Submission to the Medical Council

Review of "A Guide to Ethical Conduct and Behaviour (6th edition)"

12 October 2007

S/07/006

The Competition Authority
An tÚdarás Iomaíochta

Table of Contents

1. INTRODUCTION

Competition Policy and Ethics

1.1 The Competition Authority welcomes the opportunity to comment on the current (6th) edition of "A Guide to Ethical Conduct and Behaviour" ("the Guide"). Ethical guidelines play a vital part in promoting professional behaviour, which in turn benefits consumers and patients.

1.2 Ethical guidelines should not unduly restrict competition to the disadvantage of consumers and patients. Rather, ethical behaviour and competition can and should be entirely compatible and together they benefit consumers.

Summary

1.3 The current Guide comprises six sections of which 'Section D - Doctors in Practice' is of the most immediate interest to the Competition Authority.[1] This submission includes specific recommendations regarding four issues in Section D, namely:

- Advertising;
- Prescribing;
- Referrals;
- Financial interests.

1.4 The Guide's other sections cover matters which are for the most part outside the Authority's competence and accordingly the Authority does not wish to comment.

1.5 The Competition Authority recommends the reform of a number of existing guidelines which, in its view, go beyond ethical concerns to unnecessarily interfere with competition. In particular the Authority recommends that the revised Guide should liberalise the current guidelines restricting doctor advertising. The Authority also recommends that the revised Guidelines should, more clearly support the prescribing of generic medicines and allow out-patient cross referral from one consultant to another.

[1] The six sections are Section A: Conduct and Behaviour, Section B: Doctors and Patients, Section C: Professional Responsibilities, Section D: Doctors in Practice, Section E: Confidentiality and Consent, and Section F: Genetic Testing and Reproductive Medicine.

Structure of Submission

1.6 This submission comprises two main sections, followed by a brief conclusion. The two main sections are:

- First, a summary of key principles underpinning the Competition Authority's analysis of regulations generally, including guidelines for ethical conduct and behaviour; and

- Second, analysis and recommendations on specific guidelines, on advertising, prescribing, referrals and financial interests, contained Section D: 'Doctors in Practice'.

1.7 A list of the Authority's specific recommendations is in an Appendix.

2. PRINCIPLES OF BETTER REGULATION

Regulating Better – Six Principles

2.1 The Government White Paper *Regulating Better*[2] sets out six principles for better regulation which provide a good framework for reviewing existing regulations, amendments to existing regulations, or the introduction of new regulations. The principles are:

- Necessity – Is the regulation actually necessary? Are there alternatives available to meet the same end?
- Effectiveness – Is the regulation targeted? Will the regulation work?
- Proportionality – Do the advantages outweigh the disadvantages of the regulation?
- Transparency – Have stakeholders been consulted and is there available material to clearly explain the regulation? Are the processes used open to public debate?
- Accountability – is it clear who is responsible to whom and for what? Is there a clear appeals process?
- Consistency – Is the regulation consistent with regulations that already apply? Does the regulation draw on best practice from regulation in other areas?

2.2 The comments below identify key implications from the above principles that are most applicable in the context of reviewing ethical guidelines.

Necessity

2.3 Asymmetric information[3] is a common characteristic, if not the defining characteristic, of professional services. Most obviously, patients are reliant, sometimes to a very large extent, on the medical practitioner acting in patients' best interests.

2.4 It is not in dispute that encouraging ethical behaviour, and sanctioning unethical behaviour, benefits patients. Rather, it is both welcome and normal for professions, including medicine, to have an ethical code which promotes high standards of behaviour, and discourages professionals from taking advantage of relatively uninformed consumers or patients.

