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FROM THE GMSC

Support for BMA council's decision on AIDS

At its meeting on 19 November the General Medical Services Committee endorsed the decision of the BMA council (*i*) not to implement the resolution of the ARM "that testing for HIV antibody should be at the discretion of the patient's doctor and not necessarily require the consent of the patient"; (*ii*) in reporting back to the ARM; (*iii*) in making the legal opinion available to the profession.

The motion was taken in three parts; the first part was carried by a substantial majority and the other two were passed nem con.

Dr John Marks, the chairman of the BMA council, explained that after the annual representative meeting the BMA's AIDS working party had concluded that a change in the law would be required to implement the resolution. So he had decided to seek a legal opinion from Mr Michael Sherrard QC, who had said that in his view if a patient was tested for human immunodeficiency virus (HIV) without giving consent the doctor would be at risk. This opinion had been supported by the council, by two of the defence societies which had considered it, and by the Department of Health's legal experts. The debate in the council and the legal opinion were published on 10 October (pp 936, 911). The council referred the legal opinion to the craft committees.

Dr J W Chisholm was sure that the council had taken the right decision. Although doctors were confronted with a new and at present incurable disease, that was no reason to take an emotive and irrational stance that overthrew tried ethical standards. In considering clinical and ethical stances doctors should ask whether they would deter people from coming forward for testing, treatment, or counselling.

In Dr Ridley Gibson's view patients had a responsibility to cooperate with doctors. If a patient refused to be tested after being counselled by the doctor he or she could be told to go elsewhere. He agreed with the chairman of council, however, that a doctor had a duty to treat a patient with the acquired immune deficiency syndrome (AIDS) who came forward for treatment.

At the council meeting the solicitor had told Dr Mervyn Goodman that in his view AIDS was no different from other diseases, and that it was the doctor who took the blood test who had to get the patient's consent not the doctor who referred the patient for a test. That, Dr Goodman said, made a nonsense of the whole question. If he had a patient with suspected lung cancer and he sent him for an *x* ray examination he would not tell him the reason and ask for his consent. The same logic should apply to testing for AIDS. Many patients in renal units were screened without their consent and many of his constituents were unhappy that the council had overturned the representative body's decision.

The association's existing policy is that patients should not be examined without their consent and so the representative body's motion required a two thirds majority, Dr Simon Jenkins believed. It did not get that majority so in his opinion it was invalid anyway.

When Mr Michael Sherrard advised that a doctor might be charged with assault if he tested without consent he was reflecting the attitude of society at large, Dr P F Kielty said. That was the way the law was interpreted. Having received that advice the association had to warn its members that they could be at risk if they did not get implicit consent.

Dr C O Lister thought that the council's decision only added to the hysteria in the country. The argument hinged on the question of implied consent. There was no reason to suppose that implied consent would not be given but counsel believed that in a court of law such implied consent could not be presumed to have been given.

The medical profession did not comply with the full strength of the law, Dr D L Williams pointed out, because although doctors should have implicit and informed consent before doing anything they worried about the effect of doing so on their patients. If he counselled a patient whom he suspected of having the virus and persuaded him to be tested the patient would have difficulty in getting a mortgage and life insurance. If the patient refused the test, having been counselled, he would not know whether he had the disease or not. By making it so categorical the council had removed the ability of the individual doctor to mitigate the full explicit consent if he thought it was in the patient's interest so to do.

Several members emphasised that it was for the individual doctor to decide whether to test without consent but that he or she must always be able to justify that decision.

Dr John Ball reminded the committee that in medicine absolutes did not exist. As medical

Resolutions on AIDS

"That the GMSC endorses the decision of the BMA council (*i*) not to implement the decision of the ARM ['That testing for HIV antibody should be at the discretion of the patient's doctor and not necessarily require the consent of the patient']; (*ii*) in reporting back to the ARM; (*iii*) in making the legal opinion available to the profession."

The GMSC also endorsed two resolutions of the 1987 LMC conference:

"That this conference urges clear cut ethical guidelines regarding disclosure of HIV results to professional colleagues.

"That this conference considers that patients with AIDS are entitled to normal standards of confidentiality."

BRIEFLY . . .

