British Medical Association

Medical Ethics

B.M.A. House
Tavistock Square
London WC1H 9JP

1974

British Medical Association

(FOUNDED 1832)

(Member of the World Medical Association; Member of the Commonwealth Medical Association; affiliated with the Australian, Canadian, Fiji, Ghana, Indian, Malaysian, Nigeria, Pakistan, Rhodesian, Sarawak, Singapore, Sri Lanka, Trinidad and Tobago, and Uganda Medical Associations, the Medical Associations of the Bahamas, Jamaica, New Zealand, South Africa, Swaziland and Tanzania, and the Bermuda Medical Society)

Patron:
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MEDICAL ETHICS

1974 *Edition*

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BRITISH MEDICAL ASSOCIATION
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MEDICAL ETHICS

I. The Brotherhood of Medicine

The entrant to the profession of medicine joins a fraternity dedicated to the service of humanity. He will be expected to subordinate his personal interests to the welfare of his patients, and, together with his brother practitioners, to seek to raise the standard of health in the community among which he practises. He inherits traditions of professional behaviour on which he must base his own conduct, and which he must pass on untarnished to his successors.

The Hippocratic Oath

While the methods and details of medical practice change with the passage of time and the advance of knowledge, the fundamental principles of professional behaviour have remained unaltered through the recorded history of medicine. From time to time attempts have been made to codify the standard of conduct expected of the doctor in the practice of his profession, the most celebrated being that attributed to Hippocrates in the 5th Century B.C. This takes the form of an oath intended to be affirmed by each doctor on entry to the medical profession, and in translation reads as follows:

I swear by Apollo the physician, and Aesculapius and Health, and All-heal, and all the gods and goddesses, that, according to my ability and judgment, I will keep this Oath and this stipulation—to reckon him who taught me this Art equally dear to me as my parents, to share my substance with him, and relieve his necessities if required; to look upon his offspring in the same footing as my own brothers, and to teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine, but to none others. I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous. I will give no deadly medicine to anyone if asked, nor suggest any such counsel; and in like manner I will not give to a woman a pessary to produce abortion. With purity and with holiness I will pass my life and practise my Art. I will not cut persons labouring under the stone, but will leave this to be done by men who are practitioners of this work. Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption; and, further, from the seduction of females or males, of freemen or slaves. Whatever, in connection with my professional practice, or not in connection

with it, I see or hear, in the life of men, which ought not to be spoken of abroad, I will not divulge, as reckoning that all such should be kept secret. While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the Art, respected by all men, in all times. But should I trespass and violate this Oath, may the reverse be my lot.

This Oath has endured through the centuries, and whether or not the modern doctor formally affirms it at qualification, he accepts its spirit and intentions as his ideal standard of professional behaviour.

An International Code of Medical Ethics

The lapses from the Hippocratic ideal on the part of the profession in certain countries during the Second World War and the perpetration of crimes against the individual in the name of race or religion have shown the need for a modern restatement of the Oath and a reawakening of the sense of the high calling and the ethical responsibilities of the doctor. Accordingly, one of the first acts of the World Medical Association, when formed in 1947, on the initiative of the British Medical Association, to unite the profession throughout the world in a single brotherhood, was to produce a modern restatement of the Hippocratic Oath, known as the "Declaration of Geneva", and to base upon it an International Code of Medical Ethics which applies both in times of peace and war. The Declaration of Geneva, as amended by the 22nd World Medical Assembly, Sydney, Australia, in August 1968, states:

At the time of being admitted as a Member of the Medical Profession

I solemnly pledge myself to consecrate my life to the service of humanity.

I will give to my teachers the respect and gratitude which is their due;

I will practise my profession with conscience and dignity;

The health of my patient will be my first consideration;

I will respect the secrets which are confided in me, even after the patient has died;

I will maintain by all the means in my power, the honour and the noble traditions of the medical profession;

My colleagues will be my brothers;

I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;

I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I make these promises solemnly, freely and upon my honour.

The English text of the International Code of Medical Ethics is as follows:

Duties of Doctors in General

A DOCTOR MUST always maintain the highest standards of professional conduct.

A DOCTOR MUST practise his profession uninfluenced by motives of profit.

THE FOLLOWING PRACTICES are deemed unethical:

(*a*) Any self advertisement except such as is expressly authorized by the national code of medical ethics.

(*b*) Collaborate in any form of medical service in which the doctor does not have professional independence.

(*c*) Receiving any money in connection with services rendered to a patient other than a proper professional fee, even with the knowledge of the patient.

ANY ACT OR ADVICE which could weaken physical or mental resistance of a human being may be used only in his interest.

A DOCTOR IS ADVISED to use great caution in divulging discoveries or new techniques of treatment.

A DOCTOR SHOULD certify or testify only to that which he has personally verified.

Duties of Doctors to the Sick

A DOCTOR MUST always bear in mind the obligation of preserving human life.

A DOCTOR OWES to his patient complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond his capacity he should summon another doctor who has the necessary ability.

A DOCTOR SHALL preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him.

A DOCTOR MUST give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.

Duties of Doctors to Each Other

A DOCTOR OUGHT to behave to his colleagues as he would have them behave to him.

A DOCTOR MUST NOT entice patients from his colleagues.

A DOCTOR MUST OBSERVE the principles of "The Declaration of Geneva" approved by the World Medical Association.

Ethical Code of the Commonwealth Medical Association

The following Ethical Code of the Commonwealth Medical Association was approved at its meeting in Jamaica in 1974:

"1. The doctor's primary loyalty is to his patient.

2. His vocation and skill shall be devoted to the amelioration of symptoms, the cure of illness, and the promotion of health.

3. He shall respect human life and studiously avoid doing it injury.

4. He shall share all the knowledge he may have gained with his colleagues without any reserve.

5. He shall respect the confidence of his patient as he would his own.

6. He shall by precept and example maintain the dignity and ideals of the profession, and permit no bias based on race, creed, or socioeconomic factors to affect his professional practice."

(N.B. The word "patient" used in this Code embraces the prisoner or other persons whom a doctor might be called upon to attend at another's bidding.)

Discrimination in Medicine

The following Motion on the subject of Discrimination in Medicine was adopted by the World Medical Association in 1973:—

"WHEREAS: The Declaration of Geneva, adopted and published by The World Medical Association, states, *inter alia*, that, 'I (a Medical Practitioner) WILL NOT PERMIT considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient';

THEREFORE, BE IT RESOLVED by the 27th World Medical Assembly meeting in Munich, that The World Medical Association *vehemently condemns* colour, political and religious discrimination of any form in the training of medical practitioners and in the practice of medicine and in the provision of health services for the peoples of the world."

Human Experimentation

In 1964, the World Medical Association drew up a code of ethics on human experimentation. This code, known as the **Declaration of Helsinki,** is as follows:

It is the mission of the doctor to safeguard the health of the people. His knowledge and conscience are dedicated to the fulfilment of this mission.

The Declaration of Geneva of the World Medical Association binds the doctor with the words, "The health of my patient will be my first consideration"; and the International Code of Medical Ethics which declares that "Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest".

Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, the World Medical Association has prepared the following recommendations as a guide to each doctor in clinical research. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Doctors are not relieved from criminal, civil, and ethical responsibilities under the laws of their own countries.

In the field of clinical research a fundamental distinction must be recognized between clinical research in which the aim is essentially therapeutic for a patient, and clinical research the essential object of which is purely scientific and without therapeutic value to the person subjected to the research.

I. Basic Principles

1. Clinical research must conform to the moral and scientific principles that justify medical research, and should be based on laboratory and animal experiments or other scientifically established facts.

2. Clinical research should be conducted only by scientifically

qualified persons and under the supervision of a qualified medical man.

3. Clinical research cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

4. Every clinical research project should be preceded by careful assessment of inherent risks in comparison to foreseeable benefits to the subject or to others.

5. Special caution should be exercised by the doctor in performing clinical research in which the personality of the subject is liable to be altered by drugs or experimental procedure.