Effectiveness and Proportionality

2.5 First, and most obviously, *effective* regulations are well targeted and achieve their intended result, in this context promoting ethical

[2] *Regulating Better- A Government White Paper setting out six principles of Better Regulation.* Department of the Taoiseach, 2004. Available at: http://www.betterregulation.ie/index.asp?locID=22&docID=-1

[3] Asymmetric information refers to the situation where one party to a transaction has greater information than the other party about the products and services available (e.g. cost, quality, risks etc.). In the context of professional services the supplier has the information advantage and the consumer the information disadvantage.

behaviour by medical practitioners. Second, and as important, effective regulations also minimise or avoid significant unintended consequences which are detrimental to consumers.

2.6 The *proportionality* (or otherwise) of regulations is also important. *Proportionate* regulation restricts competition and commercial behaviour only to the extent necessary to protect consumers, while also allowing consumers to benefit from the operation of competition in a market. By contrast excessive, or disproportionate, regulation tips the balance in the wrong direction, i.e. to the benefit of suppliers, particularly already established suppliers, over the interests of consumers.

2.7 Too often, poorly targeted regulation unintentionally inhibits pro-competitive behaviour while disproportionate regulation is defended with (sometimes misplaced) references to ethical considerations.

2.8 In the course of its studies of the professions, the Competition Authority has addressed various examples of unnecessary and disproportionate regulation, which do not benefit consumers, including:

- Controls on advertising, including information on fees and specialities;
- Bans on accepting clients of a fellow professional without prior "permission" from the fellow professional; and
- Restrictions on business structures to deliver professional services.

2.9 The current Guide covers a wide range of issues and situations and consequently the risk of anti-competitive regulation cannot be discounted. Consistent with Section 7 of the Medical Practitioners Act 2007, the Medical Council has an important role to play to manage this risk by drafting guidelines that are both effective, (i.e. well targeted) and proportionate (i.e. serve the interests of patients).

Transparency, Accountability and Consistency

2.10 The principle of *transparency* applies to both the *process* by which regulations are promulgated and also the *content* of regulations (in particular the choice of language). *Regulating Better* describes the benefits of clear and unambiguous regulation as follows:

> *"Enhancing regulatory transparency contributes to the quality of regulations, increases the likelihood of compliance and reduces the risk of 'capture' or bias towards special interests. It also empowers citizens by giving access to information which enhances their decision-making abilities as consumers, and as participants in the community."*[4]

2.11 The principle of *accountability* for medical practitioners is best put in the question 'accountable to whom and accountable for what?' While doctors are accountable to the Medical Council for breaches of ethical

[4] *Regulating Better- A Government White Paper setting out six principles of Better Regulation.* Department of the Taoiseach, 2004. page 30.

guidelines, the ultimate accountability of professionals individually and the medical profession as a whole is to patients.

2.12 *Consistency* implies that new regulations should be consistent with existing national and European law and policy. A *consistent* approach to regulation implies that regulatory agencies in similar situations should have broadly similar roles, responsibilities and even broadly similar structures.

2.13 In summary, the key implications of the above three principles are:

- The content of the revised Guide should be as easily accessible to consumers (patients) as possible;
- Consumers' (patients') interests should take precedence in both the content of ethical guidelines and in the regulatory structures of the profession;
- Ethical guidelines should be consistent with existing law and policy, including competition policy. Ethical concerns do not provide a justification to restrict competition between medical practitioners excessively (either in terms of competitive rivalry between practitioners or entry of new practitioners into the market);
- Transparent, accountable and consistent processes and structures are more likely to promote effective and proportionate regulation and are less prone to capture by the profession being regulated; and
- Independent regulation is preferable to self regulation. The Competition Authority supports the provisions in Section 17 of the Medical Practitioners Act 2007 which provides for increased representation of persons other than doctors on the Medical Council.

3. DOCTORS IN PRACTICE

Introduction

3.1 Section D of the current Guide - *Doctors in Practice* - specifies various limits on how doctors and medical practices should operate as businesses. The four issues of greatest interest to the Competition Authority are:

- Advertising;
- Prescribing;
- Referrals;
- Financial interests.

