



PRIVATE PRACTICE IN DERMATOLOGY



SERVICE GUIDANCE

ETHICAL ASPECTS: A GUIDE FOR MEMBERS

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Preface

This pamphlet was first written by Dr. Harvey Baker in 1990 and modified by Dr. Robin Graham-Brown in 1996. It was a privilege to be asked to update and amend it in 2005, 2007, 2010 and again in 2017. I acknowledge the debt owed to my predecessors for laying down the fundamentals so clearly.

Introduction

Private medical practice has expanded rapidly in the United Kingdom (UK) in the last 30 years. Although the size of the private sector may fluctuate, UK regulations, media attention, changing public attitudes to medical services and the emergence of a competitive, consumer-orientated society have all had an impact on medical practice.

The injection of substantial capital (including from overseas) into new hospitals, clinics and provider groups, and the influx of foreign patients specifically seeking British medical care, but lacking the benefit of advice from a family/general practitioner (GP), have altered the nature of private practice.

The more recent disintegration of the National Health Service (NHS) has blurred the distinction between the public and private sectors, because NHS health services can be commissioned from NHS, independent, and private providers. However, clear standards have been delineated, and all providers of contracted NHS UK services must meet national and operationally mandated standards and the *NHS Constitution*¹ (England and Wales: Section 183; Scotland: Section 7; Northern Ireland: Section 20).

Well-trieed, proven principles of professional conduct have long been accepted regardless of the service setting. Throughout the history of medicine many of the ethical aspects of medical practice have become enshrined in statutory law or codes of practice, such as the 'Hippocratic Oath' or in regulations set out by the General Medical Council (GMC).

But some ethical attitudes have emerged by convention and are formally expressed from time to time in the shape of published advice or guidelines in textbooks or pamphlets, exemplified by the British Medical Association (BMA)'s publication *Medical Ethics Today* (2013)², the Royal College of Physicians (RCP)'s guide, *Good Medical Practice for Physicians* (2004)³, or the BAD publication you are reading, *Private Practice in Dermatology: Ethical Aspects* (2016). Obviously, there is overlap and gradation.

The most important and useful documents remain the GMC booklet, *Good Medical Practice* (2013)⁴, and the various GMC ethical guidance documents, such as *Consent: Patients and Doctors Making Decisions Together*⁵ and *Financial and Commercial Arrangements and Conflicts of Interest*⁶. The first⁴ should be read and re-read by all of us as the need arises.

When ethical problems arise in medicine, they might not be immediately identified or acknowledged, and even when they are, working independently does not always place doctors in a position to discuss ethical concerns with senior colleagues – an important component of medical professionalism.

Breaches of professional and ethical behaviour can be grave enough to lead to jail or loss of registration; other less serious failings or deficiencies in professional deportment can bring individuals and Medicine itself into disrepute without being actionable at law or through the GMC.

General Principles

The same basic principles regarding clinical decisions should apply equally to NHS and private practice. “Where physicians undertake private and NHS practice, they should apply the same standards of care”³. All doctors must keep up to date with, and follow: the law, GMC guidance and other regulations relevant to their practice.

“The conduct of their private practice should not be to the detriment of patients in the NHS. They should never exploit patients for financial gain”³. It is unethical to charge excessively for a service or to persuade the patient to accept a service that he or she does not need. Judgement is particularly important in those areas of clinical Dermatology which border on cosmetic medicine. It is unethical to play on fears of malignancy in relation to, say, a benign naevus where the patient cannot quantitate the hazard and relies on a specialist’s advice. Such advice should never be framed so that the benefit of the proposed treatment is to the doctor (financial) and not to the patient.

To maintain a licence to practise, the physician must demonstrate, through the revalidation process, that they work in line with the principles and values set out in *Good Medical Practice*⁴. Serious or persistent failure to follow the GMC’s guidance places a doctor’s medical registration at risk.

Physicians in private practice are required to participate in annual appraisal and maintain a portfolio of supporting information to bring to their appraisals. They will also need to link to a Responsible Officer (RO) and confirm with the GMC their prescribed connection to a RO.

Independent organisations may not always conduct appraisals, in which case the physician should find alternative routes to an annual appraisal. [The Independent Doctors Federation](#) has appointed a RO for doctors without a prescribed connection to a NHS RO.

[The Federation of Independent Practitioner Organisations](#) also offers an appraisal service.

The NHS England MAGMAF (Medical Appraisal Guide Model Appraisal Form) includes a probity statement that seeks confirmation of insurance or indemnity from the doctor through the appraisal for revalidation process.

