How To Do It

Start in private practice

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I suspect that most senior registrars are appointed to consultant posts in the National Health Service with only the sketchiest of notions about private practice. This may be an encouraging reflection on their commitment to the principles of the NHS but it leaves them unprepared for private practice, and the best advice I can give for the newly appointed consultant wishing to enter this is that he should find an approachable senior colleague and unashamedly ask for advice about the practicalities and local arrangements. I was fortunate enough to have colleagues who gave me this advice unbidden, but for those of you too shy to make that approach the following broad observations are made. They are based on experiences in surgical practice in London and I accept that they may not be relevant to the practice of venereology in Wick or anaesthesia in Penzance.

Why private practice?

From the patient's point of view private practice entails the buying of a consultant's time. In addition the patient is expecting to buy comfort and convenience. Sadly, many patients believe that they can buy a "better" consultant opinion or a more effective operation privately and though I would like to believe that there is no difference in the opinions and skills available in the two different settings, I must ruefully admit that the current fraught and constricted practice in the NHS may mean that better medicine is indeed available in the private sector, even when the same doctor is concerned.

Overall the time factor is probably the most important, and after a few relaxed half to one hour new patient consultations you will quickly wonder how we do justice to patients and their diseases in the hectic NHS schedule. Adequate time is a pleasure as well as a necessity; it improves your clinical habits and sets standards that you should hope to be able to emulate in the NHS. Much has been written about the relationship between the NHS and private practice and it is not the purpose of this chapter to root around in the ideological detritus of the various arguments. For the moment the two exist in parallel, and consultants overlap between the two. The consultant's task is to make the system work to the benefit of all his patients and there is no reason why proper care of NHS patients and of private patients should be incompatible if the consultant uses his skills honestly and his time effectively.

It goes without saying that the private patient expects the consistent personal attention of one doctor, but it is a sad indication of people's perception of the uncertainties of the NHS that they will often ask at a private consultation, "And will you be doing the operation?"

From *How To Do It: 2*, a new collection of useful advice on topics that doctors need to know about but won't find in the medical textbooks. To be published in October 1987, this is a companion volume to the popular *How To Do It: 1*, also published by the *BMJ*.

Setting aside the time

Even a very busy consultant's NHS commitments will leave him some free time for private practice. If he is less than full time that extra time will be complete sessions; if he is truly full time he may need to find that time at the beginning or end of the working day or at weekends. Wherever that time is found it is best to structure it. Arrange a definite time of the week to see patients and if you are a surgeon arrange a regular operating time. Without that, not only is your orderly practice disrupted but life becomes difficult for your secretary and your family. Don't be coy about these sessions: they are a perfectly proper part of your professional life and should feature on your hospital timetable just as your hospital schedule appears on your private timetable. There is nothing more infuriating for NHS staff than a consultant who unpredictably dematerialises and cannot be contacted.

A particular problem for those who practise in London is grappling with the tight schedules required in the treatment of patients from overseas, who frequently come unannounced and want their definitive treatment today or tomorrow (or even yesterday). All you can do is fit things in as quickly as possible, at the same time exhorting them and their advisers to give some warning next time.

Private practice is, in essence, singlehanded practice: the patient is paying for you, not someone else. This potentially makes the taking of time for holidays and meetings difficult and shows how important it is to have an effective partnership or cross cover with your colleagues for those occasions. Partnerships also allow you to offer a comprehensive emergency service, something which is not widespread in the private sector.

Premises and secretaries

Private practice must be organised from some geographically fixed base. Traditionally this is the consultant's "rooms," the place where the secretary can be found and where patients are seen. Increasingly consultants see patients in several places, perhaps at home and also in private hospitals. That is all very well and it may increase the options for the patients, but for the colleagues who refer and for the patient on the telephone a central point of contact is vital. Even for those with a secretary, an answering machine is a great boon, preferably one that can be interrogated by you from elsewhere.

Few can now afford rooms and a secretary for their sole use. A joint practice—or sessional arrangements in a private clinic—is substantially cheaper and almost as satisfactory. Wherever you

practise it is worth remembering that comfort and convenience are not just the private hospitals' concern. Your consulting room should be pleasant and tranquil to be in, for the benefit of both you and your patient. Choose your secretary carefully; she too should be pleasant and tranquil, sympathetic on the telephone, and endlessly patient with the disruptions that you will heap on her.

Full timers and those with small private practices may use their NHS secretaries but this is open to abuse, and the rules, remuneration, and hours need to be set very carefully at the outset and the agreement of the hospital administration obtained.

Many consultants employ their wives as their private secretaries and receptionists. A wife's salary is tax deductible under schedule D but to be so must actually be paid to her.

A fair amount of paper flutters around every consultation: notes have to be made up, addresses taken, tests and admissions arranged, bills sent. This inevitable mini bureaucracy works more smoothly if the secretary is in the same place as the consultation. If you are of the right bent a microcomputer might well ease these chores.