II. Clinical Research Combined with Professional Care

1. In the treatment of the sick person the doctor must be free to use a new therapeutic measure if in his judgment it offers hope of saving life, re-establishing health, or alleviating suffering.

If at all possible, consistent with patient psychology, the doctor should obtain the patient's freely given consent after the patient has been given a full explanation. In case of legal incapacity* consent should also be procured from the legal guardian; in case of physical incapacity the permission of the legal guardian replaces that of the patient.

2. The doctor can combine clinical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that clinical research is justified by its therapeutic value for the patient.

III. Non-Therapeutic Clinical Research

1. In the purely scientific application of clinical research carried out on a human being it is the duty of the doctor to remain the protector of the life and health of that person on whom clinical research is being carried out.

2. The nature, the purpose, and the risk of clinical research must be explained to the subject by the doctor.

3a. Clinical research on a human being cannot be undertaken without his free consent, after he has been fully informed; if he is legally incompetent the consent of the legal guardian should be procured.

3b. The subject of clinical research should be in such a mental, physical, and legal state as to be able to exercise fully his power of choice.

3c. Consent should as a rule be obtained in writing. However, the responsibility for clinical research always remains with the

* NOTE: The phrase "legal incapacity" means "incapacity to give consent freely".

research worker; it never falls on the subject, even after consent is obtained.

4a. The investigator must respect the right of each individual to safeguard his personal integrity, especially if the subject is in a dependent relationship to the investigator.

4b. At any time during the course of clinical research the subject or his guardian should be free to withdraw permission for research to be continued. The investigator or the investigating team should discontinue the research if in his or their judgment it may, if continued, be harmful to the individual.

Therapeutic Abortion

In 1970 the World Medical Association drew up a Statement on Therapeutic Abortion. This code, known as the **Declaration of Oslo**, states:

1. The first moral principle imposed upon the doctor is respect for human life as expressed in a clause of the Declaration of Geneva: "I will maintain the utmost respect for human life from the time of conception."

2. Circumstances which bring the vital interests of a mother into conflict with the vital interests of her unborn child create a dilemma and raise the question whether or not the pregnancy should be deliberately terminated.

3. Diversity of response to this situation results from the diversity of attitudes towards the life of the unborn child. This is a matter of individual conviction and conscience which must be respected.

4. It is not the role of the medical profession to determine the attitudes and rules of any particular state or community in this matter, but it is our duty to attempt both to ensure the protection of our patients and to safeguard the rights of the doctor within society.

5. Therefore, where the law allows therapeutic abortion to be performed, or legislation to that effect is contemplated, and this is not against the policy of the national medical association, and where the legislature desires or will accept the guidance of the medical profession the following principles are approved:

(a) Abortion should be performed only as a therapeutic measure.

(b) A decision to terminate pregnancy should normally be approved in writing by at least two doctors chosen for their professional competence.

(c) The procedure should be performed by a doctor competent to do so in premises approved by the appropriate authority.

6. If the doctor considers that his convictions do not allow him to advise or perform an abortion, he may withdraw while ensuring the continuity of (medical) care by a qualified colleague.

7. This statement, while it is endorsed by the General Assembly

of the World Medical Association, is not to be regarded as binding on any individual member association unless it is adopted by that member association.

Ethics of Transplantation

The Council of the B.M.A. has given the most careful consideration to the ethical aspects of organ transplantation and is confident that the advice contained in this statement, as well as providing guidance for the medical profession, will reassure the public that the procedures involved in tissue transplantation are not embarked upon lightly by doctors and that the utmost care is taken to protect the interests and sensibilities of all the parties concerned in such operations.

Organs from Live Donors

The existing code covering surgical procedures provides adequate safeguards for the interests of live donors. Written consent should be obtained from the donor after a full explanation of the procedure involved, and the possible consequences to the donor. Where appropriate, the donor should be advised to discuss the procedure with his or her relatives, religious advisers, and other persons of standing, who, in turn, should be given every facility to meet the medical attendants if they so wish. (The pamphlets "Consent to Treatment" published by the Medical Defence Union and by the Medical Protection Society contain comprehensive advice on procedures for obtaining consent.)

Organs from Cadavers

A. *Valid Consent*

(i) Valid consent must have been obtained before organs are removed from a cadaver or immunological studies carried out on a prospective "donor".

(ii) Consent is only valid if:

(a) The deceased had given prospective, written consent to organ donation; or

(b) A close relative can affirm that the deceased had previously clearly indicated that he or she would have no objection to such donation, AND the next-of-kin gives written consent. It is also necessary to bear in mind the additional obligations in respect of minors.

(iii) In the present state of the law it is also necessary to obtain the consent of the person lawfully in possession of the body. (Human Tissue Act, 1961, 1 (3).)

(iv) Again, tissue may not be removed if there is reason to believe that a Coroner may require an inquest or a post-mortem examination. (Human Tissue Act, 1961, 1 (5).)

Timing of Consent. The Council has been advised that immunological studies may be necessary during the terminal illness of the prospective donor. It may, therefore, be not only convenient but indeed desirable to obtain the necessary consent before death has taken place. Where, on the other hand, it is considered preferable to carry out such studies before broaching the matter to the next of kin, there need be no ethical objection, provided the studies are not of such a nature as to "weaken the physical or mental resistance" of the prospective donor. (Declaration of Geneva—English Text, see p. 2.) The transfer of a desperately ill prospective donor to another hospital simply to be near the recipient is ethically unacceptable.

B. *Determination of Moment of Death*

(i) *Criteria*

The World Medical Association formulated a Statement on Death, in August 1968. This statement, known as the **Declaration of Sydney,** is given below:

> The determination of the time of death is in most countries the legal responsibility of the physician and should remain so. Usually he will be able without special assistance to decide that a person is dead, employing the classical criteria known to all physicians.
>
> Two modern practices in medicine, however, have made it necessary to study the question of the time of death further: (1) the ability to maintain by artificial means the circulation of oxygenated blood through tissues of the body which may have been irreversibly injured and (2) the use of cadaver organs such as heart or kidneys for transplantation.
>
> A complication is that death is a gradual process at the cellular level with tissues varying in their ability to withstand deprivation of oxygen. But clinical interest lies not in the state of preservation of isolated cells but in the fate of a person. Here the point of death *of the different cells and organs* is not so important as the certainty that the process has become irreversible by whatever techniques of resuscitation that may be employed. This determination will be based on clinical judgment supplemented *if necessary* by a number of diagnostic aids of which the electroencephalograph is currently the most helpful. However, no single technological criterion is entirely satisfactory in the present state of medicine nor can any one technological procedure be substituted for the overall judgment of the physician. *If transplantation of an organ is involved, the decision that death exists should be made by two or more physicians and the physicians determining the moment of death should in no way be immediately concerned with the performance of the transplantation.*
>
> Determination of the point of death of the person makes it ethically permissible to cease attempts at resuscitation and in countries

where the law permits, to remove organs from the cadaver provided that prevailing legal requirements of consent have been fulfilled.

(ii) *Qualifications of Certifying Practitioners*

Pronouncement of death should be undertaken by two fully registered practitioners each *independent* of the team undertaking the transplant operation, and at least one of the two practitioners must have been fully registered for five years or more.

C. *Corneal Grafting*

In the case of removal of corneae for grafting there is not the same urgency as for internal organs, and the Council is anxious not to disturb long-established procedures. Formal consent has sometimes been given by the donor during his lifetime (further information is available on request from the Secretary of the Association). In fact most corneae for grafting are obtained from patients dying in hospital, after consent as above.

With reference to the point of death, however, the Council considers that the opinion of the attending practitioner, supplemented by personal examination by the practitioner proposing to carry out the enucleation (Human Tissue Act, 1 (4)), should be sufficient medical authority in such cases.

Publicity

A. *Lay*

The Association's Report on "Advertising and the Medical Profession" was revised in 1968 and 1974 (see p. 38). Doctors are reminded that every precaution should be taken to protect the anonymity of patients, whether donors or recipients. Much distress has in the past been caused to the relatives of donors, following their own consent lightly given, by reason of publicity far beyond what they might reasonably have expected, and it is wise to mention this aspect to them.