The duties of a doctor registered with the General Medical Council are stated:

“Patients must be able to trust doctors with their lives and health. To justify that trust, you must show respect for human life and make sure your practice meets the standards expected of you in the following four domains”:

Domain 1 - Knowledge, skills and performance:

- Make the care of your patient your first concern
- Provide a good standard of practice and care
 - Keep your professional knowledge and skills up to date
 - Recognise and work within the limits of your competence

Domain 2 - Safety and quality:

- Take prompt action if you think that patient safety, dignity or comfort is being compromised
- Protect and promote the health of patients and the public

Domain 3 - Communication, partnership and teamwork:

- Treat patients as individuals and respect their dignity
 - Treat patients politely and considerately
 - Respect patients' right to confidentiality
- Work in partnership with patients
 - Listen to, and respond to, their concerns and preferences
 - Give patients the information they want or need in a way they can understand
 - Respect patients' right to reach decisions with you about their treatment and care
 - Support patients in caring for themselves to improve and maintain their health
- Work with colleagues in the ways that best serve patients' interests

Domain 4 - Maintaining Trust:

- Be honest and open and act with integrity
 - Never discriminate unfairly against patients or colleagues
 - Never abuse your patients' trust in you or the public's trust in the profession.

"You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions."

The RCP pamphlet *Good Medical Practice for Physicians (2004)*³; contains five points of relevance to private practice:

- Clear records must be kept of diagnoses and actions;
- A record must be kept of information given to patients and their relatives, including a summary of all discussions between physicians and patients;
- Physicians should refer to other colleagues when an opinion from another specialty or a more specialised physician would be in the patient's best interests;
- When sharing care, colleagues should be kept well informed;
- For inpatients, there should always be a single physician ... taking responsibility for continuing care;

Observance of the guidelines abstracted and rehearsed above is directly relevant to achieving the highest ethical standards in private practice in Dermatology in the UK.

The NHS Constitution¹

All NHS bodies, private and independent providers supplying NHS services, are required by law to take account of the NHS Constitution¹ in their decisions and actions.

These core principles are shared across all health care services provided in the UK¹.

The seven key principles that guide the NHS in all it does are all relevant to Dermatologists working in the independent sector:

- The NHS provides a comprehensive service, available to all;
- Access to NHS services is based on clinical need, not an individual's ability to pay;
- The NHS aspires to the highest standards of excellence and professionalism;
- The patient will be at the heart of everything the NHS does;
- The NHS works across organisational boundaries;
- The NHS is committed to providing the best value for taxpayers' money;
- The NHS is accountable to the public, communities and patients it serves.

There are other aspects of private practice that can present ethical challenges, not specifically covered by generic ethical guidance. These areas are set out under the following headings:

- Advertising and notification of colleagues;
- Fees; financial and commercial arrangements;
- Relationship with the NHS and insurers;
- Patient Referrals;
- Clinical notes and records;
- Confidentiality.

Advertising and Notification of Colleagues

The GMC is now in favour of doctors providing accurate information about services to patients, as long as both their own guidance and that of the Advertising Standards Authority (ASA), is heeded. All this may seem a far cry from the days when advertising was deemed to amount to serious professional misconduct.

The ASA's *British Codes of Advertising and Sales Promotion*⁷ require that all advertisements should be legal, decent, honest and truthful and prepared with a sense of responsibility to customers and the public. All advertisements should respect the principles of fair competition that are generally accepted in business, and no advertisement should bring advertising into disrepute.

Responsibility for observing these Codes falls on advertisers, but others involved in preparing and publishing advertisements (which include doctors in relation to private clinics) also accept an obligation to abide by the Codes.

Another change in GMC advice is the removal of any reference to claims of superiority. The Codes of advertising expressly state that advertisers should not unfairly attack or discredit other businesses or their products.

Good Medical Practice, under the heading 'Treating patients fairly', also states: "You must not undermine patients trust in the care or treatment they receive or in the judgment of those treating them, by making malicious or unfounded criticisms of colleagues"⁴.

Direct comparisons should be avoided – they may be difficult to justify and will only antagonise practitioners who perceive themselves as being criticised and who may go on to complain to the GMC, the ASA or both.

"Doctors may advertise their services, for example on the internet, in formal advertisements in newspapers or magazines, a practice leaflet, or an editorial or news piece in a newspaper following the guidelines set out by the General Medical Council"⁸. "Advertising material, such as business cards, however, should not be given to the doctor's NHS patients, as this could be perceived as using NHS patients to promote private practice"⁸. All Independent provider services contracted to see NHS patients must comply with the NHS Identity Guidelines⁹.

