



# INDEPENDENT PRACTICE

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The Association of Anaesthetists of Great Britain and Ireland,  
21 Portland Place, London W1B 1PY  
Telephone 020 7631 1650 Fax 020 7631 4352  
[www.aagbi.org](http://www.aagbi.org)

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## Key Points

- Independent practice should only be conducted by fully trained and suitably experienced doctors. The minimum requirements include a registerable medical degree, FRCA or equivalent, a certificate of completion of training or equivalent, and entry in the appropriate specialist register of the General Medical Council.
- Maintenance of the highest possible standards of ethics, medical care and clinical governance is mandatory in the performance of independent practice, as it is for NHS practice.
- Consultants with NHS contracts must take every possible step to ensure that their private practice does not adversely impact on their NHS duties.
- Consultants should only practise in hospitals in which they have been given practising privileges or admitting rights.
- Consultants conducting private practice should have appropriate medical indemnity.
- Consultants should keep clear and accurate records of their private practice activities.
- Groups or partnerships of consultants should be established under legally acceptable agreements.

## Introduction

Information about independent practice is not commonly available and yet it is often the subject of questions asked by members. The purpose of this booklet is to provide a background to independent practice in Great Britain & Ireland and to provide advice and guidance for those consultants involved in private practice.

Before the start of the National Health Service in 1948, independent practice was the main source of income for anaesthetists in this country. With the advent of the NHS, a number of provident societies merged to form the British United Provident Association (BUPA) to preserve freedom of choice in healthcare and to help patients afford choice in terms of where, when and by whom they were treated. BUPA had some 80% of the insurance market in the 1950s, and private practice represented about 6% of acute medical activity, largely concentrated in the major metropolitan centres. At this time, insurers provided patients with a single combined benefit towards both anaesthetist's and surgeon's fees, and it was not until 1975 that, following successful representations by the AAGBI, this was divided into separate surgical and anaesthetic benefits.

In 1975, the health minister Barbara Castle closed all pay beds in NHS hospitals, and this resulted in a major expansion of independent hospital facilities, rapidly doubling the number of private beds. BUPA purchased its first group of hospitals, and US businesses invested heavily to establish what is now the largest hospital provider (BMI/Netcare) and other hospital groups. This considerably improved the quantity and quality of private facilities available. The current size of the UK private healthcare market is around £4 billion, with 7.5 million insured patients (12.7% of the population). About 2.8 million patients are insured by BUPA, who now have 41% of the insurance market. About 19% of the market is self-pay.

As with any activity, there are pros and cons to independent practice. The advantages include additional income, more clinical freedom and an opportunity to develop closer relationships with colleagues and patients. The disadvantages include the additional time spent in practice, out-of-hours and antisocial working, and a need for flexibility. Consultants may also need to be on call for their private patients and will work more often on their own. Anyone doing private practice will be required to pay a higher medical

indemnity subscription, have more complicated accounts and must make sure that their private work does not conflict with their NHS contract.

The main purpose of private practice is the income that it generates. No consideration of private practice is complete without a clear description of the difference between benefits and fees.

Benefits are what insurance companies pay out on behalf of patients according to the terms of their policy contract with them.

Fees are what consultants charge patients for their professional services.

These two terms should never be confused, and they should not be used interchangeably. Most private medical insurers (PMIs) make their benefit schedules available to consultants. Some, such as the Western Provident Association (WPA), make their schedule publicly available (<http://www.wpa.org.uk>). A small number of PMIs do not publish their benefit schedules. The AAGBI is of the view that all PMIs should make their benefit tables public.

No organisation can set consultants' private practice fees. If any membership organisation such as the AAGBI were to attempt to set fees, it would attract unwelcome interest from the Office of Fair Trading (OFT). It is for the individual consultants to determine their own fees themselves.

Anyone considering conducting private practice should consider the matter fully before embarking on it. Although it provides financial and other rewards, it demands the very highest ethical, clinical and financial standards. Private practice income is difficult to estimate accurately over time, and the private practitioner must always put clinical governance and cooperation with colleagues ahead of financial gain.

## Good Practice

Doctors should treat their private patients to the same clinical standards that they treat their NHS patients and *vice versa*. Therefore, all the guidance documents and recommendations that set standards of care for NHS patients should be presumed to be valid for private patients. Guidance documents for anaesthesia are issued by the Royal College of Anaesthetists (RCoA), the AAGBI, the British Medical Association (BMA) and the General Medical Council (GMC). The Healthcare Commission (HCC) has responsibility for setting and assessing standards in the private sector as well as in the NHS. The National Institute for Health and Clinical Excellence (NICE) also produces recommendations, most of which are directly relevant to the private sector. The websites of all these bodies are given in the Resources Section. The anaesthetist in private practice should be well versed in all relevant publication and national guidelines. Active membership of subspecialty societies is strongly recommended in order to maintain current knowledge in the areas of practice conducted in both public and private sectors.

