restrictions on clinical freedom but to have this freedom doctors had to be seen to be responsible. Could they really say to patients that they were going to suffer if they did not get their favourite cough mixture. Many doctors had abused their freedom, according to Dr M A Gilbert. They had prescribed too much and too extravagantly and iatrogenic diseases had been increasing. Each year each general practitioner in England was responsible for £70 000 worth of drugs. He thought that the principle should be accepted provided that the money saved was ploughed back into general practice. Dispensing doctors, Dr G Emrys-Jones told the committee, would not go down the road of generic prescribing until the question of product liability was sorted out. The government would have to underwrite any liability.

Care of the terminally ill

Dr M J Illingworth and Dr John Callander were concerned about the elderly and the terminally ill, who often needed a whole range of simple remedies. They thought that the scheme was unworkable. The drug bill had increased, Dr Callander agreed, but he wondered how much of this was due to the promotional activities of the drug companies.

Although agreeing about the lack of consultation, Dr David Pickersgill hoped that the committee would be prepared to talk to the government. A restricted list did not necessarily mean a two tier system if the list was acceptable and the patients were getting the right treatment. He did not think that there was any justification for spending £3 million a year on Valium when diazepam would do as well.

In Dr Simon Jenkins's view the thin end of the wedge had begun with Griffiths; then had come the deputising crisis, now the limited list. Other countries had a limited list but they accepted a two tier system of care and did not have a comprehensive service. Clinical freedom was for doctors to act in the best interests of patients, not to waste public money. Dr Jenkins said that he would prefer a list of drugs that could not be prescribed rather than a limited list that he could prescribe.

Dr M Hamid Husain hoped that the committee would not overreact. Doctors were partly to blame for the drug oriented society. Nevertheless, the list was extremely limited and should be negotiated, and all patients should receive the drugs that they needed. Dr Gordon Taylor hoped that the consultation period could be extended beyond 31 January.

Dr David Farrow from Kent local medical committee, and Dr J C D Rawlins from Avon local medical committee, reported how their committees had been taken in by the proposal. Only two doctors had voted against it in Avon. The members believed that it was what they wanted and that it would help to reduce the number of prescriptions and increase the consultation time. Dr Rawlins hoped that the GMSC and the Royal College of General Practitioners would get together and work out the technical details.

A leading article on the subject is at p 1397.

Reference

1 Informal Working Group on Effective Prescribing. *Report*. London: DHSS, 1983 (Greenfield report.)

Section 63 courses: individual allocation each year

If the proposals in the report of the working party on section 63 courses for general practitioners in England are accepted the regional allocation for travel and subsistence will be divided to produce an individual annual allocation for each general practitioner. Dr I G Bogle represented the GMSC on the working party (2 June, p 1703).

The GMSC approved the report in principle, and it will now be considered by the education subcommittee, together with the following recommendations:

- General medical practitioners should be free to make their own decisions about the choice of postgraduate education.
- The value of course money should be preserved at the cost of total reimbursement of travel and subsistence if necessary.
- The total budget for section 63 courses and expenses should be devolved to one agency at local level.
- A single budget holder should be appointed for each region.
- Devolution should be to regional level—to universities or to regional health authorities.
- Family practitioner committees should continue to undertake the payment function for travel and subsistence.
- Regional allocations should be in two distinct parts for courses and for travel and subsistence.
- The general practice subcommittee, under the overall responsibility of the postgraduate dean and the regional postgraduate medical committee, should be responsible for setting the policy framework for course approvals and financial control.
- The most appropriate person for budget holder of the regional allocations would be the regional adviser in general practice.
- General medical practitioners should be notified of individual cash limits within which they will be reimbursed expenses.
- It should be possible for some of the travel and subsistence allocation, if not used for that purpose, to be transferable to the courses budget within the same financial year.
- There should be no central prescription of rules and guidelines in the national scheme; budgetary control measures should be a matter for policy decision locally.
- Regional allocations for courses should be based on the numbers of general medical practitioners; there should be a four year period of transition; the first year should be 1985-6.
- Initially, regional allocations for courses should be made on the recommended basis without further refinements to reflect other local factors; the need for such refinements should be for subsequent review.
- Initially, regional allocations for travel and subsistence should be based on the average of the last three years' spending; steps should be taken to make future allocations more sensitive to reflect characteristics at family practitioner committee area level.
- There should be a review of the arrangements after one year by the reconvened working party; further reviews after four or five years should be undertaken by a specially convened representative body.

CCHMS advises consultants on Griffiths

The chairman of the Central Committee for Hospital Medical Services, Dr Maurice Burrows, is sending the following advice from his committee to chairmen of medical executive committees in England.

Involvement of clinicians

"As you will know, the Griffiths report and the subsequent DHSS circular, strongly emphasise the importance of the involvement of clinicians in management, particularly at unit level. Having now concluded negotiations with the Department of Health and Social Security on the terms on which they might do so (see below), the CCHMS is advising consultants to take an active role in the general management function.

"The committee believes that consultants will be able to fight most effectively for resources for patient care through active participation in the new management structures.

The CCHMS advises consultants to take an active role in the general management function

General manager appointments

"The implementation of the Griffiths proposals is now going ahead rapidly with most regional general manager posts already filled. In July the chairmen of the CCHMS

Consultants should see to it that health authorities are fulfilling the condition in circular HC(84)13 that general managers both at district and unit must have the "ability to command the confidence of the representative members of the management team"

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and the General Medical Services Committee wrote to district management team clinicians reminding them of their responsibility, enshrined in the circular HC(84)13, annex C, to be involved in the identification of candidates for the posts of district general manager and unit general manager, and the proviso that the general manager appointed must have the ability to command the confidence of the representative members of the management team. In spite of this advice such consultation has not taken place in some districts, and consultants are again asked to ensure representative medical involvement in these appointments, particularly as districts will soon begin to appoint unit general managers.