Basic information, such as name of the practitioner (and other clinical staff), qualifications, and details of the facilities and treatment provided should be listed.

Advertisements of private practice services in journals intended for the Dermatology profession is unquestionably legitimate but caution should be exercised in placing and phrasing advertisements in publications intended for the public.

Such advertisements or notifications should be strictly factual and should not contain claims to superiority in personal quantities, qualifications, experience or skills; nor should they claim to be staffed by doctors deemed 'superior' by virtue of teaching hospital appointments, etc. Claims to be able to offer 'quick' appointments, by implication quicker than elsewhere, should be avoided.

The direct circulation of advertisements to GPs and other doctors far beyond normal catchment areas is regarded as going beyond acceptable conventions of notification and borders on 'canvassing' or 'touting'. It is also discourteous to BAD colleagues in consultant practice in those areas.

The BAD accepts that tertiary referral by one consultant Dermatologist to another is an acceptable and necessary professional exercise; however, consultants do not need promotional material about this (for example in relation to genetic counselling, pre-natal diagnosis, patch testing, photobiological investigation etc.).

Dermatology consultants proposing to practice wholly or partly within commercial clinics should ensure that they do not acquiesce in promotional techniques attempting to convey an impression that 'excellence' is provided at the clinic concerned. They should also be careful about the basis on which referral of patients to such an institution is secured and the way in which consulting premises or secretarial assistance is subsidised or granted free.

The BAD advises its Dermatology members not to advertise directly to the public and not to use opportunities to broadcast or appear on the television in such a way as to give colleagues any grounds for believing that promotion of private practice motivated these activities. Notwithstanding the claims that direct advertising by doctors to the public would increase consumer choice, promote competition and bring down medical charges, the BAD believes that such advertising would not be in the best interests of patients. In particular, it potentially bypasses an important step in the private referral pathway whereby a family practitioner advises on the need for specialist care and recommends a specialist based on his or her personal knowledge of the particular expertise of the specialists available and the individual patient concerned.

Fees; Financial and Commercial Arrangements

The basic ethical principles of financial and commercial arrangements and conflicts of interests for doctors are set out in the GMC's *Good Medical Practice*⁴. It is stated that a doctor must be honest in their financial and commercial dealings with patients, employers, insurers and other organisations or individuals.

All fees and charges for the doctor's service must be disclosed to patients, if possible, before signing their consent to treatment. Patients should also be informed if any part of the doctor's fee goes to another healthcare professional and doctors may not offer inducements to colleagues. Doctors should not exploit the patient's vulnerability or lack of medical knowledge when choosing fees for treatments and services.

Trust between the doctor and patient is essential in maintaining an effective professional relationship. Doctors must not ask for, or accept any inducement, gift or hospitality that may affect or be seen to affect the way they prescribe for, treat or refer patients. If a doctor plans to refer a patient for investigation, treatment or care at an organisation in which they have a commercial or financial interest, they must tell the patient about that interest and make a note of this in the patient's medical records.

Care should be taken in negotiating financial arrangements between practitioners and clinics or hospitals. Do not seek or accept any inducement for the referral of patients to an institute, hospital or clinic. Be wary of arrangements such as free or subsidised consulting premises or secretarial assistance that may create potential for conflicts of interest. If you have a financial interest in 'healthcare' organisations these interests must not affect the way you investigate or manage patients; you must declare your interest to the patient^{4,6}.

Dermatologists working as independent practitioners in the provision of services to the NHS must embrace unimpeachable standards of ethics in the bidding for, and delivery of services, most especially to avoid charges of conflicts of interest.

Relationships with the NHS and Insurers

Some aspects of this important topic that have been created by increased independent provision of services hitherto provided within the NHS have been addressed in the preceding chapter.

It is a very important principle that patients who have no rights to NHS care in the UK and who are private patients of a Dermatologist are not provided with benefits or services of any kind using NHS facilities stemming from the Dermatologist's own NHS practice.

However, it is an equally important principle that a patient who is fully entitled to NHS care does not forfeit those rights, in the present or the future, by seeking single or multiple private consultations or private in-patient care. Thus, a patient of very limited means may through his or her practitioner seek a private consultation in the belief that treatments and skills are available in the private sector that are not to be obtained in the NHS. After seeing such a patient, it is entirely legitimate to encourage and assist in the transfer of the patient to the NHS for future care. Under all but the most urgent circumstances the explicit written acquiescence of the GP should be obtained³. This ensures that the case will be funded in the NHS department and allows triage so that the date of the subsequent NHS appointment with the specialist, or admission to hospital reflects both the urgency of the clinical situation and the length of the specialist's NHS waiting lists⁴.

