Why not standing orders for general practice?

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WHEN medical tragedies and storms in teacups arise, they may be examined by an Ombudsman, law court, tribunal, inquiry, or even the General Medical Council. This may be at the instigation of a misinformed and litigious relative, a reasonably aggrieved patient, or by ourselves. Whatever the means or the motive, more often than not the final blame is put on failures of communication.

Communication is now a problem in the medical world, both between and within teams. Lines of communication are now longer and more complex than ever before, stretching between colleagues of different disciplines, and from them to their deputies, ancillaries, and all their staff.

Membership of teams changes, responsibilities change, and in general they increase. There must therefore be a system of responsibility which is clearly understood. However, members of staff will not have a clear understanding without clear instruction. Instruction is a two-way process. Such instructions as we give, or do not give, are also considered by the staff who exercise them. They have the first-hand experience of their own tasks and it is therefore wise to use their own experience. This is where standing orders come in. Standing orders make it clear where the ultimate responsibility rests—at the top. They instruct, they inform, and they also support. They are a mechanism of management.

With this in mind, we decided to produce standing orders for our own practice, which we did by drafting and re-drafting with the help of our staff. They read as follows:

1. *Preamble.* A statement of aims, with reference to the goals of patients, staff, and doctors.

2. *Confidentiality.* Including a reference to such as the enquiring employer.

3. *Responsibility.* Limits, particularly on giving advice. "If in doubt ask a doctor."

4. *Courtesy.* Including a reference to its efficacy in the face of unreason.

5. *Appointments.* Guidance in organizing for and between doctors, and responding to urgent demands.

6. *Requests for visits.* Including a) Guidance on requests to pass at once to a doctor, e.g. for chest pain b) A means of ensuring all requests reach the doctor.

7. *Telephone.* Requirements of a proper message; guidance on when the doctors should or should not be interrupted.

8. *Dispensing and repeat prescriptions.* Including a reference to potential cheating by psycho-active drug consumers.

9. *Disputes.* With patients—if it happens.

10. *Contracts of Employment 1972.* A list of minimum requirements.

11. *Health and Safety at Work Act, 1974.* Guidance on special health risks, including reference to rubella vaccination and female staff; and personal medical care of staff.

We have found our standing orders invaluable. While doctors may have difficulty in adhering to their own guidelines, they provide a base from which to work, and one benefit is that the induction of new staff is greatly eased. The partners have yet to appear before the General Medical Council and we hope our standing orders will help to prevent this happening at all; should it do so, they will stand in our defence.

In the good old days of single-handed practice we just got on with the work. Then we had no teams, but teams are here to stay and we should therefore take steps to ensure that they and ourselves are properly protected.

So why not draft standing orders in every practice?

Addendum

See Letters to the Editor. (p. 622).