Advertising and Information

3.2 The Competition Authority has significant concerns about the current Guide in relation to advertising and information for patients. The restraints on advertising are disproportionate and not to the benefit of patients.

3.3 For some of the guidelines discussed below, the Authority cannot identify any justification and accordingly recommends they be abolished. In addition, for a number of other guidelines, the Authority recommends some changes to clarify ensure consistency of wording.

Current Guidelines

3.4 The following guidelines severely and unnecessarily restrict doctors' ability to advertise:

- **Guideline 6.1 – Setting Up Practice** specifies the content allowed in any notice announcing entry of a doctor into the market: name, address of practice, hours, contact numbers and if applicable a recognised speciality. The guideline also specifies that:

  "the announcement should not be inserted as a display notice. The notice should not measure more than 100mm in any direction"[5]

- **Guideline 7.2 - Place of Practice Signs**: A professional plate and sign may be displayed, containing the same information listed above in Guideline 6.2. In addition

  "[i]f the practice is carried on in a business premises, the doctor's name may be included in a list of the occupants of the complex."[6]

- **Guideline 7.4 – Patient Information**: Concerning the provision of appropriate information, including patient fees, the Guideline states that:

[5] *A Guide to Ethical Conduct and Behaviour* (Sixth edition). Medical Council 2004, page 20.
[6] *Ibid* page 21.

"[t]his is most suitable for display or distribution in the place of practice by the doctor or staff."[7]

- **Guideline 14.3 - Balance of Benefit (under the subheading 'The Media and Advertising'):** This guideline states:

  "In adjudicating on complaints concerning doctors in the media, the Medical Council will consider whether the benefit to the doctor has been greater than that to the public and whether there has been an element of self-advertisement or a claim of possession of special skills, either of which could be interpreted as canvassing for patients. In all circumstances benefit to the patient must outweigh any incidental advantages to the practitioner concerned."[8]

3.5 The above guidelines severely restrict the content, format and location of doctor advertising. Consumers are left with only a limited availability of information regarding the range of services, including any specialities, and the price of services which doctors provide.

Effects of Guidelines

3.6 The combined effect of the above guidelines is to restrict competition by constraining the ability of doctors to make themselves known to consumers. From a consumer perspective, the current guidelines restrict the ability to switch from one doctor, or doctors' practice, to another. To elaborate, the guidelines:

- Limit consumers' information on the availability of medical services in their area. Consequently consumers are less informed, than otherwise might be the case, about the options available and are hindered in their efforts to choose the best option for them.

- Create unnecessary obstacles to doctors, either individually or jointly in a practice, becoming established. Advertising is an important way for new practices to make themselves known.

- Benefit established doctors. Constraining the ability of doctors and/or medical practices, particularly those new to the market, to publicise their existence protects well established doctors and/or medical practices from competition.

- Reduce the incentives for innovation on the part of doctors and/or medical practices. Doctors and/or medical practices wishing to offer new or innovative ways of delivering services are restricted in how they can promote their new services and facilities. Consequently they are less able to attract new patients and recoup their investment, as would be normal in most other walks of commercial life. A reduced incentive for doctors to innovate is not to the benefit of consumers.

- Limit price competition. It is extremely difficult for consumers to make price comparisons and shop around for the best value. This

[7] *Ibid* page 21.
[8] *Ibid* page 28.

allows doctors to charge more than they would in a more transparent competitive environment.

Authority Analysis and Recommendations

3.7 The current guidelines are overly restrictive and disproportionate. The guidelines go beyond the protection of patients and excessively restrain competition. The current guidelines protect doctors, particularly established doctors, from competition and this is not to the benefit of consumers.

3.8 Inaccurate or misleading advertising can harm consumers and it is entirely appropriate for ethical guidelines and regulations to discourage and sanction such advertising. The potential harm can be significant particularly in medical and other professional services where there is asymmetric information to the disadvantage of the consumer.

