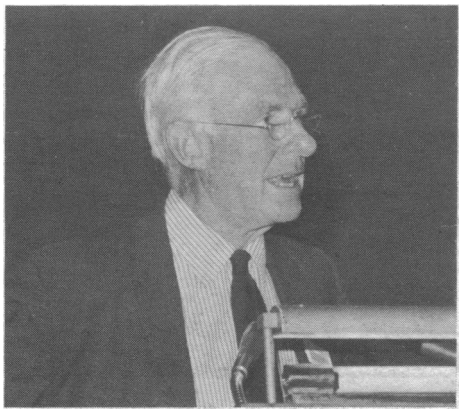

Dr W D Linsell, a consultant pathologist, addressing the conference during the debate on the Ombudsman.

A motion from North-east Thames RCHMS, "that matters of clinical judgment should not come within the scope of the Health Service Commissioner (Ombudsman)," was carried unanimously. Opening the debate, Dr W D Linsell (NE Thames) declared that in the 30 years of the NHS the status of the consultant had declined, partly because of the slow, insidious erosion of his clinical management and responsibility. If the profession did not reject the proposal to allow the Ombudsman to investigate matters of clinical judgment, it would surrender its entire independence to State control. The profession would lay itself open to malicious victimisation.

Seconding the motion, Dr G F Cohen (Derby) pointed out that no constraints on the Ombudsman's power would give joy to the malicious and frivolous complainer. It would lead to an immense reduction in the work done in hospitals, including the training of junior staff. Another speaker commented that often diagnosis and treatment had to be based on opinion and opinions differed. So doctors consulted one another. Occasionally a necropsy might prove them wrong and a complaint might be made. But how could a layman understand a complicated clinical problem? Consultants would fall into the hands of medical advisers and life would become more difficult.

Mr T M Hennebry (CCHMS) supported the motion. He had had dealings with the Ombudsman. An investigator had asked to see him and had asked several loaded questions. That seemed to be the standard practice. There was a feeling in the BMA, he thought, that it might not be a bad thing if the Ombudsman had some clinical judgment, provided that he had proper clinical support, but in Mr Hennebry's view that would be a mistake. Another member of the CCHMS, Dr W J Appleyard, warned that the Parliamentary Commissioner was already encroaching into clinical matters and producing reports. Clinical case law would be built up by which consultants would be enslaved. Any administrative civil servant's interference in medicine must be completely rejected. The Ombudsman's intervention in clinical matters would introduce double jeopardy into the law, Mr P R J Vickers (Newcastle upon Tyne and CCHMS) said. It would lead to increased malpractice allegations and to the practice of defensive medicine. The deputy chairman of the CCHMS, Dr Brian Lewis, declared that he knew no one in BMA House who thought that the Ombudsman should concern himself in clinical matters. There were too many ways of having a go at the doctor. Dr Lewis did not believe in kangaroo courts, nor did he believe the Ombudsman could take the job on with all the work he had to do at present. The push for medical audit and similar functions was unnecessary in the way medicine was practised in this country.

Priorities in health care

Dr Margaret Voysey (Ramsgate) moved on behalf of the South-east Thames RCHMS: "That this conference deplores the insistence of the DHSS on improving services in the priority areas at the expense of the acute services." Dr Voysey pointed out that the DHSS had decreed that priority areas, such as geriatrics and psychiatric services, should be developed but so far as she could see there was no special money to develop those services in her district. Doctors were forced to cut back on acute services to provide trivial improvements in the priority areas. A bed could be provided for someone who had become immobile because his hips had seized up but it was impossible to improve the orthopaedic service so that hip replacements could be done. But specialists in geriatric medicine and geriatric psychiatry did not wish to see money taken away from acute specialties, Dr C Cohen (Brechin) told the conference. It was necessary to develop a service for the elderly in the community and in hospitals but not at the expense of acute specialties, to which an increasing number of old people were requiring urgent admission. Mr P R J Vickers (Newcastle upon Tyne) agreed. Acute medicine and surgery could cure many patients and return them to make a positive contribution to the community.

From North-east Thames, Dr H Jacobs opposed the motion because he thought the wording was misleading. The whole concept of reducing the acute services was appalling, but no money from the depreciation of these services was going to mental illness, certainly in his region. Mental illness was every bit as acute as other acute services. Mr R K Greenwood (Leicester) also opposed the motion. He believed that Mr Ennals had assessed the priorities correctly. We lived in an idle and slothful society, and the Government had created a bonanza for scroungers who lived on social security, and it was more appropriate to pay unemployment benefit than to reduce the waiting lists to have hernias repaired. The Secretary of State had agreed to direct resources to the chronic sick and mentally and physically handicapped. The NHS should be a safety net to help those unable to help themselves, and acute facilities should be developed outside the NHS.

The DHSS's priorities policy was a very good example of the Government failing to understand the real relationship between acute and chronic treatment, according to Dr Brian Lewis. Most psychiatrists and geriatricians now had to practise acute medicine because they were acute specialties in many ways. What was important was to make it clear to the Government and to the public that the whole of the Health Service was grossly underfinanced. Altering the system of priorities was simply killing Peter to save Paul.

The motion was approved.

Other conference debates will be reported in a future issue.

Points from the conference

That all NHS medical laboratory and radiological services should be under the control of and administered by medical consultants appointed in administrative charge. (Scottish CHMS) CARRIED

"*The consultants' position has been severely eroded by the Zuckerman Report. Consultants who look on administrative responsibility as an unwelcome chore will soon be visitors in their own departments.*"

DR F W WHITELAW (GLASGOW)

"*If technicians have administrative charge of the radiology department they will regard the radiologist as clinical adviser to the senior radiographer.*"

DR F W WRIGHT (OXFORD)

That this conference considers the increasing length of hospital waiting lists for both inpatient and outpatient treatment, especially those relating to orthopaedic and neurological specialties, to be unacceptable, and that the proposed restriction in monies for acute services will only exacerbate the situation. (Dorset LMC) CARRIED

"*Waiting lists are used to ration health care and as an economic regulator to ration demand. No one knows what the potential unrestricted demand for any service could be.*"

MR P R J VICKERS (NEWCASTLE UPON TYNE)

"*Mr Ennals is talking about a 1·7% increase in consultants, not the 4% the profession has agreed. In such a slow moving programme the effects of the cuts will be felt for many years to come.*"

DR BRIAN LEWIS (HYTHE)

That this meeting thinks that consideration should be given to possible interference with the confidentiality of medical records, particularly in relation to internal audits for sterilisation and abortion procedures. (South-western R CHMS) CARRIED

"*It is axiomatic that medical information is confidential to the doctor and the patient, and should not be available to third parties, except for the benefit of the patient and with his permission.*"

DR S H HALL (EXETER)

Correction

Consultants' ballot

In the first column of table I of the results of the consultants' ballot (1 July, p 67) 10 895 should have read 10 985.