintain this myth of ignorance. When a patient a week away from death said, "I'll be better next week," should I really have replied, "Oh no, you'll be dead"? I have no statistics to prove my point, and I wonder whether, perhaps, warmth and humanity are becoming submerged in figures; I know that for many of my patients hope remained a feature of their peaceful dying.

Hopefully, in the not too distant future psychoneuroimmunology will be able to use the already demonstrated pathways between the hypothalamus and all the organs of the immune system to provide more than psychological support to patients with conventionally untreatable conditions.

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