Practising anaesthesia in private hospitals commonly involves working in isolation, often being the only anaesthetist in an operating theatre suite or in the whole hospital. The qualifications necessary for appointment to a substantive NHS Consultant Anaesthetist should be considered those necessary to provide private anaesthetic care: a registerable medical degree; FRCA or equivalent qualification as judged by the RCoA; a Certificate of Completion of Training (CCT) or equivalent; entry as an anaesthetist in the Specialist Register of the GMC. Some private hospitals only award practising privileges to doctors who hold or who have held a substantive consultant appointment in an NHS hospital; others consider this not to be necessary.

Anaesthetists who do private work should be appraised to standards similar to those pertaining in the NHS. If the anaesthetist holds an NHS contract, appraisal should prove easy to arrange. If the anaesthetist practises only in the private sector, he or she should make arrangements to be appraised by a suitably trained and certified colleague. The anaesthetist should maintain appropriate Continuing Professional Development training in subspecialties practised in the private sector and should be prepared to prove this to the appropriate authorities.

Anaesthetists practising in the private sector should adhere and conform to appropriate Clinical Governance requirements as determined by the private hospitals and agreed by the Medical Advisory Committees of these hospitals.

Anaesthetists should only practise in private hospitals in which they have been awarded Admitting Rights or Practising Privileges. They should conform to the regulations and guidelines adopted by the private hospital. The private hospital has the responsibility for ensuring that the Medical Advisory Committee has approved these regulations and guidelines, and that all anaesthetists are informed of the regulations and guidelines relevant to them. The hospital should make the anaesthetist aware of its disciplinary procedures. There have been instances of private hospitals demanding that consultants make all the details of their annual appraisal available. The AAGBI believes that the details of an anaesthetist's appraisal documentation are confidential, but that it is reasonable for a hospital to be given written confirmation that an anaesthetist has successfully undergone an appraisal process.

An anaesthetist should not undertake cases in the private sector for which he or she is not appropriately trained, experienced and in ongoing practice. This usually means that an anaesthetist who has an NHS appointment will have a similar clinical portfolio in both sectors. Anaesthetists should keep a logbook of cases done in the private sector and should be prepared to provide the information contained therein to appropriate supervising bodies.

The anaesthetist has an ongoing clinical responsibility to a private patient that continues into the postoperative period. However, this responsibility has limits, and we suggest that the anaesthetist makes the limits clear to the surgeon and other healthcare professionals involved in the patient's care. Such limits may be:

- Until postoperative high dependency or intensive care is no longer needed or is handed over to an intensivist or another anaesthetist.
- For patients not requiring intensive or high dependency care, the limits of the anaesthetist's care may be when the patient is:
  - Awake and discharged from the recovery room
  - Physiologically stable and satisfactory
  - Free from significant postoperative pain, nausea and vomiting
  - Not receiving intravenous opioid treatment, e.g. patient-controlled analgesia

- Not receiving neuraxial or peripheral local anaesthetic infusions
- Free from the short-term effects of peripheral or neuraxial nerve blocks

Any care provided by an anaesthetist beyond these limits may be separately chargeable if the patient has been warned of this before treatment. It is reasonable to expect an anaesthetist to be available for a private patient for the period during which the early and predictable complications of surgery may occur. However, we suggest that this period should not normally exceed 24 – 48 h and should certainly cease at the discharge of the patient from hospital.

For anaesthetists who work in both the NHS and the private sector, there will be times at which the demands of these two practices will seem to clash. The New Consultant Contract is specific about the conduct expected of an NHS consultant with regard to private practice. A copy of the contract and specific guidance can be found on the BMA website. The following general points are worthy of consideration:

- Private practice should not normally be conducted in contracted NHS hours but may on occasion be acceptable provided it causes minimal disruption and has the support of both colleagues and managers.
- Scheduled private practice should not normally be undertaken when on call for NHS patients. However, if the private practice is performed in the consultant's base NHS hospital, this may be acceptable to colleagues and managers.
- The BMA Code of Conduct for Private Practice states that "There will be circumstances in which consultants may reasonably provide emergency treatment for private patients during time when they are scheduled to be working or are on call for the NHS. Consultants should make alternative arrangements to provide cover where emergency work of this kind regularly impacts on NHS commitments". If one of your existing private patients unexpectedly develops a complication that requires the urgent presence of an anaesthetist, it is therefore acceptable to leave NHS duties or to delay them provided adequate cover is given for those NHS patients under your care. Under these uncommon circumstances it might be acceptable to delay the start of

an elective list; it would not be acceptable to abandon an NHS patient in an operating theatre or recovery room unless a suitable colleague is willing and able to take over care.

Good practice in the private sector involves treating all patients to the highest standards while maintaining appropriate skills and knowledge. Patients in both the NHS and private sector are entitled to high standards of care provided by competent professionals.

## Getting started in Independent Practice

Before embarking on independent practice, it is important to get advice from a chartered accountant about your tax situation and to get advice from one of your colleagues who is an experienced independent practitioner. If you have joined a group practice, then the best person to ask may be the person who runs the group.

