
Contractual arrangements in health care: professional responsibilities in relation to the clinical needs of patients

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Introduction

1. The reorganisation of the National Health Service (NHS) has introduced changes which affect the way doctors' practise and their relationship with patients. The Standards Committee has considered some of the concerns which have been raised and, on its recommendation; the Council has prepared this guidance for the profession.

2. It is important to set out the boundaries of the Council's responsibilities. The Council has not direct remit in relation to the policy, management and administration of the NHS; nor would it usually become involved in questions concerning the content of contracts under which doctors provide medical services, either within the NHS or independently. The statement therefore discusses only those issues which raise questions of ethical principle or relate to a doctor's standards of professional conduct.

The Council's published guidance

3. The Council's [guidance](#) to the medical profession on standards of professional conduct and on medical ethics is kept under continual review by the Standards Committee to ensure that it is up to date and relevant to the situations which doctors have to face during the course of their daily professional practice.

4. [Good Medical Practice](#) sets out a number of principles, long accepted in the profession, which are relevant to the matters under discussion. The summary of the Council's guidance which follows should be read in conjunction with *Good Medical Practice*; it cannot be regarded as a substitute for the full text.

- people are entitled to expect registered doctors to offer and maintain a good standard of medical care
- doctors must not make improper arrangements calculated to extend, or otherwise benefit, their professional practice

- patients must not be put under pressure to accept private, rather than NHS treatment
- doctors carry a prime responsibility for the protection of information given or obtained in confidence and must therefore take steps to ensure, as far as lies in their control, that adequate security systems are employed to protect all such records against improper disclosure
- when fees are charged for consultation or treatment, the payments which are to be made to individual doctors must be specified to patients

5. The Council has considered how the principles underlying the guidance should be applied in new situations which have arisen as a result of the changes since 1991 in the organisation of health care. It is clear that all the likely changes have yet to be implemented or come to full fruition and this statement therefore concentrates only on questions of principle and certain matters that arise specifically from circumstances known to be causing concern to the profession at present:

- decisions about access to medical care
- the expression of concern about management decisions
- prescribing for hospital out-patients
- companies set up by general practices
- when a general practitioner may refuse to accept a patient

Decisions about access to medical care

6. The foundation of the NHS greatly reduced inequalities in access to specialist care, but nevertheless demand has generally exceeded the capacity to supply. Initial access to out patients, and access to further investigation and treatment, has been arranged chiefly by the mechanism of the waiting list, on which the position of individual patients has been determined by the consultant's assessment of clinical need. That assessment should involve an evaluation of a range of factors, including patients' personal preferences and perceived state of distress, and their social and other circumstances.

7. Changes in NHS contractual arrangements have introduced new factors, but at this stage it is impossible to judge what their ultimate effects on access will be. It seems clear however that the processes by which access to specialist care is secured are being made more explicit. At the same time, patients and their relatives increasingly seek information about, and involvement in, decisions about their care, and general practitioners are gaining greater influence over the use of hospital facilities for their patients.

8. The Council endorses the principle that a doctor should always seek to give priority to the investigation and treatment of patients solely on the basis of clinical need. Acknowledging this, doctors have to work within resource constraints and, whatever the circumstances, they must make the best use of resources available for their patients, recognising the effects their decisions may have on the resources and choices available to others.

Expression of concern about management decisions

9. The Council encourages doctors, whether working in hospitals or general practice, to

play a full and active part in discussions on the determination of priorities, on the best use of resources, and in assessing the effects of policy on standards of health care. Some contracts of employment preclude doctors from speaking publicly about management decisions and policy. Doctors should consider carefully the implications of such contracts before signing them.

10. Doctors who believe that clinical standards are being compromised, or that the management decisions that they are asked to implement may unduly restrict access to health care, should make their concerns known to management, to the senior medical officer in their region or, where appropriate, to the Department of Health. If they are not satisfied by the response of these authorities, they will need to decide whether to make their concerns publicly known. This would be regarded by the Council as a matter of conscience. A breach of contract in these circumstances is matter between doctors and their employers.

Who is responsible for prescribing for hospital out patients?

11. Some general practitioners have expressed concern that they are being put under pressure to take more responsibility for the costs of prescribing for hospital out patients at the same time as they are required to work within indicative drug budgets, and this pressure may affect their ability to prescribe appropriately for all their patients.

12. In the Council's view the question is one of professional practice. In general doctors are expected to take account of appropriateness, effectiveness and cost when prescribing any drug. Where there is shared care doctors responsible for the continuing management of the patient must be fully competent to exercise their share of clinical responsibility and have a duty to keep themselves informed of the drugs that are recommended for their patients. Specialists, for their part, should not put general practitioners under pressure to take responsibility for their prescribing recommendations. Rather, there should be full consultation and agreement between general practitioners and hospital doctors about the indications and need for particular therapies. Where such agreements are reached doctors should have no inhibitions about prescribing on the basis of the patient's need; such agreements would be the basis for justifying cost.

Can general practices set up private companies?

13. The Council's current guidance establishes that, where doctors have a financial interest in an independent health care organisation, they must refer patients to those organisations on the basis of clinical need or patient preference, and not for personal financial gain. This advice is based on the principle that in any situation where a doctor's personal financial interests conflict with the medical interests of patients, the interests of the patients must take priority; doctors must not compromise those interests by attempting to manipulate a contractual arrangement to their own financial advantage.

14. That same principle should be applied where general practices in contract with the NHS set up private companies, partnerships or similar arrangements to which they may refer their own patients for services such as minor surgery. The Council does not regard it as improper, of itself, for a general practitioner or practice to set up a company, nor for patients to be referred from the practice to such a company, provided always that the medical interests of the patient are paramount, and that patients are made aware of any personal financial interest the doctor may have before they consent to referral. The relevant health authority, as the body paying for the patient's care, should also be informed. Similarly, doctors must not act in collusion to further their own interests: financial arrangements within such companies should not therefore involve 'fee splitting' - the undisclosed sharing of fees between the doctors referring patients to the company and those it employs.

When may a general practitioner refuse to accept a patient?

15. The Council has been asked by several correspondents about the situation resulting from the new contract for general practitioners, which has led some doctors to remove patients from their lists for economic reasons. Examples cited include the need for expensive drug therapy and patients' refusal to participate in screening or immunisation programmes. This is not a new problem. Since the NHS began a few general practitioners have used their right to remove patients from their lists for reasons which have included, for example, old age, severe disability or drug addiction, on the grounds that such patients are costly in terms of time and effort needed to provide care.

16. The general position is worth re-stating. Patients have a right, enshrined in law, to choose their family doctor. Doctors have a parallel right to refuse to accept patients, or to remove them from their lists, with no formal obligation to give reasons for their decision. These rights flow from the belief that a satisfactory relationship between patient and doctor will arise only where each is committed to it; consequently, if either party believes that the relationship has failed, they have a right to end it.

17. Given this, family doctors, as the professionals involved, have special responsibilities for making the relationship work. In particular, it is unacceptable to abuse the right to refuse to accept patients by applying criteria of access to the practice list which discriminate against groups of patients on grounds of their age, sex, sexual orientation, race, colour, religious belief, perceived economic worth or the amount of work they are likely to generate by virtue of their clinical condition.

Further advice

18. Any doctors who are in doubt about standards of professional conduct should seek advice from a medical defence society, from a professional association or by writing direct to the Council itself. The Council will, for its part, continue to monitor the developing situation and will issue further guidance to the profession should it be appropriate to do so.