Equally, excessive publicity might well occasion feelings of guilt in the recipient.

B. *Professional*

Renal transplantation is now a standard surgical procedure, but it has been drawn to the attention of the Council that the programme is now seriously behind, because of lack of organs from donors.

Though renal transplantation operations are actually performed in a relatively few centres in this country, there is scope for a much greater *collection* service. Subject to the above safeguards the profession is therefore asked to bear this need in mind when appropriate cases present.

Future Development

The Council is aware that the advances in transplantation techniques which are bound to take place in the future will necessitate a regular review of ethical considerations to ensure that the best interests of both potential donors and recipients are protected, and this it proposes to do.

Artificial Feeding of Prisoners

The following statement was adopted by the Representative Body in 1974 as representing policy of the Association on this subject:

"The procedure of artificial feeding of prisoners weakened by self-starvation has been in existence for many years. The Home Secretary has stated recently in the House of Commons that it is a long-held view that a Prison Medical Officer would be neglecting his duty if he let the health of a prisoner on hunger-strike in his charge be endangered without attempting to help.

The Association considers that this help may take several forms and must always include an explanation to the prisoner of the effects of self-starvation upon his health. On rare occasions the desirability of artificial feeding will have to be considered. In this procedure a Prison Medical Officer must be given complete clinical independence in deciding for or against the course of action under consideration. The priority between an obligation to preserve life and an acquiescence with the prisoner's wishes is one which doctors may assess differently, with equal sincerity, and the decision must take account of the prisoner's physical and mental state as well as the wishes which he may have expressed upon the subject.

The Association has been asked to condemn artificial feeding, which it is alleged is unethical and constitutes 'torture'. As far as ethics are concerned, attention is drawn to these extracts from the Declaration of Geneva (1947) of the World Medical Association: 'The health of my patient will be my first consideration.'

'I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.'

The International Code of Medical Ethics, based upon the Declaration of Geneva, applies both in time of peace and of war. The English text of the International Code includes the following statement: 'A doctor must always bear in mind the obligation of preserving human life.'

The crucial question for decision is whether a doctor ought to stand by and do nothing in a case of what could be tantamount to attempted suicide, even though the consent of the patient has not been given to the intended treatment considered necessary as a result of his own expressed wish.

The Association understands that the total of cases in this country over the past forty years is small and that most of those prisoners

have been psychiatrically disturbed. In the majority of those cases, there has been reasonable co-operation in being artificially fed. It is stressed that some psychiatrically disturbed patients may deteriorate physically very quickly unless fed artificially, but it is possible to identify a few prisoners who refuse food but who do not at the outset show any signs of serious physical or mental illness. In the case of those patients many doctors would agree that particular attention should be given to respecting their wishes, provided that they are aged 16 or over and of sufficiently sound mind to understand fully the consequences of their decision to withhold consent to and co-operation with artificial feeding. Contrary to some reports, and after careful investigation, the Association is satisfied that Prison Medical Officers *do* have complete freedom of clinical judgment on this as on all other matters involving medical care of patients. The doctor must always bear in mind the above quoted obligation to preserve human life; the final decision must be for him to make, and it is not for some outside person to seek to override the clinical judgment of the doctor by imposing his own decision upon the case in question.

The President of the General Medical Council has stated that in his personal opinion the participation by a doctor in procedures designed to feed a prisoner against his wishes, provided that such procedures were lawful and designed to preserve a prisoner's health, would not be regarded by the Council as serious professional misconduct. Equally, however, if a doctor felt that it was ethically repugnant to participate in the artificial feeding of a prisoner against his or her wishes, a refusal by the doctor to take part in such procedures would not be regarded as serious professional misconduct. These views were expressed in relation to the issue of serious professional misconduct, but the Association welcomes them as consistent with its own view of the importance of preserving freedom for individual clinical decision by the doctor concerned.

It has been alleged that artificial feeding constitutes 'torture'. A line should however be drawn between on the one hand the consequences of a voluntary act (perhaps to seek amelioration of the rigours of imprisonment) by a prisoner who has been properly tried and sentenced in this country, and, on the other hand, deliberate physical or mental torture by a totalitarian authority with the object of obtaining information from subjects who have not been tried in a normal Court of Law. The condemnatory views of the Association on the latter aspect have already been communicated to the World Medical Association.

Applicants for a post as Prison Medical Officer should be made aware that they may have to make a decision upon such a difficult issue as the initiation and continuation of artificial feeding, and this could be an important factor in deciding whether or not they proceed with their application for the post. In the meantime, Prison Medical Officers now in post should continue to carry out their duties as formerly.

The Association welcomes the statement made by the Home Secretary in the House of Commons on 23 May 1974 that he is considering the broader implications of this subject, and it would be glad to assist him in any way."

Individual Responsibility

Formulation of rules is one thing, observance of them in the rough and tumble of professional practice is quite another. A measure of the integrity of the medical profession is to be found in the degree to which each practitioner recognizes his personal responsibility for the preservation, through his own example, of the honour and dignity of the profession, and the fact that serious breaches of its ethical code are relatively rare.

The value of mutual goodwill and tolerance in the brotherhood of medicine cannot be over-emphasized. Some pertinent words in this connection were written by the late Dr. C. O. Hawthorne, who was one of the great personalities in the Association during the inter-war period and Chairman of its Central Ethical Committee for many years:

> "In the relations of the practitioner to his fellows, while certain established customs and even rules are written and must be written, the principal influence to be cultivated is that of good fellowship. Most men know what is meant by 'cricket' and the spirit of the game. Difficulties and differences will arise, but most of them can be successfully met by mutual goodwill and recognition of the other fellow's point of view."

The B.M.A. and Medical Ethics

While a formal code of ethics may provide the doctor with a standard, problems will always arise in the course of his professional work on which he needs specific guidance. They may occur, for example, in the setting up of a practice, in his relationship with colleagues, in dealings with official bodies, in contact with the general public, and in numerous other ways. One of the most important functions of the British Medical Association is to advise and assist its members on ethical problems.

Since its foundation in 1832 the Association has amassed a vast store of knowledge and experience which is freely available to its members. The Council appoints a Standing Committee to concern itself expressly with problems of medical ethics, and it has devised what is known as "ethical machinery" for the resolution of disputes between members of the profession. From time to time particular questions of principle or policy become the subject of controversy or special interest, and after debating them, the Council and the Representative Body arrive at decisions that serve as a guide to the profession generally. In the following pages the Council has brought together from the numerous sources at its disposal some statements of policy

definitions and rules to illustrate the practical application of ethical principles.

A member of the Association who has any doubt on the line of conduct he should adopt in any professional difficulty is urged to seek advice from the Secretary of the Association. A full and frank statement of the facts of the problem written in legible handwriting or preferably typed is of great assistance to the Secretary in formulating and issuing a suitable reply.

II. Professional Confidence

N.B.—The following notes set out the broad principles which it is recommended that members should follow when seeking guidance on confidentiality. Readers are reminded that in a short section of this nature it is impossible to cater for every circumstance that may arise.

1. The English text of the International Code of Medical Ethics, which stems from the Hippocratic Oath as revised by the W.M.A. in 1947, states "a doctor shall preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him". This forms the basis of the doctor/patient relationship. On the doctor's side an awareness of the patient's trust serves to invoke the observance of ethical standards and the need to act always in the best interests of the patient. The principles are set out in the following terms:

A. *General*

(i) It is a doctor's duty (except as below) strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party, information which he has learned directly or indirectly in his professional relationship with the patient. The death of the patient does not absolve the doctor from the obligation to maintain secrecy.