Common sense must be exercised in these matters so that Dermatologists with private and NHS practices should neither expose themselves to the risk of accusations of facilitating 'queue jumping' by patients via one or more private consultations nor, on the other hand, of denying such patients their proper rights and needs from the Health Service.

In general, once a private patient has been transferred to the NHS is it better to keep that patient in the NHS sector. Frequent switching between the two sectors could render the Dermatologist vulnerable to criticism. Nevertheless, if such a patient and/or their GP subsequently seek a private consultation despite discouragement it need not be refused, but it is prudent to record these details in the correspondence and clinical notes.

Similarly, problems could arise if a private patient is transferred to the NHS for the specific purpose of complex and expensive investigations but then reverts to the Dermatologist's private practice for subsequent treatment and follow-up care. Each case has to be judged individually but the specialist could become open to criticism that he or she is benefiting financially (albeit indirectly) from the use of NHS resources without which subsequent clinical care would have been difficult or impossible.

Another area of potential difficulty arises when the patient's clinical condition calls for the use of expensive therapeutic facilities, e.g. for phototherapy or an expensive drug such as one of the new biologics. A distinction has to be made here between privately insured and non-insured patients. If an insured patient needs, say phototherapy or patch testing, they should be able to obtain such services privately without difficulty. If the service is simply not available in the private sector locally (for whatever reason) then the patient should be referred by the GP for NHS care.

However, it is possible that a non-insured private patient and his referring GP may not have anticipated that diagnosis or treatment would require expensive investigations or treatment and/or protracted follow-up. Such a patient's best interests are unlikely to be served outside the NHS. A more difficult situation arises if good management demands the use of an expensive drug. Here, insured and non-insured patients may be in the same situation because private health insurers rarely reimburse prescription charges. Furthermore, the matter can be complicated by the strain that may be imposed on hospital pharmacy budgets by the use of these drugs even if clinically indicated. In general, if a patient can afford and is willing to pay the private prescription cost of such drugs, they should do so and should remain in the private sector. If the clinical need for such treatment is apparent but it cannot be afforded, NHS care should be recommended but this must, of course, be subject to the local hospitals referral and catchment policy. This may involve the patient being referred to another colleague⁴. It is always prudent, if not an absolute managerial necessity, to seek a separate referral or re-referral from the GP to the NHS service under these circumstances⁴. It is dubious whether it would subsequently be acceptable to encourage such patients to become 'private' again. It is improper for such patients to be registered as NHS patients solely for the purpose of receiving NHS prescriptions while at the same time being supervised and seen repeatedly privately.

In summary, in complex situations, the Dermatologist must exercise caution at all times: to not wittingly to abuse or manipulate NHS facilities and services for private gain nor unwittingly create the risk of an accusation of having done so. In contradistinction, a Dermatologist must not keep a patient in the private sector for private gain when it is manifestly against that patient's fiscal and/or clinical interests. It is the specialist's ethical duty to explain these issues to patients if and when they arise⁴. Relationships with insurers sometimes cause ethical difficulties. The contract between doctor and patient does not involve insurance companies. Regardless of the level of insurance cover the patient is duty bound to pay the agreed charge. If there is a shortfall in cover it is the patient's responsibility and this fact should be explicit in information sent to patients. Ideally, patients should be aware themselves or have been advised by their GP whether treatment for chronic disease or a cosmetic problem might fall beyond their level of cover but this is often not the case: members are advised to be explicit with patients on this score too.

Some insurance claim forms need to be completed by the GP who usually charges for this service. The BAD advises that consultants should not charge if asked to fill in a form, however requests for additional reports might legitimately attract a separate fee but patients should be warned about this. Ensure that the patient has given signed consent for the release of confidential information and understands the scope, purposes and consequences of disclosure and that 'relevant information cannot be concealed or withheld'. Remind them that medical details entered on such forms might be seen by partners and employers. The issue of confidentiality has been discussed at greater length above.

Patient Referrals

While it is possible for a patient to seek private treatment from a consultant or specialist, the BMA believes that, in most cases, best practice is for patients to be referred for specialist treatment by their GP².

