New controls for private hospitals

Independent hospitals' medical advisory committee chairmen are in line for a much heavier workload, says Dr Gerard Panting

INDEPENDENT PRACTITIONERS may have breathed a sigh of relief when the private sector received only a passing mention in the Government's recent white paper setting out ideas for healthcare reform. But don't be fooled.

Problems revealed by the scandals of the 1990s were dissected in a string of inquiries that threw up hundreds of recommendations. But taking the limelight, as always, was the GMC and what it does.

Last February, the Government published its white paper response to the Neale, Ayling, Kerr/Haslam and Shipman inquiries, the Chief Medical Officer of England's (CMO) review of the GMC and the parallel review of all the other health regulators. The result is a mix of firm proposals and many embryonic ideas to be developed through consultation and working parties, some now underway.

The GMC will be even leaner and fitter, wholly appointed, will lose its medical majority and be more board-like. It will retain its educational functions, continue to keep the Register, publish advice and investigate complaints.

A new independent tribunal will adjudicate fitness-to-practise cases while the Council for Healthcare Regulatory Excellence continues to monitor the GMC's handling of preliminary investigations.

But the really big new idea is the creation of GMC affiliates, to be piloted in England. Affiliates will have a lot of work, such as: advising, supporting and guiding employers if there are concerns over doctors; monitoring the performance of organisations in dealing with these issues; undertaking risk-based and random sampling of local relicensing procedures.

The CMO envisioned one affiliate in every health body, but ministers realised this would involve 450 medically qualified affiliates costing about £43m a year. One in each of the 14 strategic health authorities is more likely.

In the NHS, many functions earmarked for affiliates will fall to medical directors, who will enjoy what the white paper refers to as 'a significant extension of their authority, responsibility and workload. They will oversee local revalidation processes, act as a focal point for holding and sharing information on complaints and concerns about doctors'.

This concept will be mirrored in the independent sector. All eyes are falling on the medical advisory committee (MAC) chairmen.

Demanding duties

MAC chairmen will probably be given duties demanding more time, more hassle and a greater risk of being hauled over the coals for failing to spot the latest Ledward. For those who do not resign at the first hint of these reforms, the key issues will be time, training and remuneration.

MAC chairmen generally receive no pay, as many want to keep a distance from management and thus retain colleagues' trust.

This may need to change. Unless this post is properly paid, no one in their right mind will want to do it. It won't be easy. Training, support and access to independent advice are essential.

For the independent sector, the Federation of Independent Practitioner Organisations (FIPO) has provided *Guidelines for MAC chairmen*. It will offer training, support and advice and be capable of influencing the development of this role.

Dr Panting is chairman of FIPO's clinical governance advisory committee and director of TWG Resources