likely status as an orphan in the future. It might be interesting to consider whether the child could bring an action against the gynaecologist for "wrongful life." Consideration should also be given to any risk, however slight, of HIV transmission to health care staff involved in the care of such patients.¹³

The obverse viewpoint is that aware, consenting patients have the right to determine the course of their own child bearing, in much the same fashion as HIV infected women can elect to continue with their pregnancy rather than have a termination. It is also possible that after being refused treatment for infertility the couple could present themselves elsewhere and fail to disclose their HIV state. For the asymptomatic couple it is unlikely that their HIV state would be detected.

After careful consideration we did not feel justified in managing their infertility. We informed the couple of our decision not to undertake active management and they accepted this. The couple were also told that it was their right to seek a second opinion. We do, however, feel that patients deserve sympathetic counselling and that an explanation of their infertility in selected cases may assist this. We explained to the couple that in the future, developments may occur which will reduce the vertical transmission rate and

increase life expectancy, necessitating a change in this view. We were careful to make it clear that this was unlikely, particularly in the short term.

- 1 European Collaborative Study. Mother to child transmission of HIV infection. *Lancet* 1988;ii:1039-42.
- 2 European Collaborative Study. Children born to women with HIV-1 infection: natural history and risk of transmission. *Lancet* 1991;i:253-9.
- 3 Moq JQ, Giaquinto C, De Rossi A, Grosh-Wormer I, Ades AD, Peckham CS. Infants born to mothers seropositive for human immunodeficiency virus: preliminary findings from a multicentre European study. *Lancet* 1987;ii:1164-7.
- 4 Letsky E. The haematological system. In: Hytten F, Chamberlain G, eds. *Clinical physiology in obstetrics*. Oxford: Blackwell Scientific, 1980:49-51.
- 5 Biggar RJ, Pahwa S, Minkoff H, et al. Immunosuppression in pregnant women infected with human immunodeficiency virus. *Am J Obstet Gynecol* 1989;161:1239-44.
- 6 Adler MW, ed. *ABC of AIDS*. London: BMJ Publications, 1987:13.
- 7 Hessel NA, Lifson AR, O'Malley PM, Doll LS, Jaffe HW, Rutherford GW. Prevalence, incidence, and progression of human immunodeficiency virus infection in homosexual and bisexual men in hepatitis B vaccine trials, 1978-1988. *Am J Epidemiol* 1989;130:1167-75.
- 8 *R v Ethical Committee of St Mary's Hospital (Manchester) Ex parte Harriott* [1988] 1 FLR 512.
- 9 *Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital* [1985] 1 All ER 643.
- 10 *McKay v Essex Area Health Authority* [1982] 2 AER 771.
- 11 Barbacci M, Repke JT, Chaisson RE. Routine prenatal screening for HIV infection. *Lancet* 1991;337:709-11.
- 12 Smith JR, Reginald PW, Forster SM. Safe sex and conception: a dilemma. *Lancet* 1990;335:359.
- 13 Smith JR, Kitchen VS. Reducing the risk of infection for obstetricians. *Br J Obstet Gynaecol* 1991;98:124-6.

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How To Do It

Produce a service specification

Diana Webster

Since 1 April this year contracts have formed the basis of all NHS provision.¹ These contracts must identify the quality, quantity, and cost of services to be provided. Before a contract can be developed a service specification is needed.² Many district health authorities invited would-be providers to submit service specifications for the services they wished the health authority to purchase. In this context a service specification is an offer to provide a service.

This year's experience with contracts has shown that provider units found it difficult to describe the services they wanted to offer in a way that was meaningful and useful to a district health authority purchaser. Clinicians are expected to participate in developing service specifications.³ To help doctors to draw up service specifications I have identified the information a prospective purchaser needs to get maximum value from a specification.

What is a service specification?

A service specification is an offer to provide a service. It is made by a provider to a prospective purchaser. A service specification is therefore not the same as a specialty plan.

While examining a service specification the purchaser considers two fundamental questions: Do I wish to buy this service and do I wish to buy it from this particular provider? It is therefore in the interests of both parties that every specification attempts to give sufficient information to assist prospective purchasers in their deliberations.

The specification should provide sufficient information to allow the purchaser to answer five important questions: What is the service, how is it to be provided, how much service is being offered, what is the quality of the service, and can the provider deliver the quality

of service promised? I will address each of these questions separately. The list of information to be included is not intended to be exhaustive and should be extended when this seems appropriate to the particular service.

What is the service being offered?

The specification should include, firstly, the overall aim of the service. For example, the overall aim of a general surgical service might be to provide comprehensive general surgical care to all patients aged 16 years and above referred in need of general surgical treatment.