Private patients who are on a course of treatment requiring an expensive course of drugs are more likely to opt for NHS prescriptions. As such some patients might have two GPs – an NHS and a Private GP to keep the management of their care cost effective.

A doctor working in private practice must contribute to the safe transfer of patients between healthcare providers when the need for onwards care arises. Doctors are therefore required to share all relevant information with colleagues involved in a patients' care within and outside the team, including hand over care when off duty, and when delegating care or referring patients to other health⁴.

Where practical, doctors must also ensure that a named clinician or team has taken over responsibility when their role in providing a patient's care has ended. This may be particularly important for patients with impaired capacity or who are vulnerable for other reasons⁴.

The GMC has previously advised that: "if you provide treatment or advice for a patient, but are not the patient's GP, you should tell the GP the results of the investigations, the treatment provided and any other information necessary for the continuing care of the patient, unless the patient objects. If the patient has not been referred to you by a GP, you should inform the GP before starting treatment, except in emergencies or when it is impracticable to do so. If you do not tell the patient's GP, either before or after providing treatment, you will be responsible for providing or arranging all necessary after-care"⁴.

Doctors are advised to do everything reasonably possible to ensure that they do not see patients without the GP's knowledge and consent. It is in the patient's best interests if the doctor has prior access to all their relevant medical information (e.g. previous and present drug therapy, drug allergies, etc.).

It is sometimes difficult for doctors to control precisely who is able to make an appointment to see them but Dermatology consultants are urged to explain their policy to the receptionists and secretaries who book their clinic lists.

Certain categories of patients cannot always be referred by traditional or conventional routes, such as: foreign patients; visitors to the locality needing interim care and local patients needing emergency care; patients who are without a GP and 'self-referrals'; and secondary referrals from other specialists.

Foreign Patients

In general, it is best practice to provide foreign patients a summary letter setting out the essentials of the history, findings on physical examination, the results of any investigations and treatment prescribed as well as the diagnosis and prognosis where possible. This information should also be made available to other doctors involved in the patient's care, then or subsequently.

Visitors and Emergency Care

It is not uncommon for Dermatologists to be approached by patients who work or are living temporarily nearby but who are registered with, or notionally under the care of, a GP in another part of the country.

In an emergency, it is the duty of the specialist to provide the necessary advice and treatment (taking account of one's competence and the availability of other options for care) but a letter should always be sent subsequently to their GP unless the patient specifically requests this is not to be carried out⁴.

Patients without a General Practitioner (GP) and 'Self-Referrals'

If a UK resident self refers and states that he or she is not registered with a GP, then it is reasonable to provide whatever services are needed but it is prudent to prepare and keep a summary letter (as for foreign patients) which can be provided to colleagues on request if the facts provided by the patient prove not to be correct or other practitioners subsequently become involved.

In a non-urgent situation, if the patient has not seen his GP for many months or years, it is not unreasonable to advise and to treat the patient, writing to the GP afterwards. However, if the GP has been consulted very recently and has prescribed treatment; the patient, or if necessary, the Dermatologists' secretary or receptionist should try to obtain verbal consent to proceed by telephone. If this is impossible it is reasonable to see the patient and send written recommendations to the GP.

Secondary Care Referrals

Often when a patient is referred from another specialist the patient's GP can unwittingly be left out of the correspondence chain. When seeing such patients, endeavour to obtain the GP's details and keep that doctor informed.

When a patient is referred to a named practitioner then there can be a temporal 'grey area' of duty of care.

The BMA publication *Medical Ethics Today* (2013)² states: "A duty exists whenever a doctor interacts with a patient in a professional capacity, but questions sometimes arise about when precisely the duty of care begins and ends. Doctors may question, for example, the duty owed to patients who continually transfer between the NHS and private practice, or the duty they have to patients who consult them by email or the internet. Also, although it is clear that consultants have a duty to patients seen by them or by their team and accepted on to their waiting list, doctors may question the extent of any duty they have for patients referred but not yet seen by them. In some non-urgent situations, for example, patients are booked by GPs referring them to a consultant prior to the latter becoming aware of the patient at all. Consultants generally vet incoming referral letters in order to prioritise them according to clinical urgency. Once doctors have accepted a patient – either by examining that person or having studied the clinical details of an individual referred to them for treatment - some moral responsibility exists. It is then generally the role of that consultant to deal with the patient's problems at an appropriate time, according to their urgency, or to recommend that treatment be sought elsewhere if waiting times are inappropriate for that patient's condition. In no cases

can patients be ‘abandoned’, but another practitioner willing to take over the duty of care should be identified as promptly as possible.”²

When a patient has been assessed as non-urgent and placed on a list, consultants need periodically to review the assessment if that patient’s condition is likely to deteriorate during the waiting time. If the consultant’s clinics are overbooked and a new patient’s condition is such that it would be inappropriate to add him or her to a waiting list, the referring GP should be informed and asked to make an alternative arrangement appropriate to the patient’s need².

