From the GMS Committee

Review of complaints procedure

Report from the Chairman

Dr R A Keable-Elliott told the General Medical Services Committee on 17 February that oral evidence had been given to the Review Body on 1 and 2 February. A strong case had been made for additional remuneration to compensate for increased work load and the representatives had reported the virtual nil growth in the number of male British doctors entering general practice.

The Chairman of Council had led a deputation to meet the Secretary of State on 9 February to discuss the next round of the pay policy. Mr Ennals had been told of the anomalies which the first two phases had caused and which doctors hoped would be corrected.

The Secretary of State had received another deputation on 1 February on the remuneration of general practitioner trainees. The deputation included a representative of the Royal College of General Practitioners; Sir Kenneth Robson, representing the postgraduate deans; and the chairman of the Trainees Subcommittee, Dr G P Kittle. Mr Ennals had listened sympathetically and had agreed to see if an interim solution could be implemented within the current pay restraint period, but he was doubtful of success. The Secretary of State had estimated that the cost of correcting the anomaly in trainees' remuneration when they moved from hospital to general practice would be about £600 000 pa rising to £1 million by 1980.

At the last routine negotiating meeting with the DHSS the Department had expressed concern about the implications of the 1976 resolution of the LMC Conference calling for the abolition of short-term certification. A small joint working party would be set up to examine the various possibilities of reducing the burden of short-term certification. The group would examine in particular the arrangements made in some other countries where partial self-certification arrangements existed.

The other item discussed had been the question of the arrangements for extending the existing non-contributory invalidity pension to married women, as provided for in the Social Security Act 1975. The new benefits are to be payable to severely disabled/chronically sick married women on the basis of a dual test of incapacity for normal household duties and incapacity for work, and general practitioners are to be invited to complete reports on applicants for these payments. Subject to certain amendments, the proposals had been accepted in principle by the negotiators on the understanding that there would be a realistic fee for the completion of the report.

At a meeting on 10 February the Department had agreed to have another look at its policy on community hospitals. The LMC Conference had resolved in 1976: "That this Conference condemns the DHSS policy on community hospitals as totally unacceptable, and in the interests of patients calls on the GMSC to demand a complete change."

- *Complaints procedure*
- *GPs in hospitals*
- *Incomes policy*

Complaints procedure

The Statutes and Regulations Subcommittee had been examining and commenting on the Department' proposals—see p 663—to modify the investigation of complaints procedure. Also, Dr D L Williams had prepared a memorandum on the subject and had suggested that protection could legitimately be asked for (*a*) to protect the doctor from a patient who physically abused or who, without reasonable justification, behaved in an insulting or offensive way to the doctor, any member of his family, or any employee; (*b*) to protect the doctor from a patient who persistently and unreasonably attempted to obtain from him any service or services the doctor was not required by his terms of service to give or who persistently requested services within the doctor's terms of service at an unreasonable time or place; (*c*) to protect the doctor from any patient whose demands for medical services were so unreasonable as to interfere with the care of the doctor's other patients; and (*d*) to compensate doctors for the time and anxiety caused by complaints which were malicious or highly unreasonable.

Dealing with overpayments, Dr Williams said that it was inappropriate that overpayments—often the responsibility of the FPC administrator—should be referred to a service committee, where the guilty seemed to be judging the innocent. A different procedure was required and one that would differentiate between technical overpayments (due to minor misunderstandings in completing forms) and real overpayments where doctors had received money to which they could not have been entitled. Where the recovery of overpayments became a repeated procedure the service committee should have the power to recommend disciplinary action against the administrator.

The committee expressed concern about the one-sided nature of the existing procedure, which did not give GPs protection against unreasonable and groundless complaints. It proposed that the question of recovery of overpayments to GPs should be dealt with outside the service committee procedure.

The comments of the subcommittee and Dr Williams's memorandum were approved.