(ii) There are some exceptions to this principle: if the doctor is in doubt before making any such exception in disclosing information he should seek advice from his defence organization, the B.M.A. or an experienced colleague. The exceptions to the general principle are: (a) the patient or his legal adviser gives valid consent; (b) the information is required by law; (c) the information regarding a patient's health is given in confidence to a relative or other appropriate person, in circumstances where the doctor believes it *undesirable on medical grounds* to seek the patient's consent; (d) rarely, the public interest may persuade the doctor that his duty to the community may override his duty to maintain his patient's confidence; (e) information may be disclosed for the purposes of any medical research project specifically approved for such exception by the B.M.A. including information for cancer registration.

(iii) If, in the doctor's opinion, disclosure of confidential information

to a third party is in the best interests of the patient, it is the doctor's duty to make every reasonable effort to persuade the patient to allow the information to be so given. If the patient still refuses, then only very exceptionally will the doctor feel entitled to overrule that refusal. Again if in doubt, he should seek advice as above.

(iv) A doctor should be prepared to justify his action in disclosing confidential information.

B. *Minors*

(v) Section 8 of the Family Law Reform Act 1969 provides that the consent to treatment by a minor of 16 years shall be effective consent. A person having reached the age of consent to treatment is entitled to appropriate professional confidence.

(vi) When the patient is under 16 the doctor should act with the consent of the parent or legal guardian, but there may be occasions when his duty to the patient, a minor, conflicts with his obligation to the parent. In such cases the doctor, if in any doubt, should seek advice (as in A (ii) above).

C. *Others*

(vii) In the case of a person too ill to comprehend the situation, or incapable of giving valid consent to the disclosure of confidential information, consent should be sought where possible from the appropriate relative, guardian or legal adviser.

Courts of Law

2. The doctor's usual course when asked in a court of law for medical information concerning a patient in the absence of that patient's consent is to demur on the ground of professional secrecy. The court, however, may overrule this contention and direct the medical witness to supply the required information. The doctor must then decide whether or not to obey the court knowing that his refusal may lead to a fine or imprisonment or both.

3. Where a suspect refuses consent to a medical examination, the doctor, unless directed to the contrary by a court of law, should refuse to make any statement based on his observation of the suspect other than to advise the police whether or not the suspect appears to require immediate treatment or removal to hospital. This does not, of course, preclude the doctor from making a statement in court based on such observation in circumstances where the accused later gives his consent to disclosure.

4. Generally speaking, the State has no right to demand information from a doctor about his patient save when some notification is required by statute, as in the case of infectious disease. There is no legal compulsion upon him to provide information concerning criminal abortion or venereal diseases. When in doubt concerning matters that

have legal implications a doctor would be wise to consult his defence organization.

5. The administration of the Welfare State has brought doctors into close contact with government departments, hospital boards and many other bodies composed partly or wholly of non-medical persons, with the result that requests are made by both medical and lay officials for clinical records or other information concerning patients. The Representative Body has passed the following resolutions relating to this problem:

A.R.M. Resolutions

(i) That this Meeting considers that wherever practicable the exchange of medical details concerning patients should take place only between doctors and deplores the increasing tendency to exchange confidential medical details with lay persons. (A.R.M. 1955.)

(ii) Medical records should be lent to the medical officers employed by government departments only when written consent has been given by or on behalf of the patient. (A.R.M. 1955.)

(iii) Wherever practicable, and particularly where disclosure of information may have an adverse psychological effect upon the patient, the practitioner who compiled the record or, if he is not available, one nominated by the hospital authority for the purpose, should be consulted on the wisdom of disclosing to the patient all of the confidential information contained therein, and should take the opportunity of reviewing the notes before they leave the hospital. (A.R.M. 1955.)

(iv) That this Meeting agrees with the principle that specialists and general practitioners should not comply with requests from lay officials of local authorities for reports, as such requests should be made through the Medical Officer of Health.* (A.R.M. 1968.)

(v) That medical information should be absolutely confidential between doctor and patient and should only be divulged to para medical workers working in direct professional relationship with the doctor. (A.R.M. 1969.)

6. Other third parties who frequently seek information from a doctor are employers who request reports on the medical condition of absent or sick employees, insurance companies requiring particulars about the past history of proposers for life assurance or deceased policy holders and solicitors engaging in threatened or actual legal proceedings. In all such cases where medical information is sought the doctor should refuse to give any information in the absence of the consent of the patient. B.M.A. policy established by the A.R.M. in 1962 is that

* Now the appropriate community physician.

practitioners be strongly recommended not to issue "duration certificates". Any practitioner experiencing difficulty in implementing this recommendation is advised to consult the B.M.A.

Social Workers

7. The British Association of Social Workers was inaugurated in June 1970. That Association has not yet found it possible to promulgate an enforceable Code of Ethics. At the time of writing representatives of the B.M.A. are still discussing with the representatives of the B.A.S.W. a draft code of ethics for social workers.

8. "The tradition which leads to the present difficulties is understandable but it derives from views of professional practice that are increasingly anachronistic". This (the first sentence of paragraph 657 of the Report of the Committee on Local Authority and Allied Personal Social Services (Seebohm Report), Cmd 3703, H.M.S.O., July 1968) is not accepted by the B.M.A. It is accepted that a doctor's view about the strict confidentiality of knowledge he has about his patient is matched by equally stringent codes of practice in other professions regarding the information about clients and customers contained in their files. Nevertheless, pending joint consultation along the lines suggested in paragraph 662 of the Seebohm Report* doctors should continue to exchange medical information on a doctor-to-doctor basis, employing the good offices of the appropriate community physician in this respect.

Hospital Reports

9. Doubt sometimes arises about the propriety of hospital doctors sending copies of letters addressed to family doctors, concerning children, to colleagues in the School or other Community Child Health Services. The appropriate community physicians (e.g. the Area Medical Officer (Chief Administrative Medical Officer in Scotland and Northern Ireland) and the Specialists in Community Medicine (Child Health)) and their supporting medical staff have statutory responsibilities under the maternity and child health provisions and towards children attending local authority schools. Moreover, consultation with a specialist at a hospital or school may be initiated at a Child Health or School Clinic medical examination. It is the view of the B.M.A. that it is usually in the interests of the patient that the appropriate community physician should be informed of relevant matters concerning these

* 662. A new code of practice is essential to meet the changing situation and we think the professions concerned should initiate discussions among themselves, and with members of the public, through which such a code could be formulated. We accordingly recommend that the professional organisations most concerned take the lead in this development. It would then be for the central and local government and other agencies concerned to provide the administrative framework through which the code could operate for the benefit of all concerned.

patients and vice versa, but discretion should always be used. Transmission of confidential information on a doctor-to-doctor basis is the important safeguard in preserving confidentiality of communications of this nature.

Medical Records—*Computers*

10. The above principles apply to the computerization of medical information about patients. The responsibility of a doctor for the safe custody of his confidential records is the same whether the records are conventional or kept in a computer.

11. A doctor whose records are kept in the conventional way can reasonably be expected to supervise the measures that are taken to safeguard them when they are kept, for example, in his own surgery. When they are kept in a hospital records department, the doctor is usually dependent upon the hospital records officer for an assurance that there are adequate arrangements to prevent improper access; the procedure adopted can be quite easily understood. In general, doctors in hospitals will take the confidentiality of hospital records departments on trust, but if they have doubt about it they are in a position to insist upon appropriate safeguards.

12. A doctor who is considering committing confidential medical information to a computer or another form of data recording machine, should bear in mind that in the end he is responsible for the results of his decision. It follows that before such information is recorded the doctor should have an assurance that disclosure will be possible only to the people and to the extent that he has decided, and that the technical resources of the system will be properly used to ensure this result. He need not necessarily understand the technicalities of the system but he should be satisfied (as far as is reasonably possible) that the person from whom he has the assurance of confidentiality is competent and trustworthy.

13. It is considered that there is need, which is becoming increasingly urgent, for statutory sanctions to protect the confidentiality of sophisticated methods of keeping records.

14. The British Medical Association's Planning Unit has prepared a Report on Computers in Medicine (1969), and the Council endorses whole-heartedly chapter 5 of this Report which discusses in detail ethical problems associated with this complex field. Copies of this Report are available on application to the Secretary, price 25p.

