

8 Conclusions

The monopoly situation

8.1. We are required to report whether a complex monopoly situation¹ exists in relation to the supply of services of registered medical practitioners. We are also required to limit our consideration to agreements and practices relating to the advertising of these services.

8.2. We explain in Chapter 4 that the General Medical Council, the statutory regulatory body responsible for the registration of doctors, is also empowered by statute to give guidance on standards of professional conduct and medical ethics. The GMC's guidance on professional conduct, contained in its blue book (paragraph 4.4), includes advice on self-promotion, canvassing and related matters which makes clear that, while the ethical dissemination of relevant factual information is to be encouraged, registered practitioners should not engage in promotional advertising.

8.3. The Council has powers to erase or suspend members of the profession from the Register if it finds that they have been guilty of serious professional misconduct. In recent years a number of cases relating to advertising have been considered by the Council's disciplinary committees and in a few cases action was taken against those found guilty of misconduct. We are satisfied that the Council's guidance on advertising is observed by registered medical practitioners.

8.4. The British Medical Association, whose membership covers about 75 per cent of registered medical practitioners in the United Kingdom, issues guidance on advertising to its members. A new version of this guidance (the grey booklet) was issued to members in late October 1988, during our inquiry. This incorporates changes made since 1984 (see paragraphs 4.18 onwards) and we have thought it right to reach our conclusions with regard to the guidance as it appears in the grey booklet. The guidance is based on that of the GMC but contains additional restrictions. The Royal College of General Practitioners has also issued guidance to its members designed to reflect that of the GMC and BMA but which has the effect of introducing an additional restriction (see paragraph 4.23).

8.5. Observance of the restrictions imposed by the guidance of these bodies, of which the guidance of the GMC is the most important, restricts both the means by, and the extent to which, registered medical practitioners can compete with one another. Accordingly we conclude that a complex monopoly situation exists in favour of registered medical practitioners by virtue of section 7(1)(c) and (2) of the Fair Trading Act 1973.

8.6. We noted that a number of Royal Colleges had adopted provisions relating to advertising. The Royal College of Physicians has passed a resolution advising against advertising by its members (paragraph 4.24), the Royal College of Surgeons of Edinburgh has a law prohibiting its Fellows being associated with indelicate or immoral advertising (paragraph 4.25), and candidates who are successful in the examination for the Triple Qualification awarded by the Scottish Royal Colleges are required to take an oath of

¹See note on the complex monopoly situation at Appendix 8.

allegiance renouncing advertising (paragraph 4.25), although we were told that the observance of all these requirements is regarded as fulfilled by observance of the guidance of the GMC. We therefore did not consider it necessary to examine them further.

8.7. We are asked to consider whether any steps are being taken by registered medical practitioners for the purpose of exploiting or maintaining the monopoly situation and whether any action or omission on their part is attributable to the existence of the monopoly situation. In the circumstances of this reference and the terms in which it was made these questions are largely technical. We do not find that any steps by way of uncompetitive practices or otherwise are being taken by registered medical practitioners for the purpose of exploiting or maintaining the monopoly situation we have found to exist (paragraph 8.5), nor do we find that any action or omission on the part of these practitioners is attributable to the existence of the monopoly situation.

8.8. Finally we have to consider whether any facts found by the Commission in pursuance of their investigations operate, or may be expected to operate, against the public interest. We are required to limit our consideration to the effects on the public interest of the agreements and practices relating to advertising. In doing so we have, as a practical matter, taken account of the general context in which the services are supplied.

The public interest

8.9. In considering the public interest we have identified the following main issues:

- (a) whether the advertising rules restrict competition within the profession;
- (b) whether they deprive the consumer of information about the services of individual practitioners; and
- (c) whether any such adverse effects are outweighed by benefits from the restrictions in protecting patients and in protecting the standing of medical practitioners and of the medical profession.

8.10. In examining these issues we have had in mind some general considerations.

8.11. We have taken into account conclusions reached by the Commission in the 1970 report on the general effect of certain restrictive practices including restrictions on advertising in the professions and in the series of 1976 reports on advertising restrictions in a number of individual professions (see paragraphs 3.2 and 3.14).

8.12. Secondly we noted the changes since 1970 in the climate in which the professions operate and in public attitudes to the professions. These factors, coupled with the outside competitive pressures on some professions, have together led to an increasing acceptance of the view that competition and professional status are not incompatible, provided professional standards are maintained.