GPs in hospitals

Dr P J Enoch presented the report of the working group on the remuneration of general practitioners in the Hospital Service. The group had divided the problems into three categories—casualty work in GP hospitals, general practitioner/community hospitals, and clinical assistants. It had made several recommendations (p 663).

According to Dr P F Kielty, the report was too timid. Since 1948 GPs working in hospitals had been looking to the GMS Committee for a clear lead. The document should be tough and forthright and contain much more information.

Dr W G A Riddle proposed that the final recommendation should be deleted and

In debate . . .

Incomes policy

"*. . . the committee should go to the Government now to urge that flat rate increases were out and that differentials have to be restored . . .*"

DR L KOPELOWITZ (Newcastle upon Tyne)

"*. . . the incomes policy put forward by the Government is not in the interests of the medical profession because all too often it is geared to a different working group . . .*"

DR R A KEABLE-ELLIOTT (chairman)

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referred to the Compensation and Superannuation Subcommittee. How clinical assistant sessions would count for a pension had long been a vexed question. In some cases a general practitioner was better off being counted as an officer, in others not. The suggestion from the Department was that if the profession proceeded in the matter they would have to look at the accrual rate of 1·4% again and that was not desirable.

Dr J G Ball pointed to several omissions—on-call and the contractual obligation; travelling and expenses, which were no longer trivial sums; and the element of clinical work load. He suggested that a further recommendation might be that clinical assistant posts should be paid at locum consultant rates if there was no consultant cover.

In reply, Dr Enoch explained that the group had intended to produce suggestions on which negotiations could take place. The problem which had beset GPs, particularly over the payment in casualty departments, was that there was no national policy. Until they said that they were no longer willing to work in casualty departments no progress would be made.

The committee agreed that the document should be used as a basis for negotiation after consultation with the CCHMS and the HJSC and that the final recommendation should be deleted.

Incomes policy

Moving "That co-operation of the GMSC in an incomes policy after 31 July 1977 is dependent primarily on that policy, including measures to prevent any further fall in living standards of general practitioners," Dr M A Wilson pointed out what had happened to general practitioners' living standards because of the Government's incomes policy.

Dr D G Scott wanted to amend the motion to read "That co-operation of the GMSC in an incomes policy after 31 July 1977 is dependent primarily on that policy, including measures to restore an acceptable proportion of our lost standard of living." Supporting the amendment, Dr D L Williams said that the standard of living of everyone would have to fall and it was necessary to protect the people at the bottom of the scale. What was left would be compressed and general practitioners had to ensure that they had their rightful place in the concertina. He pointed out that if the committee asked for budget concessions rather than a higher income it would affect superannuation and compensation.

But Dr J S Happel was not keen on the motion or the amendment. If inflation was to be beaten there would have to be a fall in the living standards of everyone in the country. He said that he would prefer the committee to issue a press statement pointing out that doctors wanted only a fair incomes policy.

The chairman warned of the implications of passing the motion, as the committee was answerable to the LMC Conference. If the amendment was carried it could commit the committee to action that would not be popular. As the motion referred to a date after the LMC Conference he thought that it might be wise to refer the motion to the negotiators as an expression of the committee's opinion. The committee agreed and the motion, as amended, was carried with a large majority.

Whooping cough vaccination

There was a short debate on the statement on whooping cough vaccination made by the Secretary of State for Social Services (19 February, p 522). The committee agreed that more publicity should be given to the advantages of vaccination and of the contra-indications and a press statement was issued (26 February, p 583).

Working group on the remuneration of GPs in the hospital service

Recommendations approved by GMSC

That remuneration for casualty work in general practitioner hospitals should be on an item-of-service basis, the level of such payments being linked to emergency treatment and night visit fees. Where 140 or more "new" patients are seen per year, payment could be on a sessional basis (the top of the hospital practitioner scale), or by item-of-service payments.

General practitioner responsibility for inpatient care in general practitioner hospitals should continue to be remunerated on a staff fund basis.

