If I was Minister of Health… I would commission an independent inquiry into the safety of private healthcare providers

The publication of the inquiry report into the surgeon Ian Paterson earlier this year provided another sober reminder of the medical profession’s potential for exploitation and abuse of their patients [1]. Though cases as egregious as this are unlikely to be common, the lack of clinical governance in private healthcare was highlighted by Reverend Graham James as a particular worry, reiterated within days of the release of Reverend James’ report when concerns about orthopaedic surgery in private practice were also publicised [2].

Reverend James’ report importantly sparked concern regarding to what extent healthcare in the private sector is kept safe. Unlike the NHS, private healthcare providers are not obliged to accept Government recommendations, thereby allowing much of NHS good practice to be effectively voluntary in private practice. Furthermore, whereas consultants in the NHS are employees of the healthcare provider, consultants working in private healthcare simply rent the facilities of the company. This means that the private providers do not hold any legal accountability for the quality of the care provided, with responsibility lying with the consultants themselves. Despite highlighting these concerns, Reverend James’ report falls short of recommending a review into the UK’s private healthcare industry at large [1].

The British private healthcare sector has mostly received attention this century as a result of increasing outsourcing of NHS services to private companies [3]. Though the NHS’ clinical governance framework is far from satisfactory, data on safety issues in the private sector were examined by the Centre for Health and Private Interest (CHPI) in 2015 and shown to be strikingly inconsistent and vague in their reporting, with many key outcome indicators having not been reported at all [4]. The CHPI concluded that patients should be informed of the lack of safety data before being referred for treatment at private healthcare facilities. The responsibility of doctors to adequately inform patients of such risks was made clear by the General Medical Council in 2013 - ‘you must be satisfied that systems are in place to assure the safety and quality of care provided’ [5]. After working as an NHS doctor for over 10 years, I am unaware of such discussions to ever take place; yet outsourcing of NHS services to private providers reached over 60% between 2015 and 2019 [3].

It is particularly striking that the most lucrative private healthcare specialty as of 2019 is Oncology, leaving Orthopaedics and Paediatrics in 2nd and 3rd places respectively [6]. Would it be fair to expect a patient with newly diagnosed cancer to not only think about their family, finances and the fear of their cancer symptoms, but also have to decide on whether or not to pursue treatment at a probably less safe private healthcare provider, or wait longer to be treated in the NHS? A recommendation of Reverend James’ report is that the differences in care between NHS and private providers should be communicated to the patient beforehand. Yet how could a doctor recommend that their patient receive their cancer treatment from an external provider, for which the safety data is at best incomplete? This might be possible if the doctor has the experience of having worked there, but the conflict of interests prevalent in such cases was highlighted by the CHPI in 2019, as 1 in 16 of all oncologists own shares in the private healthcare providers in which they work [7].

The late bioethicist and physician Edmund Pellegrino described how a contractual relationship is not possible in most, if not all relationships between a patient and their doctor. The asymmetry of understanding is too great, and people usually only go to see a doctor when they are unwell and therefore partially incapacitated; the patient would rather not be unwell in the first place and therefore the decision to see a doctor is not voluntary in the sense of other commodified relationships [8]. Pellegrino emphasises the central nature of beneficence in medical practice above Beauchamp and Childress’ other core tenets of medical ethics [9]. Ethical practice ought not be dependent on external reward or fear of punishment but it would be naïve to expect doctors to be uniformly moral. Doctors are also human and prone to the same temptations as other human beings. As the Paterson case has shown, doctors are able to exploit the power and knowledge asymmetry for their own emotional and financial agendas and there is no reason to believe that a some similar rogue doctors are not working today. In a widely publicised article published in 2015, the cardiologist John Dean wrote that the practice of NHS consultants also working in the private sector introduces an unavoidable conflict of interests that renders the entire practice unethical [10]. With specific reference to Cardiology, he describes an inordinate use of expensive investigations for financial reward, even confessing to have done this himself. He does not discuss the use of invasive cardiological procedures that are not clinically indicated due to the same motivations, but as Reverend James’ report has shown, there is no reason to believe that this is not occurring.

As the American physicians and patient safety researchers Robert Wachter and Peter Provonost wrote in 2009, an abdication of responsibility on behalf of the medical profession is likely to lead to increased state regulation [11]. This would probably be damaging to a profession which, as the sociologist Eliot Freidson famously described, has an ethical obligation as its core defining feature, a feature that state regulation cannot instil and is likely to erode [12]. Our profession has a duty to speak up when patients are at risk, a duty that is largely yet to be reified. Advocacy for increased transparency in private practice would act as an excellent starting point, given the steep increase in outsourcing of NHS services private healthcare providers are now relevant to almost all UK doctors. Such advocacy would hopefully act as a precursor to a Government-commissioned inquiry into the safety of private healthcare providers, an overdue move given the evidence of tremendous harm that a single surgeon can inflict in an environment primarily driven by a desire for profit rather than quality of service.

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Conflicts of Interest: None.

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