8.13. We also had before us the 1987 White Paper *Promoting Better Health* (see paragraph 2.15) in which the Government stated its objectives of making primary health care services more responsive to the needs of the consumer and giving patients a wider range of choice in obtaining high quality services. The White Paper envisages a greater degree of competition in the provision of general practitioner services to patients and states the Government's wish to see restraints reduced on the extent to which family doctors may provide factual information about their practices and services, subject to proper safeguards for the professional status of the practitioners and for the protection of the public.

8.14. Our inquiry was influenced throughout by the fact that by far the greater part of medical services in the United Kingdom are provided through the NHS. Ninety-five per cent of expenditure on medical care in 1987 was incurred in the NHS. This factor is particularly important in considering general practitioner services since the NHS is the dominant influence on general practice in the United Kingdom. The existence of the NHS is also a major influence on the scope for private specialist practice in this country.

8.15. We recognised that practitioners providing the services covered by the inquiry fell into several distinct groups. The broad distinction is between general practitioners and specialists but this is not entirely clear cut. Given the different circumstances of these various groups and in particular the different ways in which the present restrictions on advertising affect them, we have found it necessary to examine their positions separately in assessing the public interest.

8.16. First there are general practitioners, virtually all of whom work within the NHS. While most of these get the greater part of their income from the NHS most engage in some other private work, eg insurance and other medical examinations, and some have private patients. A small number of doctors work as independent general practitioners entirely outside the NHS. The second group with whom we are concerned are specialists in private practice, most of whom have completed training in a speciality recognised by the medical colleges and faculties. Most of them have established their private practice while holding an NHS consultant post. Their patients are normally referred to them by a general practitioner. It is, however, open to any registered medical practitioner to describe himself as a specialist and offer his services to the public.

8.17. In addition there is a group of doctors who offer what can be broadly described as complementary medicine therapies, eg osteopathy, acupuncture, homeopathy, holistic medicine, or provide for special needs, eg through sports injury or obesity clinics. These services are not recognised 'specialities' in the sense used above, and many are offered privately outside the NHS by people who are not registered medical practitioners. When offered by general practitioners to their NHS patients they are regarded as part of the general medical services that a doctor has contracted to provide and the patient may not be charged for them. Accordingly in our ensuing discussion we regard these services as being provided by general practitioners and not by specialists.

The establishment and development of practices

8.18. We considered the effects of the restrictions on the establishment and development of practices by NHS general practitioners. The establishment of new general practitioner practices in the NHS is tightly controlled. Over 95 per cent of the practice areas in the United Kingdom are regarded as well or adequately provided with doctors and new practices are generally allowed only in response to population growth, although local features such as geography, communications and rates of illness are taken into account. In addition over 85 per cent of general practitioners now practise in partnership. Most doctors therefore establish themselves as general practitioners in the NHS after holding assistant posts, either by joining an existing partnership or, less frequently, by taking over a vacant practice. Very few will find themselves in the position of establishing a new practice in a new area. In these circumstances the advertising restrictions are likely to have little effect on the ability of the vast majority of NHS general practitioners to establish themselves in practice.

8.19. We considered whether the restrictions hampered the development of existing NHS practices and the introduction of new or improved facilities. It is our impression that many practices see the development of their practice in terms of new and better services rather than attracting new patients and see the

development of practice leaflets as the most effective way of publicising these services. Some existing NHS general practitioners may want more patients and if allowed to do so these practitioners might make use of the opportunity to advertise, but the existing restrictions do not appear at present to be a problem for the majority. This situation may change with the introduction of changes in general practice arrangements, including remuneration, outlined in the White Paper.

8.20. Those few doctors who wish to establish themselves outside the NHS as independent general practitioners relying entirely on private patients face particular difficulty. Although they can place their names as doctors in telephone directories and *Yellow Pages*, they are not able to have their names included in the lists produced by Family Practitioner Committees or Community Health Councils for display in local information centres. Some of them want to attract a particular kind of patient, for example, in Central London, business patients or overseas visitors. They are all handicapped by the inability to advertise in ways that are likely to reach such prospective patients.

8.21. We received evidence from doctors already in practice, some of whom were in the NHS, who wished to publicise new services for private patients. Examples were for special needs such as sports clinics, obesity clinics or alternative therapies such as acupuncture or osteopathy. Their problems are similar in kind, though perhaps less severe, to those of independent general practitioners wanting to establish a new practice.