It is the case that patients are sometimes inappropriately referred; or that in the course of their management it becomes apparent that the patients’ problem is beyond the capabilities of the individual to whom they have been referred (or that other additional skills are needed).

“Recognise, and work within, the limits of your competence” so be prepared to refer a patient on to a colleague in Dermatology or another specialty if necessary^{3,4}.

You must act in your patients’ best interest when referring on so do not accept any inducement gift or hospitality (see above) associated with this⁴.

Satisfy yourself that any other medical or non-medically registered person or practitioner, to whom you refer a patient or delegate some responsibility, has the qualifications, experience, knowledge and skills to provide the care or treatment involved and is accountable to a statutory regulatory body or employed within a managed environment. If they are not then the transfer of care will be regarded as delegation and not referral: this means that you remain responsible for the overall management of the patient and are accountable for your decision to delegate. When you refer a patient, ensure you provide and pass on all relevant information⁴.

Finally, criticisms of specialists can occur over issues of ‘ownership’ and ‘poaching’. In private practice a patient may be referred to one consultant but be seen by another. In the BMA book, *Medical Ethics Today* (2013)², it states: “in the past, when the concept of ‘poaching’ patients was current, doctors had almost a sense of ownership of ‘their’ patients in a way that is now outdated, especially as teams rather than individuals now generally provide care. In some cases, patients may prefer to wait to see the specific private consultant to whom they were referred. Their choice should be respected. ... Once an episode of care has been commenced, the doctor who initiated it has a responsibility to ensure that it is completed unless all agree to an alternative arrangement, such as when doctor-patient trust breaks down and transfer is required”².

Recognise promptly when a patient’s clinical situation is beyond your competence or best managed in a different environment (e.g. inpatient rather than outpatient; NHS rather than privately) or creates moral or ethical dilemmas for yourself and refer the case on to a suitably qualified colleague or arrange for transfer to other facilities⁴.

Clinical Notes and Records

Keep contemporaneous, clear, accurate and legible, records reporting the relevant clinical findings, the decisions made, the information given to patients and any drugs prescribed or other investigations or treatment^{3,4}.

The GMC stipulates that, “documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording; or as soon as possible afterwards”⁴.

Retain notes for the designated period including after retirement. “The UK health departments publish guidance on how long health records should be kept and how they should be disposed of. You should follow the guidance whether or not you work in the NHS”⁶.

*The NHS Code of Practice*¹⁰, *NHS Code of Practice (Scotland)*¹¹, *Welsh Health Circular*¹² and The Department of Health, Social Services and Public Safety’s guide: *Good Management, Good Records*¹³, all include schedules of minimum retention periods for different types of records. You should also consider any legal requirement of specialty-specific guidance that affects the period for which you should keep records. You should not keep records for longer than necessary¹⁴. It is advised that you state in your own will how records should be handled after your own death².

Ensure that letters go to GPs and other relevant practitioners. Ask the patient if he or she wants a copy of the GP letter and record and act on their decision.

Record discussions and decisions relating to consent carefully, using relevant forms if necessary^{4,5}. All providers of contracted NHS UK services must meet national and operationally mandated standards and reflect the NHS Constitution¹. Among these contractual terms are the provisions on clinical audit (GC15 and SC26) and consent (SC9).

Confidentiality

Doctors are expected to understand and follow the principles of confidentiality and respect for patient privacy that are set out in the GMC publications: *Confidentiality* (2009)¹⁴ and *Confidentiality: supplementary guidance* (2009)¹⁵.

Doctors need accurate, up-to-date and accessible information to deliver good and safe care to patients. Patients need to understand how information about them will be collected, stored and used and how their confidentiality and privacy will be protected. Good information governance systems can help to achieve this and contribute to providing high quality and safe care. They can also provide valuable information to allow private practice teams and services to improve the quality and safety of care they deliver. All doctors have a role to play in contributing to these systems to ensure the records they are responsible for are made, stored, transferred and disposed of in line with the Data Protection Act (1998)¹⁶ and other relevant legislation. You should make sure that administrative information, such as patient names and addresses: “can be accessed separately from clinical information so that sensitive information is not displayed automatically”⁸ when reviewing patient records.