15. The following Resolutions on "Medical Secrecy" and on "Computers in Medicine" were adopted by the World Medical Association in 1973:—

(*a*) Medical Secrecy:

"WHEREAS: The privacy of the individual is highly prized in most societies and widely accepted as a civil right; and

WHEREAS: the confidential nature of the patient-doctor relationship is

regarded by most doctors as extremely important and is taken for granted by the patient; and

WHEREAS: there is an increasing tendency towards an intrusion on medical secrecy;

THEREFORE BE IT RESOLVED that the 27th World Medical Assembly reaffirm the vital importance of maintaining medical secrecy not as a privilege for the doctor, but to protect the privacy of the individual as the basis for the confidential relation between the patient and his doctor; and ask the United Nations, representing the people of the world, to give to the medical profession the needed help and to show ways for securing this fundamental right for the individual human being;"

(*b*) Computers in Medicine:

"BE IT RESOLVED that the 27th World Medical Assembly

1. draw the attention of the peoples of the world to the great advances and advantages resulting from the use of computers and electronic data processing in the field of health, especially in patient care and epidemiology;
2. request all national medical associations to take all possible steps in their countries to assure that medical secrecy, for the sake of the patient, will be guaranteed to the same degree in the future as in the past;
3. request member countries of W.M.A. to reject all attempts having as a goal legislation authorizing any procedures to electronic data processing which could endanger or undermine the right of the patient for medical secrecy;
4. express the strong opinion that medical data banks should be available only to the medical profession and should not, therefore, be linked to other central data banks; and
5. request Council to prepare documents about the existing possibilities of safeguarding legally and technically the confidential nature of stored medical data."

III. The Doctor's Practice

Setting up in Practice

The legal agreement commonly entered into by a principal and his partner, assistant or locum tenens usually contains some reference to the position concerning the practice should the second doctor leave and wish to continue to practise in the same area. The relevant paragraph from the Association's model agreement between principals and assistants reads as follows:

"12(*a*) *The Assistant hereby further agrees with the Principal that he will not within the specified period (as herein after defined) commencing on the date of the termination of his employment hereunder (however the same may come to an end):*

(i) *Anywhere within . . . miles from the building known as . . . provide any professional medical service of a kind normally*

provided by a general medical practitioner to any person who at the time of providing such service is ordinarily resident within the said area and who either (a) was at the date of such termination a patient of the Principal or (b) was at any time within the period of six months prior thereto or the period since the Assistant commenced employment hereunder (whichever is the shorter) a patient of the Principal or to anyone who is for the time being a member of the household of any such person (being a household within the said area);

(ii) *Make use of his knowledge of the identity or affairs of any person who either (a) was at the date of such termination a patient of the Principal or (b) was at any time within the period six months prior thereto or the period since the Assistant commenced employment hereunder (whichever is the shorter) a patient of the Principal (being knowledge acquired in the course of his employment hereunder) for his own advantage as a general medical practitioner or for the advantage of another general medical practitioner or practitioners and to the detriment of the business or practice of the Principal as a general medical practitioner;*

(iii) *Apply for accept or hold any part-time professional medical appointment (including an honorary appointment) the activities of which cover or are normally carried on in any part of the area within . . . miles from the building known as . . . being an appointment . . .*

(a) which shall at any time during the employment of the Assistant hereunder have been held by the Principal or by the Assistant and whether as the holder of such appointment or as deputy for such holder and

(b) which is capable of being held by a general medical practitioner while in general practice and

(c) for which the Principal is an applicant.

"*(b) The expression 'specified period' as used in subclause (a) above shall mean the period of three years save that:*

(i) *Where less than three months employment thereunder shall have been completed prior to the date of termination as aforesaid it shall mean the period of one year;*

(ii) *where three months or more but less than six months employment hereunder shall have been completed prior to the date of termination as aforesaid it shall mean the period of eighteen months;*

(iii) *where six months or more but less than twelve months employment hereunder shall have been completed prior to the date of termination as aforesaid it shall mean the period of two years.*

"*(c) The word 'patient' as used in subclause (a) above shall include*

any person who is at the material time on the National Health Service list of the Principal.

"*(d) For the avoidance of doubt it is hereby declared that it shall not be a breach of any provision of this clause for the Assistant after the termination of his employment hereunder to render professional services as a consultant or specialist at the request of or in consultation with a patient's general medical practitioner.*

. . . . . .

"*(g) Where the Principal as defined in the first paragraph of this deed is more than one doctor the Assistant further agrees that the agreements contained in this clause shall be with each of the doctors named in the first paragraph of this deed so that each of such doctors shall be entitled to enforce the same but only so long as the doctor who is desiring to enforce the same has an interest in the goodwill of a partnership with the other or others.*"

There is an ethical obligation on a doctor not to damage the practice of a colleague with whom he has been engaged lately in professional association. A course of action taken by a doctor may be neither contrary to the law nor to the regulations governing the National Health Service, yet may be considered unethical by his colleagues to such a degree as to constitute grounds for a formal complaint to the Association.

Notices

From time to time it may happen that a doctor, whether in general or consultant practice, wishes to make some formal announcement about his practice to his patients or his colleagues. A general practitioner, for example, may need to notify his patients of a change of address or of surgery or consulting hours, or perhaps he may be changing to consultant practice. In any such case the notification should be sent as a circular letter, under cover, to the patients of the practice, this is, to those who are on its books and are not known to have transferred themselves to another doctor. There is no objection to a suitable notice being placed in the waiting room.

On no account should the lay Press be used for the purpose of making an announcement. Even if a rumour or an ill-informed statement in a newspaper appears to require correction, the doctor should still refrain from making any comment in the Press.

This policy was endorsed by the Representative Body in 1936 and a revised report by the Council on the broader subject of advertising and the medical profession was approved by the Representative Body in 1968 and 1974 (see p. 38).

A Consultant beginning practice in a particular specialty in, or transferring to, a new area must not make any public announcement of the fact. He may, however, notify colleagues of his availability for private consultations in accordance with the following statement of policy approved by the Representative Body in 1966:

A practitioner who wishes to draw the attention of his colleagues to the fact that he has commenced private practice in a particular specialty may send a sealed postal notification to those practitioners who might normally be expected to be interested. The notification should be limited to the following information:

(1) The name of the practitioner.
(2) Medical qualifications (degrees or diplomas).
(3) Title of main specialty.
(4) Home address and telephone number.
(5) Address and telephone number of main consulting premises where private appointments can be arranged.

Premises

In selecting premises for his surgery a doctor should preserve the dignity of his profession and bear in mind certain ethical considerations. It is undesirable to establish a surgery in a hotel or in the same premises as a chemist's shop. There may occasionally be special circumstances in which a modification of this rule is justified, but even then a separate entrance should be arranged and there must not be internal communication.

Location of Surgeries, including Sharing of Premises

The sharing of premises with members of allied professions, including professions supplementary to medicine, has been discouraged for many years. This attitude has been based on the overriding desire to prevent any infringement of the principle of free choice by the patient and to avoid situations which might encourage unethical practices. Advances in clinical medicine have brought with them changes in the structure of medical practice, and the present trend is towards closer integration of the various branches. The following statement has been prepared as a guide to those who may be contemplating the sharing of premises with members of other professions or who have problems connected with the location of surgeries.

Location of Surgeries, including Sharing of Professional Accommodation with Dental Practitioners and Members of the Professions Supplementary to Medicine

Buildings: There is no objection to a doctor's surgery being located in a large building such as an office block, provided that the doctor's rooms are entirely self-contained and that it is not necessary for the patients to pass through the premises of other tenants in the building in order to obtain access to or from the surgery. There can be no objection to doctors and members of such professions practising from the same building in circumstances where the professional premises are

separate and where there are separate entrances and addresses. The location of surgeries in hotels or in other buildings which are extensively used by the general public for commercial purposes is to be discouraged.