8.22. The specialist training and experience required for a consultancy post is only found within the NHS and virtually all specialists who establish themselves in private practice do so from a position as an NHS consultant. The NHS arrangements allow a consultant with a full-time NHS contract to earn up to 10 per cent of his gross whole-time salary from private practice and part-time contracts are also available. These arrangements facilitate the development of private practice. Most specialists acquire patients through referral from general practitioners and under the GMC guidance, as currently circulated in the blue book, those who set up in practice or alter their practice address may notify professional colleagues of their availability provided they confine themselves to factual information of a non-promotional nature. For most specialists first establishing themselves in practice the restrictions are not in practice likely to be a major handicap.

8.23. We did, however, receive complaints from some specialists about the effects of the restrictions on the development of existing practices. The effect of the GMC and BMA restrictions extant during our investigations on the specialist's ability to communicate with colleagues was particularly drawn to our attention. It is the normal practice for patients in the United Kingdom to be referred to specialists by their general practitioners and patients rely on the general practitioner for advice on the specialist most likely to meet their particular needs. Evidence was given to us on the benefits of the referral system. It was put to us that general practitioners are best placed to give authoritative advice on the appropriate choice of specialist. They may be able to reassure the patient when specialist consultation is unnecessary. As they retain overall responsibility for patient care, general practitioners can ensure that both they and the specialist are aware of all the relevant information. The system both protects the patient and ensures the efficient use of resources, particularly in the NHS. The Department of Health (DH) expressed to us its concern that any removal of restrictions on advertising by specialists should not undermine the referral system. Under the system the most important aspect of the restrictions for most specialists is that which in the past has limited their ability to communicate with colleagues. Restrictions on their ability to advertise directly to patients are less important to them.

8.24. The restrictions prevent specialists informing their colleagues of new facilities or equipment which may be available, and prevent them reminding colleagues of their availability. They affect particularly the specialist who wishes to disseminate wider knowledge of unusual specialities or treatments which are not available in all areas. Some witnesses, including the BMA, put to us that the existing network of informal contacts, and the arrangements for communicating the outcome of earlier referrals between specialists and general practitioners, ensured that in practice specialists could pass any necessary information and advice to general practitioners. Others, including the GMC, considered that these local information networks were no longer adequate.

8.25. There are a few branches of medicine where self-referral by patients is generally accepted by the profession for practical or social reasons, eg accident and emergency services and clinics for sexually transmitted diseases, which operate primarily within the NHS, and family planning and abortion clinics. We have received no evidence that specialists associated with these branches of medicine are hampered by the present restrictions.

8.26. There are, however, some other branches of medicine where self-referral commonly takes place, although frowned on by most of the profession. Cosmetic plastic surgery is the best known example and some associations of specialists in this field have put to us (paragraphs 5.10 to 5.14) that the present restrictions not only limit their freedom to inform the public but encourage prospective patients to seek treatment instead at clinics which can advertise freely. This is a problem to which we revert later.

Information for consumers

8.27. Almost all the evidence we received from consumer and patient bodies, whether or not they were in favour of it being provided through advertising, stressed the need for more information to be given to patients, both about general practitioner and specialist services. A large number of patients need to find a new NHS general practitioner every year, usually because they have moved home. They want to be able to find out easily and conveniently what services the general practices in the local area offer, what the practical arrangements are for such matters as appointments and home visits, and to be able to compare what is on offer. The restrictions on advertising by general practitioners prevent them taking the initiative to provide such information for individual members of the public. While it would be possible for such information to be provided by other means, and the Government has indicated its support for moves in this direction, little progress has yet been made. As matters now stand the restrictions on the provision of information by general practitioners are an impediment to the flow of information.

8.28. Most patients rely on the advice of their general practitioner in seeking specialist treatment but a number of witnesses told us that patients would benefit from more information in discussions with their general practitioner. Such information was needed even more in cases where the patient felt unable to consult his or her general practitioner. At the moment there are virtually no means by which members of the public can acquire information about particular specialists unless they happen to see features about their speciality in newspapers or other media. The proposed compilation of a specialist register (paragraph 2.37) will provide some information but it seems likely to be of more use in checking the qualifications of a known specialist than in helping the patient to make a choice.

8.29. In limiting information about the services of particular doctors the restrictions also limit more general awareness of the services that can be provided, particularly in specialist fields, where the main sources of public information are now confined to articles and features in the media.