### Admitting rights

Before you can work in a private hospital, you will need to obtain what are variously known as *admitting rights* or *practising privileges*. All private hospitals should have a Medical Advisory Committee (MAC) that comprises consultants of all subspecialties, one of whom will be the chairman. The senior manager of the hospital should grant practising privileges to consultants who meet the standards set by the MAC. Practising privileges are not awarded by right; some hospitals may refuse to award them even to consultants who meet the criteria set by the MAC. The private hospital will provide you with the necessary application forms on request. It may be a good idea to make an appointment to meet with the senior manager of the hospital before seeking practising privileges. Take advice on this from a colleague who already works in the hospital. The hospital's requirements for the award of practising privileges are likely to include:

- A curriculum vitae
- Documentary evidence of relevant qualifications and completion of subspecialty training
- A current and valid GMC certificate
- Proof of membership of a medical defence organisation (MDO)
- Evidence of hepatitis B immunity
- Proof of recent successful appraisal
- A Criminal Records Bureau (CRB) Enhancement Disclosure or the following documents that will allow the hospital to acquire one:
  - o A completed CRB application form
  - o A passport, driving licence and recent utility bill confirming home address

Some of these documents will need to be updated annually, and you should expect the hospital to ask for ongoing evidence that you fulfil their requirements for the maintenance of practising privileges.

### **Registration with PMIs**

Before a PMI will pay you directly for treating their customers, you will need to register with them. This may involve providing copies of documents that will satisfy the PMI that you are suitably qualified to provide medical care to their customers. A list of the larger PMIs along with their contact details is provided in the Resources Section.

### **Accountants**

All consultants conducting private practice should seek and heed advice from an accountant with experience in private medical practice. Accountants will provide invaluable advice on billing, banking, taxation and expenses. They will also be very helpful when planning pensions and eventual retirement from both NHS and private practice. The fee that an accountant charges for work done that relates to private medical practice is a tax-deductible expense.

### **Billing**

The keeping of accurate records is the key to efficient billing. You should keep a record of the following for every patient you treat:

- Name
- Address
- Telephone numbers
- Date of birth
- Insurance details (PMI, registration number, authorisation number)
- Date of procedure
- The hospital at which the procedure was performed
- Surgeon (if any)
- Procedures performed (both narrative and OPCS codes)
- Any unusual occurrences or circumstances

A logbook or database that contains this information will obviously contain confidential information. Electronic records come under the terms of the Data Protection Act, and appropriate registration and data protection are required. A secure backup of all data should be kept. Many consultants starting in private practice choose to do their own billing and to keep their own accounts. The consultant should keep precise and careful records of the date and amount billed, and the date and amount received. Commercial software packages are available that will facilitate this process. However, as practice volumes increase, many opt to pay others to do their billing and financial record-keeping. An increasing number of commercial billing services are available. Consultants working in a partnership or group practice often directly employ someone to do the billing or have an established arrangement with a commercial billing service. Consultants whose wives, husbands or partners have no income or whose earnings are less than the threshold for higher-rate income tax may benefit financially from paying their partners to do the billing.

### **Setting fees**

Each consultant should determine his or her own fees. Agreeing with a group of local consultants to charge the same fee as other group members can be considered anti-competitive and should be avoided unless the group is trading as a partnership with an established legal identity. If there is doubt about the trading status of a group of anaesthetists, expert legal advice should be sought.

### **Banking**

Take advice from your accountant on how to manage your bank accounts. Most consultants who conduct private practice maintain a separate bank account that is wholly dedicated to their private practice. You should keep a full and accurate record of all payments into this account and all payments made from it.

### **Tax**

Never forget that you will have to pay tax on the money that you have earned, so take advice from your accountant. Many wise anaesthetists ring-fence 40% of their private practice income in a separate account so that they always have the money available to pay the tax when a demand arrives on the doorstep.

### **Investigations by the Inland Revenue**

Every year, a number of doctors is investigated by the Inland Revenue. Most are chosen at random, some are chosen because they have drawn attention to themselves in some way. A tax investigation is time-consuming and costly for the individual concerned. It is possible to take out an annual insurance policy to cover the costs of an investigation; consultants should consider taking out this sort of insurance.

## Billing issues in Private Practice

The publication of this guideline document coincides with that of the “AAGBI Voluntary Code of Practice for Billing Private Patients”, to which the reader should refer for advice on billing in independent practice.

It is illegal for the AAGBI or any other professional body to set medical fees. However, the individual anaesthetist is free to set his or her fees according to a variety of factors that he or she may feel are pertinent. These might include:

- The time taken to provide the service, including pre-operative, intra-operative and postoperative care
- The training, qualifications and experience necessary to provide medical care safely
- The complexity of the medical care provided
- The rarity of the anaesthetic skills necessary to provide safe and effective care.
- The risk to the patient of the procedures being performed
- The time of day and day of the week that the service is provided and the degree of surgical urgency
- The risk to the anaesthetist of providing the service

Anaesthetists should review their fees on an annual basis.

