Service committee procedures—a reply to the Council on Tribunals

MICHAEL GLORNEY, LL.B
Assistant Administrator, Barnet Family Practitioner Committee

FAMILY practitioner committees in the NHS and the professions providing services in their areas have recently been considering a number of proposals to modify, and presumably improve, service committee procedures referred to in the consultative document of the Department of Health and Social Security (1976) as "Complaints Investigation Procedures".

The most radical proposal is that the chairman of the service committee should no longer be appointed by the members of the service committee themselves. It is suggested that there should be about a dozen chairmen appointed nationally by the Secretary of State from a panel drawn up by the Lord Chancellor, each of whom would cover several geographical areas. It is also suggested that an officer other than the administrator of the family practitioner services should clerk the committee.

Both proposals are obviously designed to counter the criticism that, in the words of the Council on Tribunals (DHSS, 1976), "the body which is responsible for providing the practitioners' services to the public under contractual arrangements—the family practitioner committee—also decides whether a complaint is justified." Put less obliquely, the family practitioner committee is accused of being judge in its own cause.

Assumptions by the Council on Tribunals

This is a serious charge and if it were well founded would be unanswerable. The allegation, however, depends for its validity on several assumptions about the nature and purpose of the service committee procedure, which it would be unwise to accept uncritically. In particular, it presupposes:

1. That the service committee procedure is a complaints investigation procedure in the same way that, for example, the civil jurisdiction of the courts or the proceedings of the Health Service Commissioner are complaints investigation procedures.

2. That any complaint against a doctor, dentist, chemist, or optician is a criticism not only of the professional man concerned but also of the local family practitioner committee which is described as: "the body responsible for providing the practitioners' services to the public".

© *Journal of the Royal College of General Practitioners*, 1977, 27, 597-600.

The first fallacy

At the outset it is as well to emphasize that there exists no procedure, formal or informal, for the investigation of a complaint that, for example, a doctor was rude or inconsiderate, or that his receptionist was ill-mannered, or that the vagaries of his appointment system caused the patient to be late for work. In similar circumstances, a complaint about a hospital doctor may be investigated by the Health Service Commissioner (NHS Reorganization Act, 1973) and if the complaint is upheld there will be some redress, if only an apology.

Any complaint about a contractor to the family practitioner committee is, however, expressly excluded from the Commissioner's jurisdiction and the only remedy available to a dissatisfied patient is to change his doctor. I am not advocating that there should be a remedy similar to that afforded by the Health Service Commissioner; I am merely reporting as a fact that there exists no procedure for the investigation of a complaint in the circumstances outlined at the beginning of this paragraph.

What does exist, and what only exists, is a disciplinary code (NHS Service (Committees and Tribunal) Regulations, 1974) which provides:

1. For the monitoring, for example, of the prescribing habits of doctors and the treatment patterns of dentists and their investigation by the appropriate local professional committee.

2. For the investigation of a complaint by the Dental Estimates Board or a patient (a term that is variously defined from profession to profession) that a contractor has not complied with the terms of his contract to provide professional services in the area of the committee.

3. For the investigation by a service committee of *any*

matter referred by the Dental Estimates Board or the family practitioner committee which relates to the administration of general medical, dental, ophthalmic, or pharmaceutical services.

It is essential to emphasize the very limited purpose and ambition of the service committee procedure: it does not exist to remedy patients' grievances; its primary purpose on the contrary is narrow, particular and self-interested. It is designed pre-eminently to discover whether in the particular case investigated there has been a failure by the contractor concerned to comply with his contractual obligations *to the Committee.* The service committees are not really concerned with the effect or consequence of such a failure—the common law obligations of a doctor will take care of that. The service committees are interested only in the failure *qua* failure. It would be no great exaggeration to say that the purpose of the service committee procedure is to establish whether the contractor concerned has done the job for which he has been remunerated by the family practitioner committee: in a word the procedure is disciplinary.

Second fallacy

This brings me naturally to the second assumption or fallacy that a family practitioner committee is somehow jointly responsible (with the contractor) for any failure in the service which he has contracted with the committee to provide. Put like that the assumption is patently absurd; but the absurdity of the notion has not been apparent to many people, from patients to community health councils (and evidently the Council on Tribunals), some of whose members are prone to regard service committee proceedings as a charade which allows the committee and the professions to decide in private whether the service they provide to the public is satisfactory. How else can one understand, much less explain, the insistence with which community health councils clamour to be represented at service committee hearings? How else can one explain the view, expressed by the Council on Tribunals (1976), that "an independent mind needs to be brought to bear on the investigation . . ."?

Significance of the independent contractor status

Family practitioner committees provide nothing to the public: they certainly do not provide the practitioners' services to the public in the way that an area health authority provides hospital or specialist services. Neither does the committee contract with the practitioner for the provision of services: on the contrary, the practitioner contracts with them. Subject to the negative control over doctors exercised by the Medical Practices Committee, any doctor, dentist, chemist, or optician appearing on the appropriate professional register is entitled to provide professional services under the NHS in the area of the committee.

