

Consultant 57

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To whom it may concern –

Perhaps the Competition Commission (CC) could examine the impact of medical **partnerships** on the choices available to patients (over private fees, specialist access, and the delivery of care), and on the accountability of doctors for their decisions.

Partnership status now allows doctors to exercise a virtual monopoly regarding their services and private practice fees, limiting patients' choices and even restricting the clinical activity of other doctors. Abuse of partnership status includes instances where a large anaesthetic group, dominating the service in its catchment area, collectively refused to anaesthetise for two surgeons, over-riding the findings of local clinical governance and compromising the private practice of those surgeons, who had no means of appeal. Partnership status seems to put its membership beyond accountability: none of the professional organisations dealing with doctors (the British Medical Association, Medical Protection Society/Medical Defence Union, Royal Colleges, or General Medical Council) appears to have any jurisdiction over the activity of partnerships, which have not attracted the interest of the Office of Fair Trading (OFT) since 2003 when it ruled that six anaesthetic partnerships did not infringe the Chapter 1 prohibition under the Competition Act by standardising their fees.

An increasing number of anaesthetists - the largest medical subspecialty in both the NHS and private medical practice in the UK - are members of legally constituted Anaesthetic Groups (AGs) which can now dominate the provision of anaesthetic services in a given catchment area. Within that area, private health (PH) patients are deprived of a spectrum of choice of anaesthetist or of anaesthetic fees, which are often set at 10% or more above the maxima reimbursed by private medical insurers (PMI). In addition:

- High anaesthetic fees not only confuse and irritate patients but may produce a shortfall not met by the PMI, occasionally causing reimbursed patients to refuse to pay surgical fees in full even though these are within PMI maxima.
- The Association of Anaesthetists of Great Britain and Ireland (AAGBI) has noted that the OFT linked the trend in AG growth to the assertion that "anaesthetists are the sub-specialty with which the PH patient is most likely to experience a shortfall".
- Some patients erroneously believe that surgeons are responsible, directly or indirectly, for the fee charged by the anaesthetist, or even that the surgical fee includes that of the anaesthetist.

The AAGBI contends that "shortfalls relate more to PMI benefit discrimination". It has asked the CC "to examine the hourly income (net of reasonable practice expenses) of consultants practising surgery and anaesthesia in the PH sector as set by PMI benefit schedules", and questions "whether the significant benefit disparity between these two medical consultant groups is justified". Notwithstanding that it seems specious to raise remuneration as a competition issue ahead of patient choice and quality of care, substantial differences exist

between surgical and anaesthetic practice which do justify such differential payment both clinically and logistically, a differential hallowed by time. For instance:

- The decision to proceed with a surgical operation, with its risks and liabilities, is made jointly by the patient and the surgeon, whose reputation is the impetus for the initial referral and who is responsible for obtaining informed consent from the patient and for scheduling the operation. The surgeon is also responsible for fielding the patient's pre-operative enquiries and uncertainties.
- Anaesthetic induction and recovery require expertise but during an operation the anaesthetic role largely involves monitoring (the anaesthetist may even briefly leave the theatre), whilst the surgical input is persistent and taxing.
- The surgeon furthermore has a mandatory obligation to see every post-operative in-patient daily and to assess and manage any surgical or post-operative complications, all within the operation fee. By contrast, post-operative care by anaesthetists is usually limited to a single post-operative visit.

The AAGBI suggests that "there are significant advantages for quality of patient care offered by AGs, especially in acute emergency and out-of-hours situations". However, not only is the bulk of private care elective but the key individual in dealing with emergency and out-of-hours situations is the doctor with direct clinical responsibility for that patient, who is invariably a front-line clinician (usually a physician or surgeon).

It is in the interest of all patients to have adequate choice regarding their anaesthetist, surgeon and levels of fees, and the Competition Commission may wish to ensure that partnership status does not erode such freedom.