Premises: The sharing of premises within the building by doctors and members of such professions is not undesirable unless improper advantage is taken of the arrangement, e.g. undue direction of patients or other unethical practices. In making such an arrangement the following advice should be followed:

1. Consulting and treatment rooms should not be shared and the sharing of waiting-rooms should be avoided wherever possible.
2. Other doctors in the area should be informed of the proposals and advised that there is no professional partnership. It would be wise to take cognizance of any objections raised by colleagues in the area.
3. The doctor should take the greatest possible care before accepting another doctor's patient who is attending, or has attended, his premises for the purpose of treatment by members of such professions.

Sharing of Professional Accommodation with other Doctors Outside Partnerships and Group Practices

There need be no objection to the sharing of premises by general practitioners with specialists provided there is no direction of patients, either directly or indirectly, which might be contrary to acknowledged ethical principles.

If such sharing is contemplated other doctors in the area should be informed of the proposed arrangements and the local Division of the B.M.A. consulted in case of difficulties.

Sharing of Group Practice Premises with Consultants

The Council in 1965 advised doctors proposing to share group practice premises with local consultants that, before such an arrangement is entered into, the facilities should be made available equally to all local consultants and the proposal should be abandoned if any exception is taken by professional colleagues in the area.

Door Plates

The door plate on a doctor's house or branch surgery is the means by which he indicates to the passing public his availability as a medical practitioner. It should be unostentatious in size and form, and it may bear the doctor's name, qualifications and, in small letters, his surgery hours. Notices regarding special surgery hours for ante-natal care or children are more appropriate in the waiting room. There should not be on the door plate additional descriptive wording such as "Psychiatrist" or "Consulting Surgeon", though there is no objection to the inclusion of a higher qualification, such as "F.R.C.S.". The

purpose of this rule is to avoid self-advertisement and also to prevent interference with the normal procedure of the consultant receiving patients only through the recommendation of a general practitioner.

A doctor should not put up a name plate on premises he proposes to occupy at some future date.

Where it is considered necessary for an assistant to have his own name plate, the assistant's name should appear in conjunction with the name of his principal and the normal rules relating to plates continue to apply.

A trainee should not have a door plate.

Telephone Directories

Doctors are sometimes uncertain about the form of entry they should allow in telephone directories. The rule is that the entry should appear in the ordinary small type. No special type or special entry should be permitted. There is no objection to the inclusion of a higher qualification, such as F.R.C.S., or in the case of a consultant, his specialty.

Professional telephones are rented at the business rate and the names of all doctors are listed in the Classified (Trades and Professions) Telephone Directory under the heading "Physicians and Surgeons". There is no objection to this on ethical grounds.

Local Directories

It is permissible for a doctor's name to be included in a handbook of local information, purporting to contain a list of all local medical practitioners, provided that the list is open to the whole of the profession in the area, publication of names is not dependent on the payment of a fee and the names are included under a single heading without any indication of specialties.

IV. The Doctor and his Colleagues

Modern medicine cannot be practised by a doctor in isolation. He is in continual contact with his colleagues for many purposes. He may need to have a patient examined by a consultant; it may be necessary for a patient to be examined by a medical officer representing some third party; or if the patient is in industrial employment a medical officer at his place of work may have a continuing interest in his health. Whenever two doctors are simultaneously concerned with a patient each is under certain ethical obligations and is expected to observe certain ethical rules of conduct. The Council has compiled a code of recommendations to guide the practitioner who may be called upon to examine another doctor's patient.

Examination in Consultation

The custom of consultation is very old, and through the years the profession has evolved a mode of conduct that should be followed meticulously. Failure to observe the established procedure may lead

to difficulties or unpleasantness between doctors. In 1950 the Representative Body endorsed the following series of resolutions drawn up initially by the Central Ethical Committee of the Association.

1. A practitioner consulted is a practitioner who, with the acquiescence of the practitioner already in attendance, examines a patient under this practitioner's care and, either at a meeting of the two practitioners or by correspondence, co-operates in the formulation of diagnosis, prognosis, and treatment of the case. The term "consultation" means such a co-operation between practitioners. In domiciliary consultations it is desirable that both practitioners should meet and in other circumstances similar arrangements should obtain wherever practicable.

2. It is the duty of an attending practitioner to propose a consultation where indicated, or to acquiesce in any *reasonable* request for consultation expressed by the patient or his representatives.

3. The attending practitioner should nominate the practitioner to be consulted, and should advise accordingly, but he should not unreasonably refuse to meet a registered medical practitioner selected by the patient or by the patient's representatives, although he is entitled, if such is his opinion, to urge that the practitioner selected has not the qualifications or the experience demanded by the particular requirements of the case.

4. The arrangements for consultation should be made or initiated by the attending practitioner. The attending practitioner should ascertain in advance the amount of the fee, if any, to be paid to the practitioner consulted, and should inform the patient or his representatives that this should be paid at the time of the consultation.

5. In cases where the consultant and the attending practitioner meet and personally examine the patient together, the following procedure is generally adopted and should be observed, unless in any particular instance there is substantial reason for departing from it:

(*a*) All parties meeting in consultation should be punctual, and if the attending practitioner fails to keep the appointment the practitioner consulted, after a reasonable time, may examine the patient, and should communicate his conclusions to the attending practitioner in writing and in a sealed envelope.

(*b*) If the consultation takes place at the patient's residence, the attending practitioner should, on entering the room of the patient, precede the practitioner consulted, and after the examination the attending practitioner should be the last to leave the room.

(*c*) The diagnosis, prognosis, and treatment should be discussed by the practitioner consulted and the attending practitioner in private.

(*d*) The opinion on the case and the treatment as agreed should be communicated to the patient or the patient's representatives where practicable by the practitioner consulted in the presence of the attending practitioner.

(*e*) It is the duty of the attending practitioner loyally to carry out the measures agreed at, or after, the consultation. He should refrain from making any radical alteration in these measures except upon urgent grounds or after adequate trial.

6. If for any reason the practitioner consulted and the attending practitioner cannot examine the patient together, the attending practitioner should send to the practitioner consulted a brief history of the case. After examining the patient, the practitioner consulted should forward his opinion, together with any advice as to treatment, in a sealed envelope addressed to the attending practitioner. He should exercise great discretion as to the information he gives to the patient or the patient's representatives and, in particular, he should not disclose to the patient any details of any medicaments which he has advised.

In cases where the attending practitioner accepts the opinion and advice of the practitioner consulted he should carry out the measures which have been agreed between them; where, however, the attending practitioner finds he is in disagreement with the opinion and advice of the practitioner consulted he should by suitable means communicate his disagreement to the practitioner consulted.

7. Should the practitioner consulted and the attending practitioner hold divergent views, either on the diagnosis or on the treatment of the case, and should the attending practitioner be unwilling to pursue the course of action advised by the practitioner consulted, this difference of opinion should be communicated to the patient or his representatives by the practitioner consulted and the attending practitioner jointly, and the patient or his representatives should then be advised either to choose one or other of the suggested alternatives or to obtain further professional advice.

Note.—In the following circumstances it is especially desirable that the attending practitioner should endeavour to secure consultation with a colleague.

(*a*) When the propriety has to be considered of performing an operation or of adopting some course of treatment which may involve considerable risk to the life of the patient or may permanently prejudice his activities or capacities and particularly when the condition which it is sought to relieve by this treatment is not itself dangerous to life;

(*b*) When any procedure likely to result in death of a foetus or of an unborn child is contemplated, especially if labour has not commenced;

(*c*) When continued administration of any drug of addiction is deemed desirable for the relief of symptoms of addiction;

(*d*) When there is reason to suspect that the patient (i) has been subjected to an illegal operation, or (ii) is the victim of criminal poisoning or criminal assault.

8. Arrangements for any future consultation or additional investigation should be effected only with the foreknowledge and co-operation of the attending practitioner.

9. The practitioner consulted should not attempt to secure for himself the care of a patient seen in consultation. It is his duty to avoid any word or action which might disturb the confidence of the patient in the attending practitioner. The practitioner consulted should not communicate with the patient or the patient's representatives subsequent to the consultation except with the consent of the attending practitioner.