There are occasionally problems when privately insured patients are admitted to NHS hospitals with medical conditions requiring emergency surgery. Most of these patients are entitled to be treated by the NHS without charges being made. Some patients in these circumstances choose to be treated on a private basis. In general, PMIs will not pay benefits to anaesthetists under these circumstances unless the patient signs a declaration that they wish to be treated privately. If the patient is incapable of expressing such a wish or signing such a form but his or her next of kin requests private treatment, the next of kin should sign a declaration waiving NHS treatment and requesting private treatment. Such declarations should be acquired before treatment is given.

## Indemnity for Independent Practice

Under NHS indemnity, NHS bodies take direct responsibility for costs and damages arising from clinical negligence in which employers are vicariously liable for the acts and omissions of their healthcare professional staff, including locums whether “internal” or provided by an external agency. An anaesthetist employed by one Trust working in another Trust as part of a formal agreement between the Trusts is also covered by NHS indemnity. A consultant undertaking contracted NHS work in a private hospital would also normally be covered by the NHS Litigation Authority (NHSLA). NHS indemnity does not cover the defence of staff involved in disciplinary proceedings conducted by statutory bodies like the GMC, police investigations arising from professional practice or Good Samaritan acts. Clinical negligence means actual or alleged negligence or breach of duty in connection with the provision of clinical services. A Good Samaritan act is the provision of clinical services related to a clinical emergency, accident or disaster when the anaesthetist is not present in his or her professional capacity but as a bystander. NHS indemnity does not normally extend to private practice, whether conducted in the independent sector or in NHS hospitals.

It is therefore essential for all anaesthetists, especially those undertaking private practice, to be a member of a medical defence organisation (MDO) or have some other form of appropriate insurance cover. This indemnity will cover clinical negligence claims, complaints procedures, Good Samaritan acts, advice on legal and ethical dilemmas arising from professional practice, GMC enquiries, disciplinary procedures, inquests and fatal accident enquiries, and police investigations arising from professional practice. Absence of protection will leave the anaesthetist exposed in the event of a claim, and this may lead to professional and financial ruin.

In the UK, there are three main MDOs – the Medical Defence Union (MDU), the Medical Protection Society (MPS) and the Medical and Dental Defence Union of Scotland (MDDUS). All three organisations are mutual companies and they do not have legally binding contracts with their subscribers. Their benefits are discretionary on the decision of their boards. In choosing suitable cover, one should carefully consider not just the actual costs but also the detail of the benefits and services offered by the company. The subscriptions for the above three medical organisations are based on a scale according to speciality and private income, excluding income from medicolegal work and

taking into account legitimate private practice expenses. It is also important to note that, in the event of a claim, the MDO will require documentary proof that the full subscription had been paid for indemnity cover. Subscriptions to MDOs are allowable expenses against private practice earnings.

Policies with commercial companies are on a 'claims made' basis. This means that the insured doctor is only covered for claims arising from incidents which both occur and are reported whilst the policy is in force. When the policy expires, so does the cover unless a run-off payment is made. The mutual organisations offer 'occurrence or incident-based' schemes that give protection for claims arising from incidents that occurred during the subscription period no matter when they are reported, even if it is many years after that subscription had ceased. These provide ongoing protection at retirement or death – the latter prevents one's estate being liable for claims.

The MDU introduced a version of 'claims made' membership in 1992, known as *contemporary*, which offered lower subscriptions, particularly in the first five years. The cover for this policy ceases unless a run-off payment is made and this is equivalent to approximately one year's normal premium. When a doctor switches to another organisation or company, his or her previous risk is usually covered by the new organisation or company. It is wise to get this confirmed in writing from the new organisation or company.

It is not possible to cover all aspects of indemnity in the NHS or private practice in the limited confines of this guidance and some aspects are complex. Readers are advised to consult the relevant defence organisations for further information pertaining to their personal circumstances from the web addresses given in the Resources Section.

## Independent Medicolegal Practice

Medicolegal work can be divided into personal injury and negligence. The former entails examining clients who are making claims for injuries that they have sustained outside the medical arena, often occupational in nature, e.g. repetitive strain injury or back pain, or following an accident, e.g. whiplash or nerve damage leading to a chronic regional pain syndrome. While much of this work is performed by orthopaedic colleagues, it can provide a useful source of income for the chronic pain specialist, who will often encounter patients in need of a report in the course of their daily duties.

However, this section of the guidance is about clinical negligence work and the role of the medicolegal expert. There are some misconceptions about medicolegal experts, so let's deal with these first.

***You have to be old to be an expert.*** No, in fact any consultant anaesthetist is, almost by definition, an expert in anaesthesia, although not necessarily an expert in all branches of anaesthesia – it is unwise to stray outside those areas of practice that you encounter on a regular basis. An expert has to be able to: derive a likely sequence of events from a bundle of documents, largely clinical records; explain those events in terms that an intelligent layman can understand; decide (often by reference to the literature) whether the standard of care contained in those events would be regarded as acceptable practice by a reasonable body of his or her peers; write all of this down in a logical, accessible manner; and – very rarely – hold his or her own in what many regard as the ultimate *viva voce*, the conference with Counsel or an appearance in the witness box. Yes, your qualifications and expertise will be compared to those of the expert retained by the other side, but this is a very minor issue; the calm, honest, modest and well-prepared expert will always come over well.