3.9 While asymmetric information and ethical concerns provide good reasons for regulating advertising, guidelines and regulations should be effective and proportionate; i.e. should be well targeted and should not unnecessarily restrict competition.

3.10 Limiting the size of announcement notices to a maximum of 100mm^2, (Guideline 6.1), implying prescribed content and location for professional plates (Guideline 7.2), do not benefit consumers. Rather by restricting the availability of information these guidelines benefit doctors and in particular well established doctors who have less need to advertise for patients.

3.11 Distributing price information inside a doctor's place of practice (Guideline 7.4) is of little benefit to existing patients, and even less beneficial to consumers who either do not currently have a doctor or who are considering switching from their current doctor. Broad distribution would be of much greater benefit to consumers.

3.12 Guideline 14.3 is particularly disproportionate, especially its final sentence: *"[s]elf-advertisement, or publicity to enhance or promote a professional reputation for the purpose of attracting patients is unacceptable*."[9] This portrays a mistaken view that advertising and ethical medical practice are mutually exclusive.

3.13 Furthermore, Guideline 14.3 appears to indicate that it is unprofessional for a doctor to seek to attract patients. If that interpretation is correct then it represents an extremely disproportionate restriction. From a competition policy perspective, contrary to the Guideline's current title 'Balance of Benefit' no balancing is required. Attracting customers new to the market or existing customers of other suppliers is an entirely normal and legitimate objective, and part and parcel of competition, for any commercial undertaking, including the supply of professional services such as medical services.

3.14 In summary, the current guidelines include a strong presumption against advertising and against competition between doctors which gives rise to a set of disproportionate restrictions. A more proportionate approach would be to accept the role that accurate and

[9] *Ibid* page 28.

informative advertising can play in informing patients of available services, and in reducing the information asymmetry between consumers and doctors, in order that consumers can make rational decisions. That is, the solution to the problem of information asymmetry is not to constrain the information available to consumers but to equip them with the information they need to make decisions about their health.

3.15 As Ireland increasingly becomes a mobile, international and time-poor society it will become increasingly important that consumers are aware of the doctors and medical practices in their area and the range of services that are available. Advertising is an important way in which consumers obtain such information. The focus of ethical guidelines should therefore be on minimising misleading and inaccurate advertising rather than on minimising advertising *per se*.

3.16 The Competition Authority recommends that the Medical Council abolish the following Guidelines:

- Guideline 6.1 - Setting Up Practice;
- Guideline 7.2 - Place of Practice Signs;
- Guideline 7.4 - Patient Information; and
- Guideline 14.3 - Balance of Benefit.

3.17 In addition, the Competition Authority recommends that:

- Guideline 7.3 – 'Information for the Public' be amended as appropriate to maintain consistency with any changes to Guidelines 6.1 and 7.4.
- Guideline 14.1 – 'Educating the Public' be amended to more explicitly refer to misleading advertising by individual doctors. (The alternative interpretation of the current guideline is that the profession as a whole should not claim 'unique' capabilities in treating health problems; that would clearly be a disproportionate restriction.)
- Guideline 14.2 – 'Information for the Public' be amended to give it greater emphasis particularly if, as advocated above, Guideline 14.3 is abolished. For example, Guideline 14.2 could more explicitly cover both the actions of individual doctors and collective actions of the medical profession as a whole or of bodies representing medical profession.

Prescribing

3.18 The Authority supports the prescribing of generic medicines. So long as generic medicines provide safe and effective treatment, there should not be any ethical concerns about prescribing generics over branded medicines.

3.19 The Authority also suggests that the Medical Council should consider amending its guidance on the financial interests of prescribing doctors in pharmaceutical companies.

Current Guidelines

3.20 **Guideline 10.1 – Prescribing** states:

> "*[a] doctor should prescribe appropriate therapies for the patient's condition and best interest.*"[10]

3.21 In a similar manner **Guideline 10.3 - Indicative Drugs Budgeting** states:

> "*[i]n exercising indicative drugs budgeting doctors should be principally concerned with the patient's best interests.*"[11]

3.22 The Guidelines do not contain any obvious anti-competitive provisions. They are, however, silent on the merits of prescribing generic medicines.