That the staff fund should in future be calculated on a sessional basis related to bed occupany, patient throughput, and on-call commitment, this sessional payment to be at the highest point on the hospital practitioner incremental scale.

Remuneration for that part of the work in community hospitals where the general practitioner is in sole clinical charge, controlling admissions, discharges etc, should be on the same basis as remuneration for work in GP hospitals—that is, a staff fund calculated on hospital practitioner sessions.

That the remuneration for work undertaken in community hospitals as a member of the consultant team should be on a sessional basis as a hospital practitioner or clinical assistant as appropriate.

That those clinical assistants who have worked continuously in the same post for five years should have the opportunity to apply for security of tenure and to be paid on an incremental scale.

From the agenda . . .

Investigation of complaints

Government proposals for modification and GMSC comments

The Secretary of State in 1974 said that it was intended to review the procedure prescribed in the NHS (Service Committees and Tribunal) Regulations 1974 for investigating complaints against general practitioners. Discussions began in the same year with the Council of Tribunals. It was later decided, however, that further consultations should be suspended in case any conclusions reached by the Government on the Davies Report on hospital complaints procedure might have to be taken into account. But after Mrs Barbara Castle had made a statement about the Davies Report in the House of Commons in February last year (21 February 1976, p 466) it was decided that the service committee review should proceed independently.

In October 1976 the DHSS issued *Family Practitioner Services: Review of Complaints Investigation Procedure*. The General Medical Services Committee discussed the report, which deals with England and Wales, at its meeting.

The report's most important proposals are summarised here together with the comments of the GMSC in italics.

Independent chairman

It had been suggested during discussions between the Minister of Health and representatives of the medical profession in 1966 that the service committee procedure should be based on a regional organisation. Service committees would continue to be appointed by executive councils but about 12 chairmen would be appointed by the Minister to cover a number of areas. The proposal was not acceptable to executive councils or to the dental profession, and the medical profession later thought that the argument in favour of regionalisation had been overtaken by NHS reorganisation.

Nevertheless, the Council on Tribunals liked the proposal. It felt that the existing arrangements were open to criticism on the grounds that the body which was responsible for providing the practitioners' services to the public—the family practitioner committee—also decided whether a complaint was justified.

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Present procedure

At present the NHS (Service Committees and Tribunal) Regulations 1974 govern the procedure in England and Wales—Scotland has its own, slightly different regulations—whereby a family practitioner committee can investigate treatment provided for his patients by a doctor. The procedure establishes whether a doctor has complied with his terms of service: complaints which do not allege a breach of the terms of service cannot be investigated in this way.

Investigations are carried out by service committees on behalf of the FPC. They have an equal number of lay and professional members and a lay chairman. The service committee tries to establish the facts of a complaint first by correspondence and then if necessary by a hearing. It reports with recommendations to the FPC, which then decides whether or not there has been a breach of the terms of service.

The parties can appeal to the Secretary of State against an adverse appeal but when he has reached a decision the matter is closed.

The procedure also provides for the FPC to refer a doctor to the NHS Tribunal where it considers that the continued inclusion of any person in a FPC list "would be prejudicial to the efficiency of the services." The doctor has a right of appeal to the Secretary of State. The tribunal and the Secretary of State may also remove a disqualification previously imposed. (This procedure is quite separate from the disciplinary procedure of the professional bodies such as the General Medical Council. A person disqualified by the tribunal can practise without any restriction as an employed person in the NHS or privately, whereas a person whose name has been erased from the professional register cannot practise at all.)

Furthermore, the machinery for hearing complaints about the performance of contracts and the quality of service provided rested entirely in the hands of the administering authorities and the professions which were the parties to the contractual arrangements.

So the council has proposed that about 12 chairmen with legal qualifications or experience of tribunal work should be appointed by the Secretary of State from a panel drawn up by the Lord Chancellor. The chairmen should be independent of the authorities administering the family practitioner services.

The service committee procedure should remain locally rather than regionally based.