10. The attending practitioner should carefully avoid any remark disparaging the skill or judgment of the practitioner consulted.

11. Except by mutual consent the practitioner consulted shall not supersede the attending practitioner during the illness with which the consultation was concerned (see also next section).

Acceptance of Patients

Any individual is at liberty to exercise freedom of choice in selection of medical advice and he is not bound by ethical rules in doing so—it is doctors who are so bound. A patient on a N.H.S. list, and who is not under the clinical care of the N.H.S. doctor concerned, is free to select a private practitioner and receive treatment. Similarly, a patient who has at some time in the past been treated by a private practitioner and is not at the time under his clinical care may apply to a N.H.S. G.P. for acceptance and treatment.

Occasionally, the examination of another doctor's patient may result in the patient being attracted to the examiner's own practice. The Representative Body, summarizing for the guidance of the profession the situations in which this might occur, has expressed the opinion that a practitioner ought not to accept as his patient, save with the consent of the colleague concerned:

(1) Any patient or member of a patient's household whom he has previously attended either as a consulting practitioner or as a deputy for a colleague.

(2) Any patient or member of the patient's household whom he has attended within the previous two years in the capacity of assistant or locum tenens.

(3) Any patient under active* treatment by a N.H.S. G.P. who applies to a private practitioner for treatment. The private practitioner must conform to the other provisions in this section and is in a position to refuse treatment if the patient will not advise the N.H.S. doctor that he is no longer required.

(4) Any patient who so applies because his regular medical attendant is temporarily unavailable. In such case he should render whatever treatment for the time being may be required, and should subsequently notify the patient's regular attendant of the steps he has taken.

A patient under active treatment by a private practitioner may apply

* The word "active" refers to the patient being at that time under the clinical care of the doctor.

to his N.H.S. G.P. for treatment. This G.P. is not in a position to refuse as this would constitute a breach of terms of service. Acceptance can only be along the lines laid down in this section. If the patient is unwilling to advise the private practitioner that his services are no longer required the G.P. is then left with no alternative except to follow the advice in the section on Professional Confidence (A(iii)). If the patient still refuses permission for the N.H.S. doctor to refer to the private practitioner, the N.H.S. doctor must decide whether the patient's best interests will be served by continuing treatment without reference to the private practitioner or not, but he will be under an obligation to give treatment. Common sense will dictate whether he himself will inform the private practitioner.

Ideally any new patient applying to any doctor for treatment at his first contact should be asked:

(a) Are you now under active treatment by any other doctor?
(b) Have you ever been treated by any other doctor? If so, for what and when?

It should be recognized that a truthful answer may or may not be received, but there is no solution to this. The use of personal cards for steroid, anticoagulant and similar treatment may go some way to protecting a patient's interests in this sort of circumstance.

A practitioner, in whatever form of practice, should take positive steps to satisfy himself that a patient who applies for treatment or advice is not already under the active care of another practitioner before he accepts him.

If he is so satisfied he may accept him as his patient, but his acceptance should be subject to the considerations set out below.

A practitioner in any form of specialist practice should not, except in circumstances stated below, accept a patient for examination and advice except on a reference from a general practitioner. If a specialist decides that it would be more appropriate for the patient to be examined not by himself but by a specialist in a different field of practice, the patient should be referred back to the general practitioner.

The specialist should ensure that the true position is ascertained at the time an appointment is booked and should ask that an introductory letter be brought.

Exceptions:

(*a*) Emergencies.
(*b*) Where previous inquiry indicates that the consultation is for refraction examination only.
(*c*) Where the specialist to whom a patient is referred wishes, as part of his management of the case, to obtain either a confirmatory opinion from another specialist or specialist opinion on a different aspect of the case—e.g. the advice of a radiologist or cardiologist.

(*d*) Reference by doctors in the School or other Community Child Health Services—after the general practitioner has been given the opportunity to refer the child himself.
(*e*) Consultations in venereology, either at clinics or in private.
(*f*) Overseas visitors having no family doctor in the United Kingdom.
(*g*) Where the delay in reference back to the general practitioner would be seriously detrimental to the patient and provided that in such a case the specialist informs the general practitioner at the earliest opportunity of the action he has taken and the reason for it.

After the consultation, where further medical care is indicated, and especially where such care is within the province of the general practitioner, the specialist should do all he can to persuade the patient to be referred to a general practitioner to whom a report and advice should be sent in the same way as if the consultation has arisen from a normal reference.

A general practitioner receiving such a report should be prepared to accept that the specialist is making a genuine attempt to establish a correct relationship between the patient and his doctor. (A.R.M. 1967).

Family Planning

The present situation is set out in a Health Service Circular issued by the Department of Health and Social Security in May 1974—the reference number is HSC(IS)32. Accompanying this Circular was a Memorandum of Guidance on the Family Planning Service and this provides much information, including in Paragraph 67 a list of Research References and Notes. Other subjects covered in the Memorandum of Guidance include Hospital, Family Practitioner and Domiciliary Services, Sterilisation, The Single, The Young, Communications, Publicity and Health Education.

Sterilisation

Since the M.D.U. first advised on this subject after taking leading Counsel's opinion in 1961, it is now accepted that sterilisation of the male or female is not unlawful whether it is performed on therapeutic, eugenic or any other grounds, provided that there is full and valid consent by the patient.

Recent legislation in the field of human sterilisation is to be found in the N.H.S. Reorganization Act 1973. Under the provisions of this Act:

"It shall be the duty of the Secretary of State to make arrangements, to such extent as he considers necessary to meet all reasonable requirements in England and Wales, for the giving of advice on contraception, the medical examination of persons seeking advice on contraception,

the treatment of such persons and the supply of contraceptive substances and appliances; and it is hereby declared that the power conferred by Section 1(1) of the National Health Service Act 1952 to provide for the making and recovery of charges includes power to provide for the making and recovery of charges for the supply of any such substances or appliances".

The Minister of State, Department of Health and Social Security, was asked in the House of Lords in 1973 whether "it is a fact that either under English or under Scottish Law a woman must obtain her husband's permission for a sterilisation operation, but a man can have a vasectomy performed without the permission of his wife ?". He replied that he had been advised that there was no statutory requirement either under English or Scottish Law that the consent of a spouse must be obtained to the sterilisation of the partner. However, the Association's Solicitor has advised that it is debatable whether at Common Law a man has a legal right to the opportunity of having children by his wife and whether, if deprived of that right without his agreement, he could claim damages against the surgeon. Accordingly, doctors would be wise to continue to obtain signatures of both spouses whenever possible until an actual court case arises which would set a precedent in either English or Scottish Law.

Undisclosed Sharing of Fees (Dichotomy)

A practice which on occasion has brought the profession into disrepute is that of dichotomy, i.e. the secret division by two or more doctors of fees on a basis of commission or other defined method. Any undisclosed division of professional fees, save in a medical partnership publicly known to exist, is highly improper. In certain circumstances it is also illegal.

Attendance upon Colleagues

Every effort should be made to maintain the traditional practice of the medical profession whereby attendance by one doctor upon another or upon his dependants is without direct charge.

Examining Medical Officers

It often happens that a doctor's patient has to be examined for some particular purpose by a medical officer representing an interested third party. These examinations may occur in connection with life assurance or superannuation, entry into certain employment, litigation or requests from the police. The following ethical code governing special situations was approved by the Representative Body in 1957. It does not apply to examinations performed under statutory requirements, and paragraphs (2) and (3) do not apply to pre-employment examinations or to those connected with superannuation, or with proposals for life or sickness assurance.

For the purpose of this code an examining medical officer is a practitioner undertaking the examination of a patient of another practitioner at the request of a third party with the exception of examinations under statutory requirements.

(1) An examining practitioner must be satisfied that the individual to be examined consents, personally or through his legal representative, to submit to medical examination, and understands the reason for it.

(2) When the individual to be examined is under medical care, the examining practitioner shall cause the attending practitioner to be given such notice of the time, place, and purpose of his examination as will enable the attending practitioner to be present should he or the patient so desire.