Competition with those who may advertise

8.30. We received a good deal of evidence about the effect of the restrictions on those practitioners offering services in competition with those who can advertise freely. The practitioners concerned include general practitioners who may want to offer screening services and those specialists who want to offer services such as cosmetic plastic surgery where patients frequently seek treatments at private clinics without consulting their general practitioner. It is clear in such cases that the restrictions prevent practitioners from competing on equal terms with clinics and we were told that difficulties in finding information about professionally qualified specialists not only cause inconvenience for patients but can lead to positive harm if they seek treatment at the hands of the less qualified.

Costs to the NHS

8.31. We considered the likely effect of relaxation of the restrictions on NHS costs and the demand for medical services both within the NHS and more generally.

8.32. Under present remuneration arrangements the costs of advertising by general practitioners would be borne, with their other practice expenses, by the NHS. The method of remuneration averages out these costs so that any practitioner who spends more than the average has to bear the difference himself. While this would limit excessive spending by individual doctors any significant relaxation would be bound to be reflected in increased expenditure for the NHS under the present reimbursement rules.

8.33. More generally, in so far as advertising by general practitioners or specialists led to increased awareness of the range of services that might be provided it could lead to increased pressure on the services. If specialists were to advertise their private services this could not only increase demand for those services but also stimulate demand for parallel provision in the NHS and it was put to us that this demand could not be met within the present structure of the NHS. On the other hand we note that the White Paper's proposals aim to create greater patient awareness of services that can be made available by general practitioners. The DH told us that it recognised this would lead to increased demand and that in some respects patients' expectations were at present too low.

Effects on price competition

8.34. We considered whether removal of the restrictions would encourage competition between private practitioners on the basis of price or affect the general level of costs and fees charged to private patients. It was put to us that the patient was unable to judge the quality of services, and that publication of fees would not help him to choose the most appropriate treatment. General practitioners were usually aware of the fees charged by the specialists to whom they referred private patients and took this into account in giving advice. Moreover, for the large number of private patients whose specialist treatment is covered by insurance, the insurers' scales in effect control the level of fees charged. These arguments may be relevant where specialist services are concerned. However, for the small number of patients seeking private general practitioner services, which are not normally covered by insurance, information about the general level of fees is likely to be of considerable help.

8.35. It was also suggested that advertising would raise the general level of fees because it would encourage competition on non-price factors leading to more costly services and because the costs of advertising would have to be absorbed. The argument that the costs of advertising will be passed on to the patient in increased charges (paragraph 7.31) is one that has been put forward by a number of other professions both in this country and overseas. The evidence is not clear-cut but some studies of other professions have shown that fees and charges have fallen after freer advertising was allowed (see paragraphs 3.30 and 3.31). Overall we do not consider the effects of the restrictions on fees and on price competition to be a major issue in determining the public interest issues.

The administration of the restrictions

8.36. The way in which the GMC rules were administered was alleged to create uncertainty, in that the guidance was framed in general terms and that the GMC was often unwilling to advise on whether a proposed course of action was acceptable. This uncertainty led doctors towards unnecessary caution in observing the guidance.

8.37. The GMC explained to us that its guidance on what constituted professional misconduct must necessarily be couched in general terms and that, while it tried to be as helpful as possible in responding to enquiries, its statutory judicial role imposed constraints where a situation might later arise in which the Council had to consider disciplinary proceedings. We recognise this difficulty but suggest such adverse effects as arise could be lessened if the GMC guidance went into somewhat more detail, by way of example rather than prescription, on such matters as the content of practice leaflets and their acceptable distribution.

8.38. Although the point was not put to us in evidence it appeared to us that divergences between the GMC and the BMA guidance, particularly on the content and distribution of practice leaflets, were likely to cause unnecessary confusion for general practitioners. The BMA explained to us that the GMC was laying down minimum standards while the BMA was aiming to promulgate best ethical practice. In interpreting the advertising restrictions, however, we saw no reason to think that observance of the extra restrictions suggested by the BMA was required to ensure satisfactory standards of behaviour.

Conclusions

8.39. In reaching our conclusions on the public interest we have had to balance the disadvantages of the present restrictions, in limiting the freedom of individual doctors to expand and develop practices and in limiting the flow of information to prospective patients, against the possible dangers of relaxation. Our main concerns here have been the need to avoid prospective patients being misled or exploited and to avoid damage to the fabric of the NHS.