***Experts sell their souls to the lawyers.*** This is completely untrue. Expert witnesses have always been meant to be impartial and, whichever side has instructed them, their report should be neutral. This has, in the past, been more honoured in the breach than in the observance, but recent guidance from the Department of Constitutional Affairs, in the form of the Civil Procedure Rules means that the expert's duty to the Court has been formalised, and the days of the so-called 'hired gun' are well and truly over. Modern experts should

eschew being labelled as ‘claimant’ or ‘defence’ practitioners. Indeed, recent reforms mean that they might even be instructed jointly by both sides.

### **Do I want to do it?**

Expert witness work has some distinct advantages. You are not beholden to surgeons for independent income, and the bulk of the work can be done from the comfort of your own home. The research needed to produce a report can be enlightening and educational in its own right. The rewards can be substantial, although you will be fortunate indeed to achieve an hourly rate that matches that of independent clinical practice.

However, it is not an easy option. Deadlines are rarely flexible and recent reforms have made them tighter than ever. There can be no short-cuts in writing a report; flaws are very quickly and publicly shown up if the case gets to Court. Reports are very rarely unchallenged, even by the team that has instructed you, so if you find it difficult to accept criticism, this is not a job for you. Good organisational skills are essential, especially as your practice expands, and you will need a well-ordered and persistent billing service. And, of course, medicolegal practitioners can get into very hot water indeed if they are perceived as having stepped outside their field of expertise.

### **So how do I get started?**

Word of mouth remains the best way to get your first instructions. Somewhere near you is an expert in anaesthesia with more work than he or she can handle. Ask them if you can help out, or offer to write a draft report on a simple case so that they can get an idea of your abilities. Solicitors are looking for someone who can deliver a sensible, logical, readable report that addresses the key issues, who can do it on time, and who will not overstate the strengths of the case only to retract later when under pressure.

In the past, most experts have learned on the job, but this is far from ideal, and there are now courses that the aspiring practitioner can attend. Action Against Medical Accidents (AvMA) have transformed over the years from an aggressive pressure group into a powerful and respectable training and policy-setting organisation. Details of courses, including ‘Getting Started as a Clinical Negligence Expert’, can be found on their website. Other commercial bodies offer similar courses and even the chance to stand up and be cross-examined in a court hired for the day, although the costs can be rather prohibitive.

## **Moving on**

There are also organisations out there that act as forums for medicolegal practitioners and represent their interests, such as the Academy of Experts and the Expert Witness Institute. These bodies provide useful advice to their members, and membership – which requires references from solicitors and/or barristers – is an indication to instructing solicitors that you know what you are doing. They represent a useful next step to advancing your medicolegal career, although very few solicitors will instruct you on the basis of membership of one of these organisations alone. AvMA holds a register of practitioners that does appear to be widely used by claimant solicitors looking for an expert. Inclusion is out of the expert's control but seems to be based on a good history of producing high quality reports. The Resources Section contains website addresses for the organisations mentioned above.

As timeframes for conducting cases and costs are being forced down by the courts, solicitors are looking more avidly for fast turn-around times and low costs when selecting experts. A fixed-price preliminary report is now often the first recourse for the solicitor who wants a quick opinion as to whether a case has merit, and this approach has been sanctioned by the courts and professional bodies. The ability to provide a two = to three-page report within two weeks of receipt of records often leads to further instruction in the same and other cases, although this does need careful organisation and time management.

## **A final word of caution**

As with every other area of medical practice, there are great pressures to reduce the amount of money that doctors can earn as experts. The Legal Services Commission (formerly the Legal Aid Board) has stated that expert fees should be capped at levels that are far below the sort of rates currently charged, and are actively in consultation to achieve this end. At the same time, there is a drive towards improving quality by introducing accreditation, through a process that is still far from clear.

You will, of course, have taken out professional liability insurance with one of the MDOs for your clinical practice, but be aware that this does not necessarily provide cover for medicolegal work. You can fall foul of doctors whom you have unfairly castigated in a report, of patients who feel that you have not been sufficiently supportive of their claim, or of lawyers who are

dissatisfied with the service you provided. Medicolegal insurance is available from all the major MDOs and costs very little – make sure you are covered!

It is tempting to take on every case that comes through your door – after all, it is flattering to have your opinion sought. However, always ask yourself the following questions before agreeing to help:

- Can I deliver within the requested time-frame?
- Is this within my area of expertise?
- Do I have any conflict of interests, e.g. close friendship or professional relationship with any of the doctors involved?
- Can I take on the extra work that will inevitably arise through requests for clarification, further comments, responses to challenges from the other side, conferences with Counsel, and Court appearances?

# **Independent Practice in Pain Medicine**

Independent practice in Pain Medicine should only be undertaken by those with the appropriate training and experience. In most cases this will mean that the consultant holds or has held a substantive NHS consultant post that includes regular work in this subspecialty.

## **Standards of practice**

There should be no difference in the standard of care provided to NHS or private patients. Similarly, clinical pain medicine decision-making and case-mix should be similar for an individual consultant in both public and private sectors. The only exception to this would be differences in care relating to the time available to consult with the patient, the limitations of waiting lists and the form of therapies funded by the NHS and PMIs.