The committee has no authority whatever to refuse an application for inclusion in the appropriate professional list, and on inclusion the contractors concerned will provide professional services in the committee's area from their own homes, shops, and surgeries, during hours (except for chemists) largely of their own choosing and generally (again except for chemists) only for persons for whom they have agreed to provide services.

Contrast these arrangements with those that obtain in a hospital where the practitioner, chemist or optician will be a salaried employee of the area health authority, with a contract of service whose express and implied terms will ensure his broad compliance with the lawful instructions of his employer during those days and hours when he is required by his contract to attend. The hospital doctor is there because the area health authority needs his contribution to the service *it* provides for the public: the general practitioner is at his surgery because he and nobody else has decided that that is the place he wants to be.

This distinction between the status of a general practitioner and that of his hospital counterpart is fundamental and, for the purposes of the law of negligence, critical. In common law an area health authority is liable for any negligent act of its medical (and other) employees committed in the course of their employment with the area.

Family practitioner committees are not in law similarly responsible for the negligence of independent contractors engaged in the provision of professional services *in* the area of the committee: if the contractor is suitably qualified their responsibility ends there.

However, although the committees are not in common law liable for the acts of their independent contractors—indeed because they are not so responsible —they must assume and be seen to assume some responsibility for the service the contractors provide, if only on the expedient grounds that they "permit" them to practise in the Health Service at all. In addition, however, the committees are a public body associated, if only in the most exiguous way, with a public service paid for out of public funds. For these reasons, therefore, if for no other, some modicum of control is inescapable.

That any such control over the services provided by independent contractors will be rudimentary in the extreme is only too obvious. In the first place, doctors, dentists, chemists, and opticians are all members of professions that possess their own rigorous standards of training and behaviour, and it would be difficult if not impossible to construct a code of Health Service conduct that would do very much more than restate the ethical imperatives of those professions. For example, paragraph 13 of the *Terms of Service for Doctors* (NHS (General Medical and Pharmaceutical Services) Regulations, 1974) requires a doctor merely to render to his patients all necessary and appropriate medical services of the type usually provided by general medical

practitioners. Secondly, the contractors are subject internally to the discipline of their own professional bodies, and externally to the common law obligation of care that a professional man owes to a patient, whether inside or outside the Health Service. Thirdly, any form of control or discipline will need to be acceptable to the professions themselves; and fourthly, it must not be inconsistent with their status as independent contractors.

Service committee regulations

In the NHS (Service Committees and Tribunal) Regulations (1974) will be found the formulae agreed by the professions and the Secretary of State for the regulation and discipline of those independent contractors who have undertaken to provide general medical and associated services under the NHS. The Regulations have three aims:

1. To monitor in a very general way the professional practices of contractors, for example the prescribing habits of doctors and opticians and the treatment patterns of dentists.

2. To provide a procedure whereby an allegation or complaint that a contractor has not complied with the terms of his contract may be investigated by a service committee.

3. To protect the professions from unjust allegations and from damaging publicity for imaginary or trivial breaches of contract. (For the sake of completeness I should perhaps add that the Regulations also govern the procedure of the NHS Tribunal which possesses the ultimate sanction over a contractor of disqualification from the family practitioner service.)

None of these procedures is a complaints investigation procedure in the conventional meaning of the term; that is to say one which will provide redress for a patient aggrieved by the action or inaction of a contractor. The procedures are all quintessentially disciplinary; and the fact that a service committee hearing is more often than not initiated by a complaint from a patient (for example, that a doctor did not visit when he should have done) does not make it any less a disciplinary exercise.

Report of the Franks Committee

In 1955 executive councils and their service committees were subjected to a searching examination by the Franks Committee on tribunals and enquiries (1957). The Committee had been commissioned to examine the efficiency and impartiality of those tribunals which had been established in the main to adjudicate in disputes between the citizen and the State or a public authority. Its report is chiefly remembered for its generalized recommendations that the process of investigation and decision of such disputes should be marked by openness, fairness, and impartiality.

A particular recommendation of Franks (designed to secure the independence of tribunals from the administration) and the one that most concerns us was that chairmen of tribunals should be appointed by the Lord Chancellor and should ordinarily have legal qualifications.

Explaining its terms of reference, the Committee cited the example of a claimant for benefit under the National Insurance Acts, the initial decision on whose claim would be made by an official of a government department. If the claimant objected to that decision the necessity for a further decision on his claim became inevitable and the Committee was instructed to consider how and by whom further decisions of that kind should be made. The Committee added that that analysis of the conflict between private right and public advantage held good over nearly the whole field covered by its terms of reference, although there were a few tribunals (notably rent tribunals) which decided disputes not between the citizen and the administration but between citizen and citizen.