8.40. It was put to us by both the GMC and the BMA that the maintenance of their present restrictions was essential to preserve the relationship of trust between doctor and patient and to protect the patient, who may be particularly vulnerable to promotional advertising. The unique relationship with the patient meant that comparisons with the advertising rules of other professions, even within the health care field, were not relevant. It was also put to us that the patients must be able to rely on disinterested advice from their doctor when in need of treatment and that any suspicion that the doctor was attempting to advance his own interests in treating the patient could destroy this trust. We accept that the relationship between a doctor and his patient often requires a higher degree of trust than the relationship with other professionals, even other professionals in the field of health care. When patients or their families are ill, or fear they may be ill, they are likely to be anxious and vulnerable to advertisements that exploit their anxiety for a cure. At the same time we think the arguments put to us are exaggerated. We do not think that the patient's trust in his doctor is likely to be undermined by the realisation that the doctor himself benefits from his work. Doctors, like other professionals, may expect material rewards from their work and may hope for enhanced reputation. We consider that patients will not think the worse of doctors for these ambitions, provided that they are not pursued at the expense of patient care. Doubtless there are already incompetent and exploitative doctors, as there are incompetent or exploitative individuals in other professions, but we do not think that freedom to advertise would be likely to increase their numbers. Nor do we think that overt recognition of competition between doctors need undermine trust and teamwork between doctors when it is needed.

8.41. We have also borne in mind that the removal of restrictions should not undermine the structure of the NHS or the effectiveness of its provision of health care for the public. The medical profession differs from others examined by the Commission in that the great majority of its services are provided to the public through a centrally controlled organisation, the NHS. We recognise that the structure of the NHS limits the benefits which might otherwise accrue from greater competition between doctors. While the competitive advantages of advertising may be less against the NHS background, freedom to advertise might also help to introduce some elements of competition into this regulated structure. Finally we have fully accepted the benefits to patients and the public generally of maintaining the present referral system.

8.42. Against this background we now consider in turn restrictions as they apply to advertising by specialists to the public, by specialists to professional colleagues and by general practitioners to the public. We also consider advertising by medical practitioners to persons or bodies other than prospective patients.

**Advertising by specialists
to the public**

8.43. In considering the restrictions on advertising by specialists we recognise that the prospective patient normally chooses a private specialist in discussion with his general practitioner and that it is in his interest to do so. The present restrictions deprive the public of some information which they may find useful in discussing the choice of consultant and making a final decision. But the main need is for the general practitioner to be fully informed, and we revert to this later. The benefit of direct advertising by specialists to the public in providing information has to be set against the dangers. Direct advertising might undermine the referral system, or encourage the patient to seek inappropriate treatment on the basis of self-diagnosis. It might therefore lead to exploitation particularly in some specialities. We think the arguments about patient vulnerability have particular weight in this context since few people consult a specialist unless they are already anxious about some aspect of their health. We also accept the view of the DH that it would not be possible to devise watertight safeguards to avoid these adverse effects. We therefore find that the observance of the GMC and BMA guidance restricting advertising by specialists to members of the public does not operate against the public interest, with the one qualification described in the following paragraph.

8.44. In reaching this conclusion we were particularly concerned about those areas where self-referral, although unwelcome to the profession, does take place. Cosmetic plastic surgery is the most important example. We note the concern expressed by the GMC, and a number of other bodies representing both doctors and consumers, over the effects of the freedom for clinics and hospitals to advertise freely. To consider the effects of advertising by clinics or individuals other than registered medical practitioners was not within our terms of reference. We have not investigated the problem and cannot therefore comment on its extent. We do not, however, consider that the problem should be dealt with by a relaxation of the restrictions on advertising by specialists, with one exception. We understand that under the present GMC rules associations representing plastic surgeons, or other specialities, are not allowed to respond to direct requests from members of the public for a list of their members and their qualifications, although the individual member may respond to a request for information about his speciality and qualifications made directly to him by a member of the public. The GMC put to us that freedom to respond to such requests could not be confined to reputable associations. The less reputable, however, appear already to find ways of making themselves known. A prospective patient who makes a direct request has already decided not to rely solely on advice from his general practitioner and to forbid him the information he requests does nothing to buttress the referral system and interferes unnecessarily with his freedom of choice. We think therefore that any association of specialists should be able to respond to

such a direct request for information about their members and qualifications and find that, to the extent that it prevents such response, observance of GMC guidance operates against the public interest.