## **Clinic facilities**

Clinics should be held in an environment in which access to adequate and appropriate support facilities is available. This should include adequate facilities for consultation and examination of patients, chaperone facilities, resuscitation equipment and access to appropriate clinical investigations. Facilities for more complex investigations and scans should be available but not necessarily present on site.

## **Interventions**

If any form of intervention is undertaken, suitable sterile conditions, equipment and nursing support should be available, along with recovery facilities if sedation or anaesthesia is given. Major interventions may demand operating theatre facilities, trained nurses and radiological facilities. Patients should follow a defined and documented pathway of pre-operative assessment, informed consent, procedure, recovery, ward care and discharge.

## **Mode of practice**

When practising in pain medicine, the anaesthetist's mode of practice more resembles that of a surgeon than an anaesthetist. A pain specialist will need to arrange for outpatient consultation facilities to be made available by a private hospital or he or she may rent private consulting rooms. Referrals will come from General Practitioners (GPs), consultant colleagues, physiotherapists, osteopaths or chiropractors. When the referral does not come from a GP, it is good practice to notify the patient's GP and to ensure that the GP is fully

informed about the progress of the treatment. A pain specialist may well have to invest in secretarial and administrative support.

### **On-call cover**

A consultant will need to be on call and available for their own patients throughout any hospital admission. They will also need to provide some form of availability at other times for their patients who are undergoing treatment. It is advisable to arrange cross-cover with one or more colleagues in the same specialty. This allows adequate cover for patients during holidays and other absences.

### **Multidisciplinary work**

Although it is less usual for pain consultants in private practice to run multidisciplinary clinics, referral pathways to the relevant allied health professionals such as physiotherapists, occupational therapists, psychologists and pharmacists should be available in order to provide appropriate standards of care.

### **Fees**

Fees should be set in accordance with the advice set out in the section on “Billing issues” above. Most PMIs provide schedules of benefit maxima for pain therapy procedures.

### **Indemnity**

Consultants undertaking independent practice in pain medicine will require full indemnity from their MDO, which should be informed of the exact nature of the consultant’s practice, i.e. the relative proportions of the consultant’s income that are sourced from pain management and from purely anaesthetic practice.

# Independent Practice in Intensive Care

## **Responsibility for patients admitted to an Intensive Care Unit (ICU)**

When a private patient requires admission to an ICU, their medical management should become the responsibility of one clinician who should be a *recognised intensivist*. A recognised intensivist is a clinician with appropriate training and experience who holds or has held a substantive consultant's post that includes clinical responsibilities for patients in intensive care. This clinician should be the only consultant to charge the patient for their services. Only if the intensivist requests another consultant, e.g. a cardiologist, to attend the patient should any other consultant charge be made.

## **Postoperative intensive care as a 'routine' part of anaesthesia**

Many major surgical procedures are followed by a short and predictable stay in an ICU, e.g. cardiac bypass or aortic aneurysm surgery. In these circumstances, and if the patient's postoperative treatment and course are uncomplicated, it is common practice for the anaesthetist who has managed the patient before and during surgery to be responsible for the patient while in the ICU. The fee charged by the consultant anaesthetist should include this routine ICU care. However, if intensive care extends beyond this routine postoperative period, usually taken to be a period of no more than 24 h, responsibility for the patient's ongoing care should become the responsibility of an intensivist, who should be able to make separate charges for the patient's care. If the anaesthetist providing the anaesthetic care is also an intensivist, he or she can make additional charges after the first 24 h in the ICU provided the patient has been given appropriate warning that this may happen.

## **Unexpected postoperative ICU admission**

In the event of a private patient unexpectedly requiring postoperative ICU management, the patient's medical management should be handed over to an intensivist, who will make appropriate charges.

## **Standard of care**

The same standard of care should be provided to patients in the ICUs of both independent and NHS hospitals. Equipment and beds should comply with existing national standards. Adequate numbers of intensive care trained nursing staff must be available to manage the required patient dependency. Junior medical staff with intensive care training, including airway management

skills and resuscitation, must be immediately available. An on-call consultant intensivist without other responsibilities should be available at all times.

### **Transfer of patients from independent hospitals to NHS ICUs**

Many independent hospitals do not have adequate Level 3 ICU facilities, and patients may therefore need to be transferred to an appropriate NHS hospital. The independent hospital should have in place a contractual agreement with a neighbouring NHS ICU to provide transfer of a sick private patient to the NHS ICU or, if full, provide transfer to an ICU where a bed is available.

Patients may elect either to continue to be fee-paying or to become an NHS patient if they are entitled to receive free NHS care. If the patient is too sick to make a decision, then they remain a private patient in an NHS hospital until such time as they are competent to express their preference. Under these circumstances, some PMIs will try to claim that, if the patient is entitled to NHS care, they will no longer provide cover after such a transfer. Patients, or their next of kin, should be told that this is not usually the case and they should be advised to contact their relative's PMI to seek confirmation of continued private patient status.