When the Committee came to consider tribunals in the NHS, it became immediately apparent to the Committee that the adjudicatory function of executive councils and their service committees did not consist of the resolution of a dispute or conflict between the citizen and the administration at all; neither did it deal with a dispute between one citizen and another (as did rent tribunals) although 'in form' it looked very much like that.

Executive councils, the Committee concluded, were principally administrative bodies concerned with the detailed operation of the NHS to whom the Committee's general recommendations (concerning, for example, the independence of tribunal chairmen) should not be strictly applied. It was true, the Franks Committee went on, that when considering reports by service committees in disciplinary cases they might be said to be acting as tribunals, but the Committee nevertheless did not think that those functions should be separated and entrusted to other bodies. There were a number of important distinctions: the disciplinary matters were generally initiated by patients; the executive council was in a contractual relationship with the practitioners; and the preliminary investigation was carried out by separate bodies (i.e. service committees) *largely independent* of the councils.

The Committee gave considerable thought to the general nature and purpose of the system of adjudication enshrined in the Service Committees and Tribunal Regulations and some of the results of their analysis are well worth repeating in full:

> "We take the view that the purpose of the system is to be regarded as disciplinary rather than for the redress of patients' grievances. The ultimate question which can arise is whether a practitioner should be retained in the NHS or not, and the decision here must turn upon his general professional skill and behaviour as indicated by the evidence in one or more individual cases brought to the notice of the deciding authority. It may well be true

COLLEGE ACCOMMODATION

Charges for college accommodation are reduced for members (i.e. fellows, members and associates). Members of overseas colleges are welcome when rooms are available. All charges for accommodation include breakfast and are subject to VAT. A service charge of 12½ per cent is added. Members are reminded that children under the age of 12 years cannot be admitted and dogs are not allowed.

From 1 January 1977, charges are:

	Members	Others
Single room	£5	£9
Double room	£9	£14
Flat 1	£11 (£70 per week)	£14 (£90 per week)
Flat 3	£12 (£75 per week)	£15 (£95 per week)

Charges are also reduced for members hiring reception rooms compared with outside organisations which apply to hold meetings at the College. All hirings are subject to approval and VAT is added.

	Members	Others
Long room	£30	£40
Damask room	£20	£30
Common room and terrace	£20	£30
Kitchen		£10
Dining room	£10	£10

Enquiries should be addressed to:

The Accommodation Secretary
The Royal College of General Practitioners
14 Princes Gate, Hyde Park
London SW7 1PU.

Tel: 01-584 6262

Whenever possible bookings should be made well in advance.

that the general public regards the purpose of the process as the redress of grievances, in as much as it provides for the imposition of penalties upon practitioners adjudged to have broken the terms of their contracts for services. But this view overlooks the point that the patient does not obtain redress in any normal sense: he himself obtains no benefit or recompense if the allegation which he brings is ultimately held to be well founded. For material redress he would have to resort to action in the courts, and it is noted that the statutory system does not in any way affect his ordinary legal rights against a practitioner.

"This being so, the fact that the system is an important part of the terms negotiated for the employment of these professions by the State and has the general support of the professions concerned must carry great weight. *We are accordingly disinclined to suggest major changes in it.* We consider that cases should continue to be first heard before a service committee with a decision by an executive council and provision for a further appeal. But, as will appear later, we have some changes to propose in relation to the hearing and determination of appeals *from* executive councils." (My italics.)

References

Department of Health and Social Security (1976). Consultative document. *Complaints Investigation Procedures.*

NHS Reorganization Act (1973). London: HMSO.

NHS (Service Committees and Tribunal) Regulations (1974). S.I. No. 455. London: HMSO.

NHS (General Medical and Pharmaceutical Services) Regulations (1974). SI No. 160. London: HMSO.

Franks Committee (1957). *Report on Administrative Tribunals and Enquiries.* Cmnd 218. London: HMSO.

Oral contraceptives and breast neoplasia

Between 1 December 1968 and 31 December 1971, 345 women aged 16 to 39 years with a lump in the breast (90 malignant and 255 benign) were interviewed at five London teaching hospitals with 347 matched controls suffering from acute medical or surgical conditions or admitted to hospital for routine elective surgery. Questions were asked about each patient's medical, obstetric, menstrual, contraceptive, and social histories.

The data do not suggest that the use of oral contraceptives is related in any way to the risk of breast cancer, but provide some evidence that the preparations may actually protect against benign breast disease. This protective effect is largely confined to women who continue to use oral contraceptives and have used them altogether for more than two years. Such women appear to have only about 25 per cent as great risk of being admitted to hospital for a breast biopsy as women who have never used oral contraceptives at all.

Reference

Vessey, M. P., Doll, Sir Richard & Sutton, P. M. (1972). Author's summary. *British Medical Journal,* 3, 719.