8.45. We suggest, however, that the DH and ASA should examine the case for additional controls on the advertising of cosmetic plastic surgery, particularly on the use of such phrases as 'registered clinic', 'specialist' and 'consultant'. Such control might be linked to the proposed establishment of a specialist register. The GMC might also consider strengthening, and rigorously enforcing, those parts of its guidance which warn doctors against the dangers of serious professional misconduct if they practise a branch of medicine for which they do not have the appropriate skills and experience, or if they are associated with clinics or other organisations which do not follow the principles stated in the section of the blue book dealing with relationship between doctors and such organisations (paragraph 4.5). The establishment of an approved register of practitioners with specialist qualifications should help the patient to assess the claims of specialists and we urge that the GMC's work on this be completed as quickly as possible and that the existence of the register then be given wide publicity. Finally, better information for general practitioners about specialist services, which we discuss below, and better ways of passing such information on to patients should lessen the need for patients to make their own enquiries.

Advertising by specialists to professional colleagues

8.46. We turn now to advertising by specialists to their professional colleagues. The guidance of the GMC as presently circulated to the profession limits severely the occasions on which consultants can communicate with their colleagues. We have received evidence from both consultants and bodies representing patients that general practitioners are not adequately informed about specialist services available and the GMC itself has told us that present informal contacts are not sufficient to provide the information that general practitioners need. These disadvantages are not outweighed by any benefits to the patient and the removal of the present restrictions would not undermine the referral system – indeed it would increase its effectiveness. Accordingly we find observance of the guidance on advertising by specialists to their professional colleagues set out in paragraph 95 of the blue book to operate against the public interest. We find observance of the similar guidance issued by the BMA in Chapter 11 of its grey booklet to operate against the public interest.

8.47. The GMC has now announced publicly, by a Press Notice issued on 3 November 1988, that it has decided to withdraw these restrictions and that specialists should be free to inform colleagues by direct personal communication of their services as frequently as they wish and in as much detail as they think appropriate. The revised guidance will be drawn to the attention of registered medical practitioners in the Council's Annual Report, to be published next March. We consider that these changes will remove the adverse effects of the GMC guidance that we identified above and we invite the BMA also to review its rules in the light of the GMC changes.

Advertising other than to actual or prospective patients

8.48. We also received complaints from a number of medical practitioners that the present restrictions prevented them offering their services to firms or companies or professional associations. Examples were those who wanted to offer services in forensic pathology, occupational medicine and aviation consultancy. We were told that the present rules also prevent a professional association of consultants responding to a request for information from another profession. The GMC has now announced, in the Press Notice referred to in the preceding paragraph, significant relaxation in its guidance to allow doctors to communicate directly with firms or companies in some but not all of these circumstances (see paragraph 4.7(b)). The question of patient vulnerability does not arise here and we see no benefit to the public in maintaining the remaining restrictions. We therefore find the remaining restrictions imposed by the GMC and BMA guidance on the provision of information by medical practitioners or their associations to firms,

associations or indeed to other individuals, eg solicitors, when they are not offering to treat them as patients, to operate against the public interest. We invite the GMC and the BMA further to review their guidance to make clear that information may be provided to all such persons or bodies either on request or unsolicited.

Advertising by general practitioners to the public

8.49. The restrictions on advertising by general practitioners may have an effect on the small minority of the profession establishing new practices, whether in the NHS or independently, but have less effect on existing practices. More important are their effects on limiting the information available and the ways in which this information is made available. Against this must be set the special relationship between doctor and patient and the need for patient protection. Where the choice of a general practitioner is concerned this should not normally be an overriding consideration, as the potential patient can generally select a general practitioner when not actually ill or under pressure and the choice is reversible. Many of the occasions on which patients need to consult a doctor are of a routine and not stressful nature and the ongoing nature of the relationship allows patients to assess the quality of the service they are receiving and if necessary to take action.

8.50. In urging us to conclude that the present restrictions were not against the public interest the GMC drew our attention to the progress made over the last year in providing information, particularly through practice leaflets. It expects further significant progress in the next few years, primarily through wider dissemination of information by FPCs and other impartial bodies.