- The directors of the GMS Defence Fund had explored the possibility of independent funding and staffing of the committee secretariat, and their recommendation that the staff should continue to be engaged and employed by the BMA was endorsed by the GMSC.
- The committee is to seek a separate meeting with representatives of the Royal College of General Practitioners to discuss subject access to manual records with the DHSS.
- The GMSC will be represented on a BMA working party set up to consider the effects of increases in defence society subscriptions.
- A study day on drug misuse and the general practitioner has been organised by the GMSC/RCGP liaison committee and will be held at BMA House on 30 March 1988.
- Dr J D Watts will represent the committee on the BMA's working group on human infertility services and embryo research, which will be chaired by Sir Malcolm Macnaughton.
- The GMSC is to seek additional medical representation in the shape of a general practitioner on the Health Education Authority.

This report was prepared by LINDA BEECHAM, assistant editor, *BMJ*.

students they were told to abandon the words "always" and "never." He thought that the BMA was trying to make black and white guidelines in what was a nebulous situation.

The representative from the Central Committee for Community Medicine and Community Health, Dr Fleur Fisher, said that patients expected doctors to share with them the reasons for their actions. In the past doctors had assumed that patients did not want to know but informed consent was now much more important.

Summing up the debate, Dr Marks said that he agreed with Dr Williams that ethics came above the law. The experts had said that as a general rule patients did give consent for tests to be done. But where they were tested without consent the result could be disastrous. In his view the ethics of AIDS was the same as that for any other disease.

Downloading patient registration data from FPCs

The committee discussed the question of confidentiality when patients' registration data were downloaded from family practitioner committees' computers to general practitioners' computers indirectly—that is, via a commercial company's computers.

The managing director of AAH Meditel, one of the two firms supplying computers free to general practitioners, wrote to a general practitioner who was worried about the procedure explaining why the downloading could not be handled at the time of installation. He gave an assurance that the data would be used only for transference to the general practitioner's system, that access would be restricted to those needed to perform the task, and that all copies of the data would be destroyed.

Helping the homeless

A working party has been set up with the Health Visitors Association to seek practical ways of improving the availability and uptake of primary health care for homeless families. The GMSC will be represented by Dr J W Chisholm, Dr D G Eastham, Dr J B Lynch, and Dr D M Wilks.

Dr J F Milligan believed that there were breaches of confidentiality and he proposed "that patients' details held at the family practitioner committee should be transferred to the practice computer at the family practitioner committee concerned to ensure confidentiality of the patient's record." But this was not supported, and Dr Simon Jenkins said that it was in the companies' interests to guard the information as closely as did general practitioners. He pointed out that when computers needed repairing engineers often had to take disks away so that confidentiality was already breached to a certain extent.

After further debate the GMSC resolved: "That the GMSC's guidelines on confidentiality should be reviewed in the light of current developing arrangements for the transfer of patient information from family practitioner committees to general practice. Modification of these guidelines should include all necessary safeguards regarding the involvement of third parties."

BRIEFLY . . .

- The 1987 conference called for an expansion of general practitioner hospital beds and did not want such beds classified as acute; the committee recommended that the success of individual general practitioner hospitals should be publicised.
- The LMC conference asked for the problem of job sharing to be investigated and local medical committees will be asked about the extent of the practice and about practical problems experienced by family pactitioner committees and general practitioners; the committee also wants examples of where the basic practice allowance is split and where it is not.
- General practitioners will be warned against signing research contracts with disclosure clauses which would indemnify the pharmaceutical company or sponsor to the detriment of the general practitioner's rights.
- In the 1988 annual report local medical committees will be advised to discuss with local dental committees the adequacy of emergency dental services in their areas.
- The statutes and regulations subcommittee has been discussing advice on handling formal complaints in medical service hearings; a paper prepared by Dr D L Williams, the subcommittee's chairman, will be redrafted and sent to local medical committee secretaries together with guidelines on complaints procedures produced by the defence societies.

GPFC's activities curtailed

In his opening oral report the chairman, Dr M A Wilson, reported that the profession would give oral evidence to the review body on 20 and 27 January 1988. At a postmortem meeting on the 1987 report earlier this month the negotiators had told the review body of the importance they placed on the review body's independence. They were concerned that the review body had decided to cease publishing statistics on comparable earnings and that so little mention had been made of the study of workload in general practice.

There had been a tripartite meeting between the department, the negotiators, and the General Practice Finance Corporation on the latter's future. The government's determination to reduce the public sector borrowing requirement had curtailed the corporation's activities, Dr Wilson said. But the department had been looking at ways in which the corporation could operate without increasing the borrowing requirement and an announcement was expected at the same time as the white paper on primary health care was issued.