It was more important for the chairman to come from the locality and be acceptable to the professional members of the service committee than to be legally qualified. It was inappropriate for him to be appointed by the Secretary of State.

Committee size

The present size of the service committee is, according to the council, too large—three lay members, three professional, and a chairman. It has proposed four members, plus the chairman, with only one lay and one professional member coming from the area of the authority which appointed the members. In addition, the chairman should be able to vote, particularly if he is independent. At present he has only a casting vote.

A smaller committee would not necessarily be less daunting.

The chairman should not be concerned in the final decision unless the members were equally divided.

Administrator's role

The clerk to the service committee should have had no prior connection with the handling of the complaint under investigation. The alternatives proposed would be either to continue with the present arrangement under which the administrator of family practitioner services acts both as administrator and as servant of the service committee or to provide for the service committee to be served by another officer of the area health authority.

The administrator of the family practitioner committee should continue his service committee duties; these should not be delegated to another officer of the area health authority.

Legal representation

On this matter the council considers that "there is a case for undertaking a fresh examination in depth of the need for restriction on legal representation in service committees, comparable to that last carried out by the council in 1960." The term "paid advocate" should be amplified, with specific reference to the position of members of Parliament, paid officials of trade unions, professional associations, and community health councils.

So long as there was a right of appeal, possibly with increased rights to an oral hearing, at which there could be legal representation and evidence on oath, the balance of advantage lay in retaining the status quo for service committee hearings.

Other proposals

Because of the difficulties in obtaining professional members for service committees there should be provision for a larger number of deputies.

The GMSC agreed with this proposal. If possible the lay members should not outnumber the professional members.

Complainants should be allowed to make their complaint orally; the complaint would be recorded by the officer to whom it is made.

As in the case of dentists the time limit of eight weeks should run from the date on which the event giving rise to the complaint came to the complainants' notice.

It is proposed that the Secretary of State's decision whether or not to allow a late complaint to be heard should be final and conclusive to avoid the possibility of repeated applications.

The committee agreed that the Secretary of State's decision should be final and conclusive.

Provisions should be made for the service committee to have power to allow a complaint to be withdrawn.

Provision should be made to enable an organisation to make a complaint on a complainant's behalf. There should also be provision for a complaint to be pursued by another person if the original complainant dies before the complaint, including any appeal, is finally determined—that is, without the need for a fresh complaint to be lodged.

Nurses and midwives who are called as witnesses at service committee proceedings should be entitled to be accompanied by a representative.

Nurses and midwives who were called as witnesses should not be entitled to be accompanied by a representative. This would mean that they were treated differently from other witnesses.

It has been suggested that, as a respondent may have a member of his local professional committee present as an observer at a service committee hearing, the complainant should likewise be able to ask that a trade union official or a representative from an interested voluntary organisation should be allowed to attend in the same capacity.

The committee disagreed with the proposal that a complainant should be able to ask a trade union official or a representative from a voluntary organisation to attend as an observer.

At present the tribunal may determine how long the complainant shall have in which to submit a precise statement of the alleged facts and contentions on which the representations to the tribunal are based. It has been suggested that the regulations should include a specific time limit for such submission.

The tribunal should be required to send to the respondent a copy of the documents which it is proposed to put in evidence, rather than just a list of such documents.

The proposal that the respondent should have a copy of the documents to be put in evidence was approved.

It has been suggested that every surgery or health centre should display a notice indicating that complaints about general medical services should be addressed to the appropriate family practitioner committee, and giving its address. It has also been suggested that practitioners should be required to keep a record book of complaints received, giving details of the complaint and any action taken on it, which should be required to be produced to the family practitioner committee on request.

The proposal to display a notice in surgeries and health centres indicating that complaints could be addressed to the FPC was unacceptable, as was the suggestion that GPs should be required to keep a record book of complaints received. Receiving and recording complaints was a function of the administration and would be a misuse of doctors' time.

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