8.51. The GMC made clear to us that while it would strongly welcome these developments it was not in a position to ensure that they happened. The wider dissemination of information depends on the co-operation of a range of bodies outside the scope of our inquiry and on their possessing the necessary resources. We comment on this later but in considering the case for maintaining the present restrictions we cannot assume that the needs of the consumer will be met by these initiatives.

8.52. Moreover the distinction that the GMC draws between the publication of information by impartial bodies and by the individual practice seems to us misconceived. It made clear that while it approved of the initiatives described above it was firmly opposed to any unsolicited dissemination by the individual doctor or practice of its practice leaflets, or to the publication of information in an individual advertisement. The distinction rests on the proposition that to offer patients information about a single practice will distort their choice and that only if they are presented with a range of comparable and comprehensive information about all the practices in the area can they make a reasoned choice. But this distinction is already compromised by the endorsement by the GMC of individual practice leaflets which are made available widely in surgeries in circumstances which do not provide for comparison with other practices. Moreover, while the GMC is anxious that practice leaflets from every practice in an area should be made available together in a wide range of local information centres, it has recognised that, where not all doctors are ready to participate, this should not prevent others from making their leaflets available in this way. The GMC has also made clear that it places no restrictions on the range of factual information included in leaflets, or on their presentation and format, so that the leaflets may vary widely in content and appearance. Some we have seen seem to us to provide information in a distinctly persuasive way. We are clear that the distinction the GMC wishes to preserve cannot be maintained under the restrictions as they at present stand.

8.53. The BMA's main argument against promotional advertising was patient vulnerability. As consumers, patients were uniquely susceptible to the

dangers that could arise. Sick or anxious people might be unable to evaluate claims and were often in no state of mind to make a rational choice. Their health, if not their life, depended upon proper treatment and confidence in their doctors. For these reasons strong ethical guidelines were needed for the profession. The BMA, like the GMC, drew attention to the need for comparable and comprehensive information about general practitioners. Most people were satisfied with their doctor and the necessary information was already available for those who wished to change doctors. Nothing in the restrictions prevented the flow of information to patients being improved and the BMA would welcome this.

8.54. Again we are not persuaded by these arguments. As noted above, in choosing a general practitioner prospective patients are not usually in a vulnerable state or under stress and even without medical expertise can usually form a fair view of the service they are receiving and whether it satisfies them. We do not think that the present FPC lists, supplemented by word of mouth and personal visits to local surgeries, are a completely satisfactory way of finding out about local practices.

8.55. We also considered the effects that greater freedom for general practitioners to advertise might have on the NHS, both on internal competition and on competition between private practitioners and those within the NHS. We have already noted the constraints on the establishment of NHS practices, and it may be that against this restrictive background most NHS general practitioners would not rush to advertise on any scale in order to attract new patients. The DH nevertheless wishes to see greater competition between practitioners in meeting consumers' needs and regards greater freedom to advertise as contributing to this. It considers that any movements between practices resulting from advertising can be accommodated without serious strain, bearing in mind the considerable numbers that already find a new doctor each year. Greater freedom to advertise might also favour larger group practices, who could more readily absorb the costs. There is already a steady move to group practices and this seems likely to continue but we were told by DH that there would continue to be a place for the singlehanded practitioner. Freedom to advertise seems unlikely to affect present trends very much.

8.56. Independent general practitioners can be expected to make more use of greater freedom to advertise but it seems unlikely to us that more than a small proportion of patients would be prepared to pay for their services and for the full cost of prescriptions, while they can get satisfactory treatment under the NHS. The DH agreed with this view.

8.57. It seems to us more likely that the patient may be prepared to pay for some of the complementary medicine therapies, for example osteopathy, which are gaining increasing acceptance but are not generally available under the NHS although some NHS general practitioners offer them as part of their general medical services. We have noted in this context that the recent relaxation in GMC guidance on the use of *Yellow Pages* by general practitioners (paragraph 4.7(a)) may offer such practitioners some scope for publicising their services. In order to build up private practices, some doctors might cut back on NHS work or withdraw from NHS general practice completely. But again, given the relatively small numbers of doctors interested in and qualified to offer the alternative therapies, we doubt the effect would be major. In any event we were told that competition for vacancies in NHS general practice is so strong that it seems likely doctors cutting down on NHS work or leaving the NHS would be easily replaced. The net result would probably be an overall increase in the provision of services in response to consumer demand.

8.58. Against this background we concluded that the balance of advantage lies in allowing general practitioners to exercise their own judgment on how to make themselves known to potential patients. They should therefore be free to advertise, subject to certain constraints.