At a recent routine negotiating meeting there had, Dr Wilson said, been no progress on the profession's request that general practitioners should be paid for cervical cytology tests on women from the age of 20 every three years. The GMSC supported this policy instead of the government's present policy of testing women every five years from the age of 35.

Assessing general practice

The GMSC had a long debate on a confidential report from a working party of the Joint Committee on Postgraduate Training for General Practice on assessment and vocational training for general practice. The joint committee had accepted the working party's recommendations and sent the report out for consultation. The GMSC decided that it was not ready to submit its comments, nor could it approve the document at this stage. A working party has been set up to report back to the GMSC in January. Dr J B Lynch will chair the working party and the other members are Dr Sarah Divall, Dr H I Humphreys, Dr J D Watts, Dr Fay Wilson, and Dr D L Williams.

Advice to health authorities

Local medical committees are to be asked for examples of where health authorities reject advice from medical advisory committees and fail to give an explanation for the rejection.

The 1987 annual representative meeting of the BMA passed two resolutions on the subject:

"That health authorities should (*i*) be obliged to seek advice from the competent medical advisory committee on all matters of health care, and (*ii*) if the advice be rejected give a written explanation.

"That this meeting deprecates the practice of health authorities which develop an executive team without full time medical and nursing advice."

These resolutions were sent to the chief medical officer, who pointed out that there was no legal requirement to set up advisory committees, but when they were set up and the Secretary of State was satisfied that they were representative he had a duty to recognise them. The chief medical officer quoted from the 1982 circular on professional advisory machinery: "The professions concerned should have the absolute right to give advice when necessary, to be consulted on professional matters involving them, and to be satisfied their advice is being properly considered."[1]

Sir Donald Acheson went on to say: "In the majority of cases district management boards do include both clinical representatives and a community physician and the department supports this approach. However, we have been convinced from the outset of the importance of allowing management structures to be determined at local level, so that local circumstances may best be catered for. In this respect the guidance issued by the department concerning professional advice

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in management is that the arrangements should command the confidence and commitment of the profession locally. The importance of medical advice to health authorities is fully recognised. I would be glad if you would let me know if there are any particular difficulties."

Service committee withholdings

The DHSS is to be asked to explain why it believes that the level of service committee withholdings was regarded as a valid criterion in determining whether or not a referral should be made to the General Medical Council.

The 1987 LMC conference carried as a reference the following motion: "That, as withholdings of £100 or more in medical service committee cases are referred to the GMC, and such amounts are now imposed for comparatively minor breaches of the terms of service, this conference instructs the GMSC to negotiate a reasonable and realistic amount above which cases are, in future, automatically referred to the GMC."

At the meeting of the statutes and regulations subcommittee the chairman, Dr D L Williams, had reported that the department had previously been asked about referrals to the GMC and the GMSC had been told that any review of the level of withholding at which referral to the GMC was automatic would be made only in response to a request from the GMC. It was the view of the subcommittee that referrals to the GMC should be determined on the basis of whether or not professional misconduct as opposed to a breach of the terms of service had taken place; such a determination could not be made solely on the level of the withholding.

A former member of the GMC, Dr J S Happel, hoped that the department would not be asked for an explanation. He believed that the GMC needed all the information it could get in trying to establish patterns of behaviour among doctors.

Reference

1 Department of Health and Social Security. *Health service development. Professional advisory machinery.* London: DHSS, 1982. (HC(82)1.)

Telephone repairs for GPs

Earlier in the year the Department of Health negotiated a central agreement with British Telecom (BT) for a "total care" telephone repair service (21 March, p 788). BT has now confirmed the inclusion of customer controlled call forwarding within the terms of the central contract and has clarified the arrangements for priority fault repair in relation to equipment that is not manufactured or supplied by BT.

"Basically, the scheme covers the telephone lines serving a general practitioner's surgery, pharmacist's premises, general practitioner's home, or pharmacist's home. In addition, the following equipment is also covered, but it has to be either rented from BT (which includes StandardCare maintenance) or maintained by BT—that is, covered by a BT StandardCare maintenance contract:

"(*a*) Telephone switchboard, telephones, and telephone answering machine (if appropriate) for general practitioners' surgeries.

"(*b*) Telephone instrument for pharmacies and home addresses."