Effects of Guidelines

3.23 Given that generic medicines are generally cheaper than their patent equivalents, the use of patent medicines, when a suitable generic alternative is available, increases the costs of medicines. Any such increase in cost will be met either by patients directly or by the Exchequer.

Authority Analysis and Recommendation

3.24 So long as a generic medicine meets required standards, i.e. is safe and effective, then no ethical issues should arise to preclude or to discourage the use of generics. Accordingly Guideline 10.1 should not be interpreted as discouraging the use of generics. Rather the use of generics should be seen as entirely consistent with Guideline 10.1.

3.25 Lower costs are to the benefit of patients, most directly those paying for medicines privately. Prescribing of generic medicines also reduces the impact on the Exchequer, potentially freeing up resources that can be used to assist other patients. Consequently, as with Guideline 10.1, Guideline 10.3 should not be interpreted as implicitly playing down the importance of budgets as a means of managing the costs of medicines.

3.26 The second paragraph of Guideline 10.1 states:

> "*The manner in which doctors are remunerated,* ***or any financial interest they may have in the pharmaceutical or allied industries****, must not influence the doctor when recommending therapy for their patients*".
>
> The Medical Council may wish to consider whether there are simply too many ethical or conflict-of-interest issues involved where prescribing doctors hold financial interests in pharmaceutical companies whose products they are prescribing, and whether such holdings should simply be prohibited, or at least discouraged.

[10] *Ibid* page 23.
[11] *Ibid* page 23.

3.27 The Competition Authority recommends that:

- Guideline 10.1 be amended, perhaps along the following lines:

  "*A doctor should prescribe appropriate therapies for the patient's condition and best interest. It is acceptable to prescribe generic medicines that provide equivalent therapies to patent medicines*."

- Guideline 10.3 be amended to refer to generic medicines, i.e. replace the current Guideline 10.3 with:

  "*In exercising indicative drug budgeting, doctors should be concerned with the patient's best interests principally in terms of the effectiveness of treatment but also in terms of costs of medicine. It is acceptable to prescribe generic medicines that provide equivalent therapies to patent medicines*."

Referrals

3.28 The Competition Authority's concerns regarding referrals focus on consultants accepting patients without a GP referral (Guideline 12.2) and cross referrals, in particular cross referrals for out-patients (Guideline 12.5).

3.29 In addition, the Competition Authority emphasises its support for Guidelines 12.1 and 12.7. The Authority supports:

- the principle that a general practitioner is well placed to manage the role of managing the overall health care of the patient (Guideline 12.1);

- the principle that the patient has the right to request further opinions and/or referrals (also Guideline 12.1); and

- the current ban on fee-splitting (Guideline 12.7).

Current Guidelines

3.30 **Guideline 12.2 – Accepting a Referral** states:

"*[a] consultant should not normally accept a patient without referral from a general practitioner.*"[12]

3.31 However, acknowledging the possibility of direct access by the patient (i.e. without first seeing their general practitioner) Guideline 12.2 also states that

"*[i]n the exceptional circumstances that a consultant sees a patient without referral, the patient's general practitioner*

[12] *Ibid* page 26.

should be informed of the consultant's findings and treatment."[13]

3.32 **Guideline 12.5 – Cross Referral/Inter Referral** states:

"*Cross referral during out-patient care is inappropriate; patients should be referred to their general practitioner for further management."*[14]

Effects of Guidelines

3.33 Guideline 12.2 effectively discourages 'direct access' of patients to consultants. This limits the choices available to patients in their choice of secondary care and, on the assumption that the GP will charge for their services (including referral advice), increases the cost to the consumer.