Doctors working privately will need to register with the Information Commissioner’s Office. “You should follow the technical guidance of the Information Commissioner’s Office. The ISO 27001 *Security Standard and the Code of Practice for Information Security Management* in ISO 27002 gives more detailed guidance”¹⁴. Difficulties can arise in the rapidly changing world of multimedia and information technology.

Independent providers of NHS contracted services must complete and publish an annual information governance assessment using the NHS Information Governance Toolkit. They must also adopt and implement the recommendations of the Caldicott review into data security and comply with any Guidance issued by the Department of Health, NHS England and/or Health Social Care Information Centre (HSCIC) pursuant to or in connection with those recommendations. This includes a yearly audit of practice against quality statements regarding data sharing set out in *NICE Clinical Guideline 138*.

Some insurance companies may request full medical records rather than asking for a report from patients GP. This is excessive, as disclosures of should be proportionate to the purpose for which the information is required¹. If a doctor is asked to provide information to a patient’s insurer, it is not unreasonable that a charge be levied for the time and expense of copying records.

Miscellaneous

Repeat Prescriptions

This is seen by the GMC as an area of potential hazard. “Prescribe drugs or treatment, including repeat prescriptions only when you have adequate knowledge of the patient’s health and are satisfied that the drugs or treatment serve the patient’s needs”⁴.

Where patients require monitoring and review, this must be undertaken directly by the prescriber, or arrangements made for the transition of patient care to an NHS or other service setting.

Chaperones

Be mindful of the pertinence of this issue to your private practice. The GMC and medical defence organisations recommend that chaperones should be offered for intimate examinations whenever possible^{2,17}.

Children

The basic principles governing medical interaction with children are laid out in the BMA book *Medical Ethics Today* (2013)² and in the GMC booklets *Good Medical Practice* (2013)⁴, *0-18years: guidance for all doctors* (2007)¹⁸ and *Confidentiality: supplementary guidance* (2009)¹⁵. It is legislated that children should be seen where there are suitable facilities and personnel. Children must be able to expect doctors and other health professionals to be their advocates. They should be kept informed about their care and treatment and have their views and wishes taken into account. They should be encouraged to take decisions with input from their parents, if feasible, and be presumed able to make their own treatment decisions when they have sufficient ‘understanding and intelligence’. People over 16 are presumed competent to give consent to medical treatment unless the contrary is shown^{2,17}.

Domiciliary Consultations

These are now more rarely undertaken. However, some niceties pertain. A domiciliary visit may be requested by the GP, another specialist or the patient but these latter situations require the acquiescence of the GP. The GP may or may not be present but if he or she is then the custom is for the GP to enter the patients’ room first and leave last. After the consultation, it is often best for the diagnosis and management to be discussed by the two practitioners in private. The decisions reached should then be communicated to the patient (and relatives) by the specialist in the presence of the GP. Where the GP has not been present, he or she should be informed by letter (or, in an acute situation, by telephone) as soon as possible of the substance of the Dermatologist’s opinion.

Cover for Absences

You must: “be readily accessible when you are on duty”⁴ and this stricture has to be kept in mind and interpreted by each individual for the care of his/her private patients.

“You must be satisfied that when you are off duty, suitable arrangements have been made for your patients’ medical care”, including effective hand-over procedures⁴. “Physicians must

ensure that the care of their patients is maintained by appropriate [sic] colleagues during their absence”³.

It should be axiomatic that when absent from work every care should be taken to ensure that one’s duty of care to patients in general or any specific patient whose condition is changing, or might change, is not compromised. A message should be left on an answerphone or with a secretary or receptionist so that patients can get assistance if needs be, usually from their GP. Most of us have informal relationships with colleagues to cover each other for absences from practice due to holidays or sickness. It is likely that more formality in these arrangements will be defined in the future.

Gifts and Bequests

The GMC states that “you must not encourage patients to give, lend or bequeath money or gifts that will directly or indirectly benefit you. You must not put pressure on patients or their families to make donations to other people or organisations”. Colleagues who are affiliated to charities and trusts should take particular heed that their probity in this regard is not challenged^{3,4}.

Research

There is no reason why private patients should not be included and participate in clinical research or trials. Private patients should be treated no differently from any other participant or subject in that they must understand what is involved, what is the purpose of the trial or study and what are the hazards, if any. Informed consent must be obtained and recorded and the patients’ GP kept informed.