If no retrieval contract has been agreed, it remains the responsibility of the independent hospital to undertake the transfer of the patient. Such transfers must be prearranged in accordance with Intensive Care Society guidelines, with the availability of appropriate monitoring and equipment. Accompanying medical and nursing staff should have suitable training and experience in transporting critically ill patients.

### **Charging for ICU services**

Some elements of ICU management may be charged as individual procedures. For example, the procedure of percutaneous tracheostomy requires both an operator (intensivist) and an anaesthetist, and both may submit accounts for the procedure. Most ICU management is a combination of procedures, ward rounds, therapy adjustments and waiting for these adjustments to work, and availability. This work may be charged as an hourly rate for actual attendance or as a daily rate taking on-call availability into account. A fixed daily charge for each patient covering all procedures may be more practical for billing purposes, and more acceptable to PMIs. As for anaesthetic fees, the actual rate charged is up to the individual, but in calculating the rate it may be helpful to consider the degree of expertise required and the length of training undertaken to become an intensivist.

Accurate records of procedures undertaken and time spent treating patients should be kept, in case submitted accounts are questioned either by the patients or their healthcare insurance companies.

### **Charging for ward consultations**

Requests for consultation for possible ICU admission should be charged at the rate of a complex outpatient referral, and may be repeated over consecutive days if indicated. Intensivists may also oversee a patient's management in the first few days after discharge from ICU, and may charge for this at a suitable daily attendance rate.

### **Charging for patient transfers**

If a patient is transferred from an independent hospital to a hospital with ICU facilities, the accompanying consultant anaesthetist or intensivist may charge for their services. This may most appropriately be at an hourly rate to include stabilising the patient for transfer, and the time taken to perform the handover.

### **“Fixed cost” cases and intensive care**

Many independent hospitals offer “Fixed cost” packages for uninsured patients. Hospitals offering such packages should have made arrangements in advance to cover unexpected complications, including unanticipated critical care requirements and transfer to NHS facilities. Such arrangements may include a contingency fund to cover additional medical and hospital fees, or an increased payment for each case to cover such complications.

### **The 2003 Consultant Contract**

Under the terms of the new consultant contract, independent practice should not be undertaken during NHS time except with the explicit permission of the employing NHS hospital management. It is not considered permissible to be paid twice for the same event. This is a problem for intensivists who may be asked to take over the management of private patients during their normal NHS duties.

The agreement between the BMA and the Department of Health relating to the new consultant contract allows for some independent practice to be undertaken alongside a consultant's scheduled NHS duties at the discretion of their NHS employers. This may be taken to cover the situation where an NHS Intensive Care Unit contains the occasional private patient.

Otherwise, the options are:

- Invoice the patient for the intensive care services provided and then pay the fee directly to the hospital. This may cause problems with tax records.
- Invoice the patient, keep the fee, then reimburse the hospital in time spent looking after patients.
- If the work is undertaken outside of contracted NHS time as defined in the individual's job plan, it is acceptable to invoice the patient and keep the fee.
- Arrange either for a colleague to undertake the management of the patient, or for this colleague to cover the intensivist's NHS responsibilities in order to avoid such a conflict of interest.
- Formalise an agreement with Trust management that allows intensivists to charge for the management of private patients on the basis they are a source of additional income to NHS hospitals and as such a suitable mutually agreeable solution should be possible between clinicians and management.

# Chambers and Group Practice

For anaesthetists, the prospect of practice in the independent sector may be a lonely one, as for many their introduction to private practice soon after appointment to consultant status is as a single-handed practitioner. Many will find that an established group practice already exists and if their job plan makes them attractive to the established group or they express an interest in becoming part of the group, an invitation to join might be forthcoming soon after appointment. Within the specialties such as anaesthesia, radiology and pathology, group practice is particularly attractive as a result of the usually discrete episodes of direct patient responsibility.

## The advantages of group practice

Sharing:	Practice costs and expenses Practice accommodation and secretarial assistance Administrative responsibilities Practice cover and on-call Specialty expertise, i.e. not everyone in the group needs to be able to cover all specialties
Maximising:	Income Free and off-call time Strength in negotiating with private hospitals, Treatment Centres and PMIs

## The disadvantages of group practice

Loss of:	Practice and professional autonomy Income, if your personal practice becomes very busy or only involves high-value procedures Tax advantage of paying a low-earning partner for secretarial services.
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For an increasing number of anaesthetists, the concept of group practice has of late been particularly attractive, and it is important to understand the terminology in use. Group practices generally fall into one of two types: chambers or partnerships.

## **Chambers**

This title has been borrowed from the legal profession in the UK. Here, following completion of his or her training, a new barrister must find a seat or “tenancy” in a set of chambers. Chambers are groups of barristers, and tend to comprise between 20 and 60 barristers. The term can equally be used to describe any group of professionals who choose to work together and who share rent and facilities such as the service of secretaries and other support staff. Most chambers offer a system whereby the members contribute to these common expenses by paying a percentage of their gross income. However, there is no profit-sharing as in a partnership (see below), and individual members of the group keep the fees they themselves earn beyond what they have to pay towards the chambers expenses.