Secondly, the specific objectives of the service should be stated. In a general surgical service these might include prompt assessment of acutely ill patients by a doctor with appropriate experience and training; provision of timely and appropriate operative care by adequately skilled and supervised medical staff; provision of care by doctors who are personally participating in comprehensive medical audit of the care they provide; and effective communication between medical and nursing staff and patients (and their general practitioner).

Thirdly, a description of the service is needed. This should include the range of clinical activities encompassed by the service, the specialist interests and expertise; the modes of treatment (inpatient, outpatient, day care, etc), the input from other medical and paramedical specialties (pathology, anaesthesia, physiotherapy, social work, etc), the relation and communication with services provided by other provider units (such as community child health services, community nursing, social services), the access to the service (consultant, general practitioner, non-medical health professional, self-referral, restrictions or pre-

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Clinicians are now expected to help to develop service specifications

requisites for treatment), and the provider's involvement in teaching, training, and research.

How is the service provided, and by whom?

Purchasers need to know the type and location of facilities:

What are they? Are they good, and if so, why? What, if any, are the facilities for parents or relatives to stay overnight? What are the facilities for visitors?

The philosophy underpinning the staffing of the service should also be described. Is it a consultant-based service? If so, what is the provider's interpretation of consultant based and how is 24 hour consultant cover maintained (especially when consultants have commitments on more than one site)? Are staff with particular expertise and qualifications employed (for example, with specialist training in intensive or paediatric care)? What are the policies for continuing within service education and updating of staff in all disciplines?

Relevant policies or codes of practice, or both, concerning the way care is provided are also important. For example, policies concerning the supervision of junior staff; communication with patients, relatives, other medical or paramedical staff, etc; and individual nursing care programmes for patients. Any clinical protocols or policies should also be included (for postoperative pain relief; rehabilitation of patients with fractured neck of femur; prescribing and management of myocardial infarction, head injuries, stroke, and deliberate self harm), as should use of day surgery, five day wards, and a planned investigation facility.

What quantity of service does the provider expect the purchaser's residents to require?

Activity data relating to residents of the purchasing district health authority are required. For example, data on episodes of inpatient care and length of stay (elective and acute); outpatient, day, and domiciliary care, readmission rates; relevant activity data for procedures (number of hip replacements, child development assessments, etc). The specification should also include an analysis of trends and an analysis of waiting lists, including current numbers on the waiting list and waiting times, and of performance over the preceding 12 months—for example, mean and range of waiting times for admission for elective surgery during the past 12 months.

What is the quality of the service being offered?

The purchaser needs objective information to explain why providers believe their service is of good quality. Information should be provided on the effectiveness, efficiency, equity, acceptability, accessibility, and appropriateness of the service being offered.

Purchasers also look for specific standards set and response to quality issues the authority has identified as priorities for the contract period.

Will the provider deliver the stated quality of service?

To assess this purchasers look at proposals for monitoring the quality of service, in particular whether both process and outcome of care are monitored. Information on how the provider intends to implement and monitor quality standards the provider has set is also considered.

When medical audit is being practised, purchasers consider whether the provider has identified any recent changes that have been prompted by the findings of medical audit and look for details of the medical audit programme to be implemented during the next 12 months. Specifically, are the topics for audit identified and are the standards being used within the audit identified?

Finally, the purchaser considers whether the provider has confirmed that it intends to comply with the district health authority's targets and quality standards and if so how it intends to achieve compliance and monitor its performance.

The format of a service specification is a matter for discussion with individual purchasing district health authorities. Nevertheless, if providers covered the above topics this would help to reduce purchasers' concerns about the content of these specifications.

1 NHS Management Executive. *Contracts for health services: operating contracts*. London: HMSO, 1990.

2 NHS Management Executive. *Starting specifications—a DHA project paper*. London: NHS Management Executive, 1990. (EL/90)161.)

3 NHS Management Executive. *Involving professional staff in drawing up NHS contracts*. London: NHS Management Executive, 1990. (EL/90)221.)

THE MEMOIR CLUB

I had been the first professor of anatomy in the University of Western Australia and the last professor of anatomy in the University of Aberdeen. When I had begun teaching anatomy, thirty years previously, the objective was to teach students to find their way confidently round the bodies of their patients and to give them a sufficiency of human histology to provide a basis for the study of pathology. Now, however, topography was relegated to a completely subsidiary position, being regarded by many as useless and perhaps even harmful. The human body was being squeezed out of the curriculum, for medical education was now preoccupied with sociology and psychology. I felt that the pendulum had swung much too far, and that students were now being educated to deal with a utopian community in which injuries did not occur, every disease had its origin in mental distress, and a knowledge of the nerves, blood vessels, and internal organs was an unnecessary luxury. I prepared to leave my chosen profession without regret.

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