It is a legal requirement that all research involving trials of medicinal products with human participants shall be subject to independent ethical review^{3,4}. The Research Ethics Committee (REC) is responsible for ensuring that appropriate indemnity arrangements are in place for private patients participating in research¹⁹. The RCP also encourages RECs to review protocols arising from the private sector.

Medicolegal Work

Most consultants who undertake this type of work do so as part of their private practice. Normally an individual is seen following instructions from a solicitor rather than at the request of a GP. Sometimes issues may arise of a diagnostic or therapeutic clinical nature that should, in the interest of that individual as a patient, be communicated to the GP or another specialist: this should be done with the consent of the patient.

You are expected to ‘be honest and trustworthy’ when writing reports, completing forms or providing evidence in litigation or other formal inquiries. This means that you must take reasonable steps to verify any statement before you sign a document. You must not write or sign documents which are false or misleading because they omit relevant information. If you have agreed to prepare a report, complete or sign a document or provide evidence, you must do so ‘without unreasonable delay’. “Restrict the report to areas in which you have direct experience or relevant knowledge and make sure that any opinion you include is balanced, and be able to state the facts or assumptions on which it is based”^{4,15}.) Remember your duty is to the court, not the party by whom you have been instructed and paid your fee²⁰.

Insurance

You must make sure you have adequate indemnity cover for your private practice. This is in your own interests as well as those of your patients⁴.

Illness

Dermatologists are dedicated to providing the best and most up to date care of their patients. They are morally accountable for their actions. Their conduct is guided by professional values and standards against which they are judged. All doctors, including those in training, must have integrity and honesty, and must take care of their own health and well-being so as not to put patients at risk.

The GMC's guidance in Good Medical Practice regarding serious communicable diseases specifies that if a doctor has a serious condition which can be passed on to patients or colleagues you must have any necessary tests and act on the advice given by a suitably qualified colleague about necessary treatment and/or modifications to your clinical practice. Moreover, if your judgement or performance could be significantly affected by a condition or illness, physical disease or by taking medication, they must take and follow advice from a consultant in occupational health or another suitably qualified colleague on whether, and in what ways, they should modify their practice.

You must not rely on your own assessment of the risk to patients⁴. Obtain advice about professional issues from your Medical Director especially relating to sick-leave from the NHS and your private commitments.

When Things Go Wrong

Unfortunately, disputes between doctors and patients are not uncommon in private practice. Many relate to misunderstandings about fees. Others relate to clinical issues such as outcome, or lack of outcome, of treatment such as surgery. Hopefully, the preceding advice will minimise the risk of some of these disputes but there will always be disputatious patients with difficult problems. Ensure (and record) that there has always been a full discussion about options, risks, benefits, pros, cons, side-effects and complications: 'hand-outs', such as the BMA's: *Setting up in Private Practice*⁸, may help.

If things go wrong then observe astutely the advice of the RCP: "if a patient suffers an untoward incident or complains about the service they have received, the physician should ensure a prompt, honest and courteous response. An apology should be offered and action taken to put things right when appropriate [sic]. Physicians must co-operate with any complaints procedure that applies to their practice and must not allow a complaint to prejudice patient care"^{3,4,21}.

"You must disclose to anyone entitled to ask for it any information relevant to an investigation into your own ... conduct, performance or health"⁴. If a complaint is made against you in private practice you are advised to notify your NHS Medical Director and your insurance/indemnity organisation. Likewise, if you are the subject of an investigation at your NHS place of work, or suspended, take advice from the Medical Director, the BMA and your defence organisation about how to proceed in the private sector. "If you are suspended by an organisation from a medical post, or have restrictions placed on your practice, you must, without delay, inform any other organisations for which you undertake medical work and any patients you see independently"⁴.

Very rarely will it be necessary to sever a professional relationship with a patient unilaterally. You should explain to the patient why this has happened in a clear and courteous way, wherever practical in writing, and the patient and GP must be advised where and from whom further care might reasonably be sought, if necessary. The patient's GP will probably be best suited to organise this, in most instances. Ensure that you pass on all relevant clinical information promptly⁴.

Conclusion

It is to be hoped that the above notes will cover most eventualities. If in doubt at any time, ask yourself how you, or a relative, would expect to be treated in a similar situation; ask a respected and senior colleague; phone your defence organisation. *Primum non nocere*.

Further guidance on private practice can be obtained by contacting the BAD's Clinical Services Unit (clinicalservices@bad.org.uk or 020 7391 6356).

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