District management teams

"We have heard that certain health authorities are proposing substantial changes in the role and composition of the district management team, or even its abolition. The CCHMS has protested strongly about any such moves to the DHSS and to the Minister for Health, and has received an assurance from the DHSS that, as far as district management teams are concerned, the provisions of HC(84)13 do not supersede the provisions of the circular HC(80)8, by which the district management teams were set up.

The CCHMS asks consultants to seek to ensure that the role of the district management team continues under the new arrangements or that where alternative arrangements are proposed they include the same level of medical involvement as at present

Role of regional medical officer

"The CCHMS has strongly endorsed the support expressed by the BMA council for the role of the regional medical officers to continue under the new arrangements. The BMA has written to the Secretary of State expressing concern at a report that certain regional authorities were considering removing the chief officer status from the post of regional medical officer, and requesting a meeting to discuss this.

Remuneration of unit medical representatives and clinician general managers

"Negotiations with the DHSS on the terms on which clinicians might become more actively involved in NHS management, as advocated in the Griffiths report, have been taking place throughout the summer. On 4 October the CCHMS accepted a document containing an offer from the Department that the negotiators felt was the best achievable for clinicians taking on management responsibilities. We have succeeded in convincing the Department of the validity of our main principles:

- That any arrangements agreed for the remuneration of clinicians should include provision for the payment of unit medical representatives.
- That in most units where a clinician becomes the general manager, the unit medical representative and the unit general manager could well be the same person, so that an element of payment for both roles would be appropriate.
- That one of the main obstacles for clinicians taking on management roles is the lack of cover for their clinical workload, and that there must therefore be proper arrangements for locums or cover by colleagues.
- That there must be proper administrative and secretarial support for clinicians taking on management roles.

Terms of the offer

UNIT MEDICAL REPRESENTATIVES

"Payment of a fee of up to £2500 a year to unit medical representatives for duties falling within the general management function. This will be on the basis of a written job description agreed beforehand between the district health authority and the clinician concerned. The level of the fee is regarded as falling within the remit of the review body.

"Arrangements for clinical cover for unit medical representatives will be the same as those currently operating for district management team consultants—that is, they will be for determination by the health authority locally.

UNIT GENERAL MANAGER

"A clinician appointed as general manager will receive, in addition to the present full salary, including merit award if held:

"(*a*) A responsibility allowance of up to £3000 a year.

"(*b*) An additional session will be available. This will enable consultant general managers to reduce the amount of clinical work dropped. This will be available to maximum part timers or whole timers.

"(*c*) Locum cover will be provided for the clinical sessions dropped either in the form of an additional session available to consultant colleagues of a consultant general manager who are covering his clinical sessions or, probably less frequently, in the form of a part time locum consultant. This will apply to both whole time and maximum part time consultants.

"A consultant carrying out the duties of unit medical representative and unit general manager simultaneously may receive up to £4000 a year as a combined value of unit medical representative fee and unit general manager allowance.

The CCHMS hopes that many consultant unit medical representatives will seek to be appointed as unit general manager: BMA members should consult their BMA regional office about the terms of their appointment and about the model job description for unit medical representatives which the BMA has prepared (see below)

"Clinicians who drop sessions to become general managers will have the right to resume them at the end of their term of office.

"The negotiators will now continue discussions with the DHSS on the guidance which will be sent to health authorities to implement this agreement. The question of superannuation on the two new payments is under active discussion, but remains unresolved at present.

"The CCHMS will continue closely to monitor developments on the implementation of the Griffiths proposals, and has an open channel of communication with the DHSS, so that any problems arising can quickly be taken up with those who carry ultimate responsibility for the success of the changes. In order to keep in close touch with what is happening at local level, we need you to keep us informed either directly, through the CCHMS secretariat, your BMA regional office, or through your regional committee for hospital medical services, and shall be grateful both for information on developments in your district and for your views."

Job description for unit medical representatives

The unit medical representative has a responsibility to undertake the management duties defined below to enable the policies and plans determined for the unit by the district health authority to be achieved.

The representative will seek to establish management and administrative practices to ensure that care of patients is constantly to the fore; ensure that he/she is provided with the range of advice and information that he/she needs to be involved in the formulation of policies, decisions on priorities, the setting of objectives, and the monitoring of progress; be responsible for medical input in determining clinical priorities within the unit; be responsible for the coordination and effective operation of clinical management budgets throughout the unit; cooperate in the functioning of the unit management group, to ensure that timely decisions are reached and that objectives are achieved; stimulate initiative, urgency, and vitality in management, cooperating with the unit general manager in such matters as require coordination within the unit; accept delegated responsibility for taking effective action; aim to secure effective motivation of staff, and the cooperation and understanding of medical colleagues.

The representative is accountable to the unit general manager for the management component of his/her role as unit medical representative.

The representative will accept management responsibility as a member of the unit management group in accordance with circular HC(80)8.

The health authority must ensure that adequate supporting services are available for the representative to carry out his/her role efficiently in the general management function at unit level; must provide the representative with access to relevant and timely information; should, with the facilities referred to above, ensure that the representative is able to use his/her time effectively with the elimination of unnecessary bureaucracy and committee work.

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