3.34 Similarly, Guideline 12.5 may limit patient choice and also increase the total cost of treatment by discouraging consultant-to-consultant outpatient referrals. Instead the current guideline requires the additional involvement of the patient's General Practitioner.

Authority Analysis and Recommendations

3.35 The current presumption that a General Practitioner will be involved in <u>all</u> referrals to consultants is disproportionate and not necessarily in the best interests of patients. Patients may wish to see a particular specialist or consultant, or may wish to switch consultants, or alternatively may wish to see the same consultant again on a similar or possibly even a different matter. A patient may wish to do any of these without first seeing their General Practitioner.

3.36 It is possible that if approached directly in this way a consultant may consider that another practitioner may be a better option for the patient. In that instance, the guidelines on inappropriate referral (Guideline 12.4), amended if necessary to explicitly include patient self-referral, should be sufficient.

3.37 Guideline 12.5 effectively requires the involvement of the General Practitioner in <u>every</u> out-patient referral. As with Guideline 12.2, the result is, at least potentially, an increased overall cost of treatment and a risk of diminished quality of treatment.

3.38 It is reasonable to expect that a GP will have some influence over the consumer's choice specialist/secondary care. The expertise of a GP is of valuable assistance to the patient in deciding what course of action to take. It is also possible that a GP, due to the broad nature of their work, coupled with knowledge of their patients' general health, will have an extensive knowledge of the specialists and consultants available for secondary care.

3.39 Against that where a cross referral is necessary it is possible, if not likely, that the additional secondary care will be in a familiar or related

[13] *Ibid* page 26.
[14] *Ibid* page 26.

field (e.g. ophthalmology and neurology or neurology and endocrinology). In such cases a referring consultant may have at least as much knowledge, and possibly more, than a referring general practitioner of the secondary care options available.

3.40 Consequently, if the guideline is followed to the letter, it is possible that a GP, and therefore the consumer, may not be aware of all the relevant specialists or consultants to provide secondary care. This is not in the interests of the patient.

3.41 Furthermore, cross referral implies that the patient is already in need of secondary care. Cross referral provides an opportunity to minimise the time between the provision of different sorts of secondary care required by the patient, thereby avoiding any medical risks to a patient that might derive from a delay in the provision of care, as could occur if only general practitioners refer patients to consultants.

3.42 The Competition Authority does not have anything beyond anecdotal evidence on this point. It would not be surprising, however, if Guideline 12.5 is honoured more in the breach than the observance. It is also possible, for example, that the involvement of GPs in outpatient cross referrals is on a passive rather than an active basis.

3.43 In summary Guidelines 12.2 and 12.5 are disproportionate. It may well be normal, in a statistical or historical sense, for consultants to see patients only after referral from a General Practitioner. This does not, however, equate to an ethical requirement or presumption that any or all consultant or specialist appointments (or most, taking account of the current allowance for exceptional circumstances) should only take place only after a GP referral.

3.44 A more proportionate guideline would require only that a patient's General Practitioner is informed of any direct access or out-patient cross referral appointments.

3.45 The Competition Authority supports the ban on fee-splitting currently expressed in Guideline 7. The Authority recommends that the guideline be strengthened with a more explicit definition of fee-splitting to cover any arrangement whereby one practitioner pays a fee for referral to them by another practitioner.

3.46 The Competition Authority recommends that:

- Guideline 12.2 be amended to state that, even if not normal in a statistical sense or in terms of common practice, it is nevertheless entirely acceptable for a consultant to see a patient without prior referral from a GP. The following provides alternative wording to the current Guideline 12.2:

> "It is acceptable for a consultant to see a patient directly (i.e. a patient not referred by a General Practitioner). In circumstances where a consultant sees a patient without referral the patient's General Practitioner should subsequently be informed of any findings or treatments."