## **Partnerships**

This title has a much more significant legal meaning under UK law whereby a partnership is a type of business entity in which partners share the profits or losses of the business undertaking in which they have all invested. The shares may be equal (equity partnership) or may be fractional, based upon the seniority or some other factor that varies only by the consent of all partners. A true partnership must have a legally drafted partnership agreement signed by all partners and there should be regular partnership meetings.

Generally, partners have an obligation of strict liability to third parties injured by the partnership. Partners may have joint liability or joint and several liability depending upon circumstances. The liability of limited partners is limited to their investment in the partnership, hence the term Limited Liability Partnership. Without a legally drafted partnership agreement, the group acting as a partnership will be regarded in law as a “sham” partnership and will not benefit from the legal advantages of a real partnership, such as the ability for all partners to charge the same fee without an accusation of price fixing.

The key to the success of a partnership rests in a sense of mutual trust between partners so that there is a feeling that the work is genuinely being shared equally. One important element in achieving this feeling is the important part played by the partnership manager who allocates work according to the agreed partnership rules laid down in the agreement. Partnership administration can be largely left to the salaried partnership manager who acts under the immediate direction of the elected partnership chairperson. Larger partnerships may also choose to appoint a partnership secretary and a

treasurer, but the arrangements of the partnership executive are matters to be decided by the members of the partnership with professional advice from their nominated legal and financial advisors.

Since partners are jointly responsible for third party damage, one important item that must be agreed at the onset is the individuals' responsibility for medical indemnity insurance, which should ideally be made an absolute obligation for continued membership of the partnership. Some partnerships take on the responsibility of payment on behalf of the individuals to avoid any inadvertent lapses.

## Resources and useful contacts

Medical Defence Union	<a href="http://www.the-mdu.com">www.the-mdu.com</a>
Medical and Dental Defence Union of Scotland	<a href="http://www.mddus.org.uk">www.mddus.org.uk</a>
Medical Protection Society	<a href="http://www.mps.org.uk">www.mps.org.uk</a>
Academy of Experts	<a href="http://www.academy-experts.org">www.academy-experts.org</a>
Action Against Medical Accidents	<a href="http://www.avma.org.uk">www.avma.org.uk</a>
Association of Anaesthetists of Great Britain & Ireland	<a href="http://www.aagbi.org">www.aagbi.org</a>
Criminal Records Bureau	<a href="http://www.crb.gov.uk">www.crb.gov.uk</a>
Department of Constitutional Affairs	<a href="http://www.dca.gov.uk">www.dca.gov.uk</a>
Expert Witness Institute	<a href="http://www.ewi.org.uk">www.ewi.org.uk</a>
General Medical Council	<a href="http://www.gmc-uk.org">www.gmc-uk.org</a>
Healthcare Commission	<a href="http://www.healthcarecommission.org.uk">www.healthcarecommission.org.uk</a>
Intensive Care Society	<a href="http://www.ics.ac.uk">www.ics.ac.uk</a>
Legal Services Commission	<a href="http://www.legalservices.gov.uk">http://www.legalservices.gov.uk</a>
National Institute for Health and Clinical Excellence	<a href="http://www.nice.org.uk">www.nice.org.uk</a>
National Patient Safety Agency	<a href="http://www.npsa.nhs.uk">www.npsa.nhs.uk</a>
NHS Litigation Authority	<a href="http://www.nhsla.com">www.nhsla.com</a>
Office of Fair Trading	<a href="http://www.ofl.gov.uk">www.ofl.gov.uk</a>
Royal College of Anaesthetists	<a href="http://www.rcoa.ac.uk">www.rcoa.ac.uk</a>
Small Claims Court	<a href="http://www.hmcourts-service.gov.uk">www.hmcourts-service.gov.uk</a>
The British Pain Society	<a href="http://www.britishpainsociety.org">www.britishpainsociety.org</a>
UK Department of Health	<a href="http://www.dh.gov.uk">www.dh.gov.uk</a>
AXA PPP	<a href="http://www.axapphealthcare.co.uk">www.axapphealthcare.co.uk</a>
BCWA	<a href="http://www.bcwa.co.uk">www.bcwa.co.uk</a>
BUPA	<a href="http://www.bupa.co.uk">www.bupa.co.uk</a>
CIGNA	<a href="http://www.cigna.co.uk">www.cigna.co.uk</a>
Norwich Union	<a href="http://www.norwichunion.com/health">www.norwichunion.com/health</a>
Standard Life	<a href="http://www.standardlifehealthcare.co.uk">www.standardlifehealthcare.co.uk</a>
WPA	<a href="http://www.wpa.org.uk">www.wpa.org.uk</a>







**THE ASSOCIATION OF ANAESTHETISTS**  
*of Great Britain & Ireland*

**21 Portland Place, London W1B 1PY**  
**Tel: 020 7631 1650**  
**Fax: 020 7631 4352**  
**Email: [info@aagbi.org](mailto:info@aagbi.org)**  
**[www.aagbi.org](http://www.aagbi.org)**