For London readers I should perhaps add a note here about Harley Street. Indeed not just for London readers. Otherwise sane men travel miles from hospitals in the outer suburbs to get to an address in Harley Street where they see patients who have made the same awful journey. I wonder for whose benefit this time honoured quirk persists. In fairness, however, I should admit that Harley Street and its environs contain a very talented and comprehensive set of medical facilities—though nobody should be under the illusion that the address guarantees quality, as any reader of the Sunday newspapers will know. The phenomenon of Harley Street persists out of conservatism and snobbery as much as for any other reason and I don't think that new consultants really ought to feel an obligation to take rooms or sessions there, certainly not at the outset of their careers, unless the romance of the Harley Street reputation really appeals to them.

Where to practise

Private patients still have the option of either a private bed in an NHS hospital or a bed in a private hospital. Hospitals in the NHS may lack the thick carpets and warm lighting of the private clinics, but make up with a wider range of medical services. Where you admit the patient depends on his wishes and his diseases. Not all private hospitals can cope with complex or severe illness and in dealing with these the full NHS team has advantages. Remember, however, that though such patients may be educational, junior NHS staff may resent time spent with them, and their efforts should be not taken for granted or abused.

When a surgeon has another doctor to assist him at a private operation in a private hospital the assistant must be paid—and promptly. Some surgeons do not pay if the patient defaults; though this may serve as an object lesson in financial reality, it seems to me to be improper. When the assistant is the patient's general practitioner a fee is usually still expected though the amount may be difficult to judge.

Private hospitals are in general pleasant places in which to practise, and nurses are less stressed than they seem to be in the NHS. The quieter environment and the smaller scale of most such hospitals gives them an atmosphere reminiscent of cottage hospitals of old.

For those consultants who do private practice in health service hospitals the Department of Health and Social Security's handbook, *Management of Private Practice in Health Service Hospitals in England and Wales* is essential reading. The handbook reminds consultants that they should ensure that their patient's private status is established in writing, that they have a copy of the signed undertaking in writing, and that they should tell the private patient office when the episode of illness is completed.

Developing a practice

Britain's position near the bottom of the European "league table" of doctors per head of population guarantees that in the NHS none

of us sits in the outpatient clinic twiddling his thumbs waiting for patients to be referred. One is led to believe that in certain well heeled southern county towns the same applies in private practice, but for most consultants there is the sobering realisation that in the private sector practice has to be earned not taken for granted. This is one of the virtues of the activity. Advertising for practice is not allowed beyond a restrained card to general practitioners and colleagues advising them that you are available and giving them your address and your consultation times; after that, like the man in the newly opened shop or gallery, you must just sit smiling confidently and wait to see what happens.

At the outset some patients will come, as doctors try you out; after that your practice can go either way—up or down. One would like to think that the progress of one's practice reflected the quality of service offered but it is of course more complicated than that. Social contacts probably count more than anything—a fact not wasted on those who, to the disgust of their colleagues, spend time and money developing social bonds with people with whom they might not otherwise bother to pass the time of day. Nevertheless, it is nice to think that patients come because they want to see you, and there is enormous satisfaction in seeing as new patients people who come on the specific recommendation of a patient previously treated. It is worth noting in passing at this point that though it is preferable for patients to be referred from their general practitioners or other doctors, as they are in the health service, there is no rule that says this must be done, and private practice continues to offer a convenient escape route for patients who feel dissatisfied with their general practitioner or local hospital. Most health insurance companies do, however, insist on referral being from a general practitioner.

There are two fallacies to beware of. Firstly, do not expect to inherit the practice of your NHS predecessor. Very few give up their NHS and private practices simultaneously. Secondly, never believe what you are told about the size of other people's practices, particularly if they are vulgar enough to tell you themselves. Such claims are like fishing stories, and the magnification quotient ranges upwards from two times reality.

Money

We are all spoilt by being brought up in the NHS with a regular salary and hardly a care in the world about the money we spend on our patients. For this reason the financial side of private practice brings surprises for the newcomer.

The nice surprise is of course the extra income that it brings. The other surprise is the sudden awareness of how much everything costs. You see the bills for the bed and the blood tests, and if the patient is uninsured you must quickly develop a lean view of what is really essential for his care. Those few extra days in hospital can set him back £1000; the computed tomography done to document the lesion that you are not going to treat, £300; the frozen section done so that the nature of the lump will be known tonight not tomorrow, £250. Now try pricing unnecessary parenteral nutrition, fancy drugs, the endoscopies to watch an ulcer healing, and you quickly realise how prodigal the health service can be. The uninsured or underinsured patient brings with him a lot of anxieties about the cost of his care and it is important to spell out very carefully for such people the possible costs that they are or may be committing themselves to; indeed they may need to be persuaded back into the arms of the NHS. This is allowed. Patients may change horses in midstream, but only once in any particular episode of illness. Patients very rarely ask how much their treatment will cost, and the doctor is honour bound to have done those sums even if the patient doesn't ask. One colleague of mine produces written estimates like a builder. That is no bad thing, and incidentally one does not need to add VAT: doctors are exempt.