- Guideline 12.4 be amended, for consistency with the recommended amendment to Guideline 12.2, to explicitly include instances of self referral, i.e. replace current Guideline 12.4 with:

> "If a consultant considers that a patient has been inappropriately referred, or has inappropriately self-referred, or should have visited some other specialist, the consultant should liaise with the patient's general practitioner."

- Guideline 12.5 be amended to state that cross referral of out-patients is acceptable so long, as with in-patient cross referral, as the patient's General Practitioner is informed, i.e. replace the current first two sentences of Guideline 12.5 with:

> "Cross referral between consultants during an in-patient stay may be in the patient's best interest. Cross referral during out-patient care may also be appropriate. In both instances the patient's general practitioner should be kept informed."

- Guideline 12.7 be amended to more explicitly define the term 'fee-splitting', i.e. replace the current Guideline 12.7 with:

> "Fee splitting, i.e. any form of payment (especially any made without the patient's' knowledge) in return for the referral of a patient, is against the interests of patients."

Financial Interests

3.47 **Guideline 13. 1 – Financial Interest** provides a means of ensuring that patients are aware of any potential conflict of interest and also places an onus on the doctor to ensure that his or her actions are not influenced by any financial interest. Guideline 13.1 states:

> "[a] *doctor who has a financial interest in a private clinic, hospital, pharmacy or any institution to which he/she is referring patients for investigation or therapy, has a duty to declare such an interest to patients. Such doctors must take exceptional care to prevent their financial interests influencing their management of patients.*"[15]

3.48 Section 63(3) of the Pharmacy Act 2007 provides that it is professional misconduct for a registered medical practitioner to have a beneficial interest in a retail pharmacy business. The Guidelines will need to be amended to take account of section 63, and also sections 64 and 65, of the Pharmacy Act 2007 on conflicts of interest.

[15] *Ibid* page 27.

4. CONCLUSION

4.1 Ethical behaviour and conduct can and should be compatible with competition in the market for medical services. It is important to recognise the risks of overly restricting competition, in the pursuit of ethics, to the detriment of consumers.

4.2 For medical services the consumer is, in the vast majority of cases, less well informed than the doctor. Consequently ethical behaviour is vital to the reputation of individual doctors, to the reputation of the profession as a whole, and most importantly to the welfare of patients.

4.3 It is important, however, that codes of ethical conduct are ultimately to the benefit of consumers (i.e. patients in the context of medical practice). Ineffective regulation that is poorly targeted leads to unintended consequences which do not benefit consumers. Disproportionate regulations benefit suppliers (i.e. doctors and medical practices) by restricting competition beyond the extent necessary to protect consumers (patients).

4.4 Periodic review of ethical guidelines is an important way of rectifying the unintended consequences of ineffective regulation and also allows the opportunity to reform disproportionate regulation. The Competition Authority welcomes the opportunity to contribute to this review process.

4.5 In its submission the Competition Authority has made a number of recommendations on four issues:

- Advertising;
- Prescribing;
- Referrals;
- Financial interests.

4.6 There are many other issues, covered by the Guidelines, which fall outside the Competition Authority's competence and for which the Authority does not offer any specific comment beyond advocating the use of six regulatory principles outlined in *Regulating Better*.

4.7 The Competition Authority is available to discuss these issues further with the Medical Council if that was thought useful.

APPENDIX: SPECIFIC RECOMMENDATIONS

Advertising

A.1 The Competition Authority recommends that The Medical Council abolish the following Guidelines:

- Guideline 6.1 - Setting Up Practice;
- Guideline 7.2 - Place of Practice Signs;
- Guideline 7.4 - Patient Information; and
- Guideline 14.3 - Balance of Benefit.

A.2 The Competition Authority recommends that Guideline 7.3 be amended as appropriate to maintain consistency with any changes to Guidelines 6.1 and 7.4.

A.3 The Competition Authority recommends that Guideline 14.1 be amended to more explicitly refer to misleading advertising by individual doctors.