8.59. Accordingly we conclude that the observance by general practitioners of the restrictions imposed by the GMC on advertising operates against the public interest. The BMA guidance on advertising by general practitioners is based on that of the GMC but is more restrictive on presentation, content and dissemination. For the same reasons we find observance of the BMA guidance to operate against the public interest. We invite the BMA to modify the GMC and their guidance to conform with the proposals we make below.

8.60. The RCGP has issued guidance on practice leaflets which, although designed to assist practitioners in interpreting the guidance of the GMC and BMA, introduces an additional restriction, by suggesting that general practitioners should ensure that the content and distribution of their practice leaflets are acceptable to local colleagues. We consider that such a provision introduces no additional protection for the patient and may deprive him of useful information on arbitrary grounds. We find observance of this restriction to operate against the public interest, and we invite the RCGP to withdraw it.

8.61. In reaching these findings we have not dismissed the arguments on patient vulnerability that were put to us but we consider the necessary protection can be provided through certain constraints on general practitioners' freedom to advertise. As in earlier Commission reports we think it appropriate for us to lay down certain principles. The two broad principles that we consider should govern advertising by doctors are that advertising by them should not be of a character that could reasonably be regarded as likely to bring the profession into disrepute and that their advertising should not be such as to abuse the trust of patients or potential patients or exploit their lack of knowledge.

8.62. We do not think it appropriate for us to lay down detailed guidelines. We see that as remaining the responsibility of the professional bodies concerned and recognise that guidelines may need to be modified from time to time to reflect changing circumstances. The guidelines should, however, at all times conform to the principles set out above and be no more restrictive than is necessary to give effect to these principles.

8.63. It may, however, be helpful to the bodies if we indicate in broad terms some provisions that would, in our view, reflect these principles in today's circumstances and could properly be included in the guidelines.

8.64. First, on content of advertisements, we endorse the advice given in the GMC blue book that the material should be factual information, should be 'legal, decent, honest and truthful' (ie should conform to the principles of the British Code of Advertising Practice), and should not disparage other doctors, or make claims of superiority either for the service provided or for the doctor himself. There could also properly be a provision that no advertisements should include explicit or implicit claims to cure particular complaints. The proviso, however, that factual information should be 'of a non-promotional' nature is no longer appropriate in the light of our recommendations and we consider that it should be withdrawn. The GMC guidance relates at present only to practice leaflets but our comments apply equally to the content of any type of advertising.

8.65. We see no grounds for restricting any media that might be used. We recognise, however, that there may exceptionally be places or media where it would not be appropriate to place leaflets or other advertisements. We think this aspect could be controlled by the GMC under the general proviso that advertisements should not be such as could reasonably be regarded as likely to bring the profession into disrepute.

8.66. At the moment doctors are allowed to place their practice leaflets in local information centres (although the term is not defined) and to make them available to patients and prospective patients on request. We think general practitioners should be allowed general unsolicited distribution of these leaflets within the area from which they would expect to draw patients. A provision could properly be included, however, forbidding cold calling and targeted distribution to particular groups or individuals who can be singled out by age or some other factor and put under pressure.

8.67. Finally, a provision could properly be included against unsolicited distribution of practice leaflets or other advertising so frequently as to become a nuisance or put prospective patients under pressure.

8.68. For the reasons set out earlier we see no danger to the standards of NHS care in our proposals and possibly some advantages. We have noted, however, that the costs of wider dissemination of practice leaflets by NHS practitioners and other forms of advertising will fall on the NHS. The way in which expenses are reimbursed, however, means that the practitioner who spends more than the average will not be compensated for the difference. Existing plans to develop the use of practice leaflets already involve extra spending and we would not expect our proposals to lead to a major additional burden on the NHS. If unreasonable expenditure took place, either by the profession as a whole or by particular groups of doctors such as larger practices, the basis of reimbursement would need to be re-examined.

8.69. We noted earlier the DH proposals that FPCs and Health Boards should be required to provide more comprehensive information about practices in their areas for patients and the GMC view that dissemination of information by FPCs could play a major role in informing patients. We strongly endorse these views.

M S LIPWORTH (*Chairman*)

C C BAILLIEU

L BRITZ

M B BUNTING

P H DEAN

B C OWENS

S N BURBRIDGE (*Secretary*)

22 December 1988