The financial side of private practice requires two things. The first is accurate and tidy book keeping; the second is an accountant. The new consultant who thinks he can manage his own accounts will, unless he takes an unhealthy pleasure in figures, find himself quickly out of his depth in the murkier corners of self employed income tax, schedule 4 National Insurance exemption, and rolled

over capital gains tax. I doubt if many accountants inject their own haemorrhoids and likewise I would advise you not to attempt your own accounts. It is worth talking to your accountant well before the first tax demand appears as a certain amount of forward planning is needed. You may for instance need to set the end of your accounting year at the end of April, allowing an extra year's breathing space before the first tax is due. To someone brought up on PAYE the need to write cheques for the Inland Revenue on fees long since spent may come as an embarrassment. Thus from the start it is prudent to set aside, say, 25% of your private earnings in anticipation of a juicy tax demand. Although schedule D is more generous with allowances than the schedule E of PAYE, the costs of setting up in practice are by no means all tax deductible, so don't rush out and buy a new car.

New consultants may be anxious about what fees they should charge patients. This need not be a source of anxiety as in each geographical area there are fairly standard fees for new and for follow up consultations and the insurance companies issue lists categorising operations into minor, intermediate, major, and major plus types. In addition they settle the amount that they will reimburse for an operation in any category. There are ill concealed

murmurs of dissatisfaction about the levels of these fees and their unbalanced nature favouring certain specialties. Nevertheless, insured patients reasonably expect to be charged what the insurance company specifies, and if you intend to charge more than that you ought to tell the patient in advance.

Conclusion

However small it might be, most people find private practice is instructive, stimulating, and rewarding—so much so that its enticements may be considerable—and it will thus do no harm to conclude with a warning about abuses of private practice that can too easily be slipped into. These include overtreating, overcharging, and overvaluing your own skills so that you are tempted to treat in private practice those conditions that you would refer to your colleague in the context of the health service. Lastly, remember to be punctilious about your commitments in the NHS. Don't let an enthusiasm for private practice nibble into your NHS time. Your junior staff may not get any formal education in private practice but watching you will be their informal education and it should be correct.

Clinical Topics

Impotence: treatment by autoinjection of vasoactive drugs

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Abstract

One hundred and twenty five men with psychogenic or organic impotence used autoinjection of the penile corpora cavernosa with either papaverine or papaverine and phentolamine for a mean period of 10.5 months (range 1-24 months) to achieve penile erection for sexual intercourse. Prolonged (over four hours) painless erection resulted from 34 of the 3513 self administered injections.

This seems to be a highly effective approach to treating impotence irrespective of the aetiology.

Introduction

Advances in the investigation, diagnosis, and treatment of impotence¹ have led to more and more men being referred for treatment. Half of those who are referred for treatment have a predominantly organic cause.² Men who have venous leaks (5-10%) can be treated by surgery.³ Penile revascularisation procedures for men with arteriogenic impotence are available in only a few centres, and results are generally poor.^{4,5} Endocrine treatment for a low serum testosterone or high prolactin concentration is rarely effective.⁷ Few of the remaining patients will be offered or can afford a penile implant. Those with psychogenic impotence respond poorly to psychotherapy.⁸

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Intracavernosal injections of papaverine or papaverine and phentolamine are both diagnostic and therapeutic^{1,9}: diagnostic because the failure to achieve an erection when arterial inflow is normal suggests venous leakage, and therapeutic because patients with psychogenic impotence often regain spontaneous erections.¹¹ Most of these patients or their partners can be easily taught to administer the injection, allowing the time of the erection to be varied to suit them and their partners.¹⁰

We report the results of treatment of 125 men with impotence of various aetiologies who practised self injection.

Patients and methods

Altogether 181 men who were referred to the male sexual dysfunction clinic underwent a full clinical history and examination. Their penile brachial index was determined using a 10 MHz Doppler probe as a measure of arterial inflow,¹¹ and liver function tests were performed and blood glucose and plasma lipid concentrations measured. Serum testosterone and prolactin concentrations were also measured.

Patients who show a poor erectile response to intracavernosal papaverine and phentolamine and have a penile brachial index of >0.7 have venous leaks (unpublished results). Sixteen such patients were excluded from this study, as were three patients with abnormal results from liver function tests and 17 whose potency returned after their first pharmacologically induced penile erection. Of the remaining 145 patients, 125 aged from 27 to 79 (mean 49) entered the autoinjection programme; 109 had regular partners. Sixty two patients had diabetes mellitus, of whom 46 were insulin dependent. Of these 62, 18 had either a peripheral or an autonomic neuropathy, and 21 had an abnormally low penile brachial index of <0.6. No vascular or neurological abnormality was found in the remaining 23. A penile arteriopathy was suggested in a further 25 non-diabetic patients who had a penile brachial index of <0.6. Fourteen patients had neurogenic impotence: four as the result of spinal cord injuries and three after pelvic surgery, six had multiple sclerosis, and one had Guillain-Barré syndrome. In the remaining