A.4 The Competition Authority recommends that Guideline 14.2 be amended to give it greater emphasis particularly if, as advocated above, Guideline 14.3 is abolished. For example, Guideline 14.2 could more explicitly cover both the actions of individual doctors and collective actions of the medical profession as a whole or of bodies representing medical profession.

Prescribing

A.5 The Competition Authority recommends that Guideline 10.1 be amended, along the following lines:

> "*A doctor should prescribe appropriate therapies for the patient's condition and best interest. It is acceptable to prescribe generic medicines that provide equivalent therapies to patent medicines*."

A.6 The Competition Authority recommends that Guideline 10.3 be amended to refer to generic medicines, i.e. replace the current Guideline 10.3 with:

> "*In exercising indicative drug budgeting, doctors should be concerned with the patient's best interests principally in terms of the effectiveness of treatment but also in terms of costs of medicine. It is acceptable to prescribe generic medicines that provide equivalent therapies to patent medicines*."

Referrals

A.7 The Competition Authority recommends that Guideline 12.2 be amended to state that it is acceptable for a consultant to see a patient without prior referral from a GP. The following provides alternative wording to the current Guideline 12.2:

> *"It is acceptable for a consultant to see a patient directly (i.e. a patient not referred by a General Practitioner). In circumstances where a consultant sees a patient without referral the patient's General Practitioner should subsequently be informed of any findings or treatments."*

A.8 The Competition Authority recommends that Guideline 12.4 be amended, for consistency with the recommended amendment to Guideline 12.2, to explicitly include instances of self referral, i.e. replace current Guideline 12.4 with:

> *"If a consultant considers that a patient has been inappropriately referred, or has inappropriately self-referred, or should have visited some other specialist, the consultant should liaise with the patient's general practitioner."*

A.9 The Competition Authority recommends that Guideline 12.5 be amended to state that cross referral of out-patients is acceptable so long, as with in-patient cross referral, as the patient's General Practitioner is informed. i.e. replace the current first two sentences of Guideline 12.5 with:

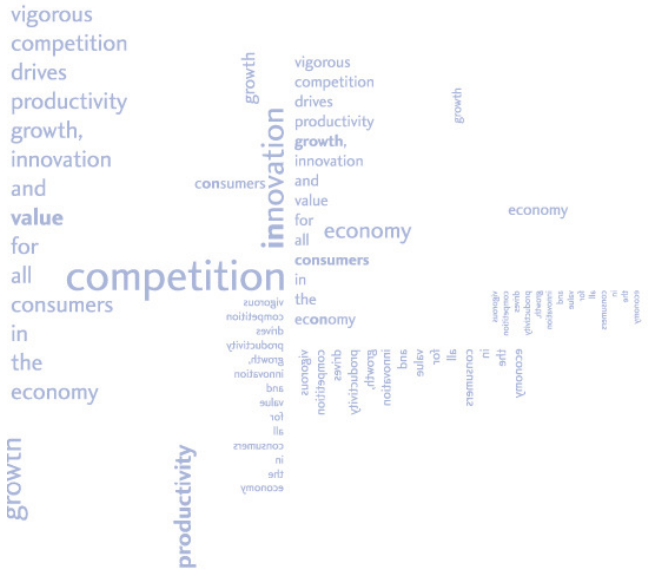
> *"Cross referral between consultants during an in-patient stay may be in the patient's best interest. Cross referral during out-patient care may also be appropriate. In both instances the patient's general practitioner should be kept informed."*

A.10 The Competition Authority recommends that Guideline 12.7 be amended to more explicitly define the term 'fee-splitting', i.e. replace the current Guideline 12.7 with:

> *"Fee splitting, i.e. any form of payment (especially any made without the patient's' knowledge) in return for the referral of a patient, is against the interests of patients."*

Financial Interests

A.11 The Competition Authority recommends that Guidelines on financial interests be amended to take account of section 63, and also sections 64 and 65, of the Pharmacy Act 2007 on conflicts of interest.



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