SUPPLEMENT

The Week

A personal view of current medicopolitical events

Despite its limitations I had hoped that the Griffiths management plan would at least loosen the suffocating embrace in which the Department of Health and Social Security holds health authorities. I should have known better with politicians and civil servants holding the levers of change. The announcement of the NHS management board (p 1228)—one of Roy Griffiths's major proposals—is depressing on two counts. Firstly, the board's establishment is not just late but almost too late to have any real influence on the formative stage of the Griffiths plan. It is rather as if the Duke of Wellington had limped late into the Battle of Waterloo to find that his troops had been obliged to start the battle on their own. That said, the delay might, paradoxically, have been fortuitous, for the second depressing—and in the long term more damaging—defect of the board is its constitution. The membership is so DHSS dominated as to mock Mr Griffiths's aim of introducing modern management into the NHS, for since when were civil servants noted for their collective management ability or techniques?

The eight members joining Victor Paige, the chairman, will comprise the Chief Medical and Nursing Officers, three lay civil servants, a former regional administrator, who has been working at the DHSS, and (presumably) two private sector representatives, one to oversee financial planning and the other personnel. Health authorities who have struggled to meet unrealistic deadlines and ministerial demands to introduce outsiders into the NHS may be forgiven for asking was it worth it when paid up members of the same old gang will be in charge at the top. (And don't forget that there is a supervisory board containing ministers and senior civil servants above the management board.) Plus ça change, etc.

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The questions came thick and fast. How can I advertise? What sort of assistance can I expect in a private hospital? How do I know if my hospital is authorised for private practice? Is category II work private practice? What can I claim for having my consulting room at home? The answers were given by a group experienced in private practice, accountancy, and pension arrangements during a seminar on private practice last weekend for new consultants and senior registrars due for elevation. Organised by the Central Committee for Hospital Medical Services with generous sponsorship from AMI Hospitals Limited the meeting attracted around 50 doctors from most specialties. They heard some down to earth advice from Dr Brian Lewis, chairman of the CCHMS's negotiating subcommittee, and Mr John Chawner, a member of the CCHMS and chairman of the private practice and professional fees committee.

All paperwork had to be scrupulous as private practitioners were under constant scrutiny, Dr Lewis warned. Each consultant could expect lifetime earnings of around £0·75 m from the NHS and it was not worth putting that at risk by cutting corners. It was courteous to keep general practitioners fully informed and to seek their opinion on the choice of physician, for instance. Before patients could be treated privately in an NHS hospital the hospital had to be approved for private inpatients or outpatients or both under sections 65 and 66 of the 1977 National Health Service Act, as amended by the 1980 Health Services Act.

Mr Chawner admitted to being astounded at the number of consultants who were doing private practice in the NHS and did not know the regulations. He hoped that new guidance would soon be published on the relevant regulations on private practice. Junior staff were bound to help their consultants treat private patients in the NHS unless they had a conscientious objection to operating the provisions of the 1967 Abortion Act. Mr Chawner also hoped that there would soon be a common triplicate form that patients could sign giving consent to private treatment in the NHS. If a patient did not give consent in writing he could not legally be charged.

Full time consultants are permitted to earn up to 10% of their *gross* salary from private practice. This concession, Mr Chawner thought, had been responsible for the recent increase in private practice, particularly by pathologists and radiologists. Advertising was always tricky, but doctors hoping to start practising privately could circularise the following details—name, address, telephone number, specialty, and where they planned to consult and practise—to other consultants and general practitioners. This information, however, had to be in a sealed envelope; otherwise the doctors concerned could well incur the wrath of the General Medical Council—unless, of course, this competition obsessed government changes the rules.

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The Royal College of Nursing is sounding off about nurses' pay. I have some sympathy: nurses' pay is low in comparison with other occupations, bearing in mind the profession's responsibilities. That was why nurses made such a fuss two years ago, with Norman Fowler buying peace with the promise of an independent review body for their pay. He was so slow in setting up the review body that in its first award (last year) it had time to make only an interim assessment. This year was supposed to be a review in depth. The review body may well have done this—the report is said to be on the Prime Minister's desk—but Kenneth Clarke, Minister for Health, is making loud noises to the effect that any NHS pay awards over 3% will be at the expense of services to patients. The secretary of the RCN calls it moral blackmail—I'd be inclined to call it immoral blackmail. But doctors have been down this road before—and will doubtless be treading it this year, too (13 April, p 1160). They know that independence means what governments say it will mean.

SCRUTATOR