If the telephone instrument is rented from BT it is automatically covered. If the instrument has been purchased it will be covered if (*i*) it is the only telephone on the installation, *and* (*ii*) the customer has taken out a separate StandardCare maintenance contract for the telephone. BT has suggested that it could be more economical for the owner to have a spare telephone to plug in in the event of failure, particularly if the instrument is not BT maintained. Similar constraints apply to telephone answering machines.

On the question of customer controlled call forwarding BT says: "The equipment providing this service is rather specialised and not all of our districts have the capability to guarantee a four hour response for maintenance of this equipment. However, I would add that we will always [endeavour] to ensure speedy restoration of service. On a separate note, we did not take account of this equipment when originally assessing our charges for priority fault repair. With regard to coverage of the telephone numbers to which calls are forwarded from a general practitioner's surgery, if these premises are [those of] another NHS general practitioner then they will be covered by the scheme. If, however, the remote premises are those of a commercial deputising agency then they are not covered by the scheme. The deputising agency would need to contract with us for TotalCare coverage on their own account, unless [the] DHSS agreed to pay for them."

Financial loss allowance for GPs

The General Medical Services Committee's negotiators have discussed financial loss allowances for doctors who attend medical advisory committees with the Department of Health. The latter has reaffirmed that if a general practitioner can produce evidence that he has made a payment to his partnership or group in order to cover his absence at an appropriate committee he should have no difficulty in obtaining payment of the financial loss allowance. Any doctor who encounters difficulty after producing such evidence should contact the GMSC secretariat.

The current rates of the financial loss allowance are:

Not more than four hours £13.75.

More than four hours £27.50.

The payments are tax free. There are no provisions for a claim for a notional loss—for instance, where a doctor is absent from his practice but a payment is not made to the practice at the time.

GMC corrects misunderstanding on AIDS and confidentiality

In their issues of 12 November the journals *Doctor* and *Hospital Doctor* reported that the General Medical Council had decided to advise doctors to break confidentiality over patients with the acquired immune deficiency syndrome (AIDS) who are at risk to others and that "doctors have a duty to inform those at risk if patients refuse permission to pass on the information." The papers also report GMC leaders as saying that "testing for human immunodeficiency virus (HIV) infection is also justifiable without consent, if other people are threatened."

The president of the GMC, Sir John Walton, has told the editors of both journals that the articles were misleading and if uncorrected would spread confusion where both the profession and the public expect clear thinking and common sense. In his letter he goes on to say: "The council has not yet given precise advice to the profession on the matters to which the article refers—in particular it most certainly has not advised general practitioners to 'break any patient/doctor confidentiality code in AIDS cases.' Nor has it made any formal statement on testing for HIV infection without the consent of patients. Doctors should continue to be guided by the general principles of professional confidence, as set out in the council's blue pamphlet, with which doctors have long been familiar and which are well understood in society at large."

London weighting claim rejected

The staff side of the General Whitley Council has rejected as totally inadequate the offer of a 5·5% increase in all rates of London weighting. The health service unions had submitted a claim for an increase of £1000 (21 November, p 1362). They have decided to mount a publicity campaign to put pressure on members of parliament in the hope that the Thames regional health authorities can be persuaded to approach the Secretary of State for Social Services for additional funds. The BMA has been asked for evidence of the effects on recruitment and retention problems among nurses, medical records staff, and medical secretaries.

RDC's annual report

The fourth annual report of the Rural Dispensing Committee has been presented to the Secretary of State for Social Services and the Secretary of State for Wales. It will go to family practitioner committees and to representatives of the medical and pharmaceutical professions and will also be made available to organisations concerned with providing health care in rural communities. The report shows that in the year ending 31 March 1987 the committee received 66 applications to provide pharmaceutical services in rural areas, with nine applications brought forward from the previous year. The committee also received 44 notifications of decisions made by family practitioner committees on the rurality of particular areas, with one notification brought forward from the previous year. In its role as the final appellate body in such cases the committee received seven appeals against those decisions with one appeal brought forward from the previous year. The annual report contains details of a survey, based on a representative sample, of the effect of decisions made by the committee (or the Secretary of State where the committee's decision was subject to appeal) between April 1983 and August 1985.

The Rural Dispensing Committee, whose present chairman is Mr Patrick Brenner, was established as a special health authority in April 1983 to decide how significant changes proposed for dispensing in rural areas could be regulated in the interests of patients.

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