(Preferably such notice should be sent to the attending practitioner through the post, or by telephone, but in certain circumstances a communication might be properly conveyed by the patient.)

Exceptions to this are:

(*a*) When circumstances justify a surprise visit.

(*b*) When circumstances necessitate a visit within a period which does not afford time for notification.

Where the examining practitioner has acted under (*a*) or (*b*) he shall promptly inform the attending practitioner of the fact of his visit and the reason for his action.

(3) If the attending practitioner fails to attend at the time arranged the examining practitioner shall be at liberty to proceed with the examination.

(4) An examining practitioner must avoid any word or action which might disturb the confidence of the patient in the attending practitioner and must not, without the consent of the attending practitioner, do anything which involves interference with the treatment of the patient.

(5) An examining practitioner shall confine himself strictly to such investigation and examination as are necessary for the purpose of submitting an adequate report.

(6) Any proposal or suggestion which an examining practitioner may wish to put forward regarding treatment shall be first discussed with the attending practitioner either personally or by correspondence.

(7) When in the course of an examination there come to light material clinical findings, of which the attending practitioner is believed to be unaware, the examining practitioner shall, with the consent of the patient, inform the attending practitioner of the relevant details.

(8) An examining practitioner shall not utilize his position to influence the person examined to choose him as his medical attendant.

(9) When the terms of contract with his employing body interfere with the free application of this code, an examining medical officer shall make honest endeavour to obtain the necessary amendment of his contract himself or through the British Medical Association.

Doctors in Occupational Medicine

The Representative Body in 1961 approved notes for the guidance of doctors in occupational medicine, and has subsequently approved amendments to these notes:

A doctor in occupational medicine needs to exercise constant care in his relationships, for while he holds his appointment from the management, his duties concern the health and welfare of the workers, individually and collectively, and in the course of his duties he will constantly be dealing with patients of other doctors.

The following notes have been prepared to assist him in avoiding difficulties. Where existing ethical custom fails to cover the circumstances, they will help to govern his professional relationships with medical colleagues in other branches of practice, with those workers under his care, and with managements. The notes are intended for all doctors in occupational medicine whether they are working whole-time or in a part-time capacity.

(A) The doctor in occupational medicine and the general practitioner have a common concern—the health and welfare of the individual workers coming under their care. Less often, this concern may be shared with the hospital doctor, the community physician or some other professional colleague. As in all cases where two or more doctors are so concerned together the greatest possible degree of consultation and co-operation between them is essential at all times—subject only to the consent of the individual concerned.

As his contribution towards achieving and maintaining this vital relationship with his colleagues, the doctor in an occupational medical appointment should be guided by the following:

1. Save in emergency, the doctor in occupational medicine should undertake treatment which is normally the responsibility of the worker's general practitioner only in co-operation with him. This applies both to treatment personally given and to the use of any special facilities and staff which may exist in his department. When he makes findings which he believes should, in the worker's interest, be made known to the general practitioner, or similarly when details of treatment given should be passed on, he should communicate with the general practitioner.

2. If, for any reason, the doctor in occupational medicine believes that the worker should consult his general practitioner, he should urge him to do so.

3. Save in emergency, the doctor in occupational medicine should refer a worker direct to hospital only in consultation or by prior understanding with the general practitioner.

4. The Association considers that it is not normally the function of a doctor in occupational medicine to verify justification for absence from work on grounds of sickness. If the doctor in occupa-

tional medicine proposes to examine a worker who is absent for health reasons, he should inform the general practitioner concerned of the time and place of his intended examination.

5. The doctor in occupational medicine should not, without the consent of the parties concerned, express an opinion as to liability in accidents at work or industrial diseases, except when so required by a competent court or tribunal.

6. Doctors in occupational medicine should beware of influencing —or of appearing to influence—any worker in his choice of general practitioner.

Note: When a letter is sent from the doctor in occupational medicine to a worker's general practitioner and no reply is received within a reasonable time, it can be assumed that the general practitioner takes no exception to the contents of the letter.

(B) The following points should guide doctors in occupational medicine in certain other important aspects of their work:

1. It is the view of the Association that the personal medical records of workers maintained by him (the doctor in occupational medicine) for his professional use are his own confidential documents, and that access to them must not be allowed to any other person, save with his consent and that of the worker concerned or by order of a competent court or tribunal directed to the doctor. The Association further believes that the doctor in occupational medicine is solely responsible for the safe custody of his records, which on termination of his appointment he should hand over only to his successor. If there should be no successor, he retains responsibility for the custody of these records.

2. He should not in any circumstances disclose his knowledge of industrial processes acquired in the course of his duties, except with the consent of management or by order of a competent court or tribunal.

V. The Doctor and Other Professions

The doctor is frequently in contact with members of other professions, e.g. nurses, dentists, pharmacists and the clergy. These relationships give rise to ethical problems. Some illustrations of how the doctor should conduct himself in such inter-professional relationships are mentioned below.

Dentists

The following rules for the professional conduct of doctors in relation to dentists have been prepared by the Central Ethical Committee in agreement with the British Dental Association:

Consultations

1. Where a patient, in the opinion of his medical attendant, needs

dental treatment, the patient should be referred in all but exceptional circumstances to his own dentist. In the event of the patient having no regular dentist, there is no objection to a doctor recommending a dentist of his own choice.

2. When on behalf of one of his patients a doctor wishes to consult a dentist, the doctor should communicate in the first instance with the patient's own dentist. In the event of the patient having no regular dentist there is no objection to the doctor consulting the dentist of his own choice.

3. Where the dentist has reason to believe that the patient has some constitutional disorder and considers some major dental procedure is necessary, he should consult the patient's doctor before carrying out such treatment.

4. Where there is a conflict of opinion between a doctor and a dentist concerning the diagnosis and/or treatment of the condition of a patient, they should consult with each other to reach an agreement which is satisfactory to both.

Where the conflict of opinion remains unresolved, the patient should be so informed and invited to choose one of the alternatives or assisted to obtain other professional advice.

Anaesthetics

Where an anaesthetic is advised by the dentist, it is competent for him to select the anaesthetist, but, if such anaesthetist is not the patient's doctor, no objection should be taken to the patient inviting his doctor to be present. Where the operation proposed is a major one, or if it is known to the dentist that the patient is under medical care, the dentist should consult the patient's doctor upon the operation proposed and should invite him to be present if the patient so desires. Similarly, where the patient is under dental care and the doctor advises operative or other major treatment arising from the patient's dental condition, the dentist should be consulted.

On completion of any dental operation, and especially if there is any reason to think that post-operative complications may ensue, the patient should be advised to consult the dentist immediately if such complications arise and the dentist should take all reasonable steps to facilitate such consultation.

The sharing of premises with dentists is referred to on page 21.

Clergy

There is no ethical reason why doctors should not co-operate with the clergy in the care of their patients. Indeed, such co-operation is especially desirable when the doctor believes that religious ministration may be conducive to his patient's health and peace of mind, or may assist recovery.

Chemists

Collusion between doctors and chemists for financial gain is reprehensible. A doctor should not arrange with a chemist for the payment of a commission on business transacted, nor should he hold a financial interest in a chemist's shop in the area of his practice. Professional cards should not be handed to chemists for further distribution. It is undesirable for messages for a doctor to be received and left at a chemist's shop.

In 1970 the Council of the Pharmaceutical Society issued a "Statement upon Matters of Professional Conduct" as a general guide to the subject, stressing that it was not a comprehensive list of all the topics involved but that it covered the major ones which might give rise to problems. The Council will always give an opinion on any relevant queries from pharmacists, "to ensure that their professional work is of the highest standard and is seen to be so by the public". The two most relevant paragraphs are:

"*Relationship with Other Professions:*

(14) A pharmacist should not recommend a medical practitioner or medical practice unless so requested by a member of the public seeking medical advice.

(15) While the closest professional co-operation between pharmacist and doctor is desirable, a pharmacist should neither
  (a) have a business association with a doctor in the sense of either of them having a financial interest in the professional work of the other, nor
  (b) so conduct himself as to lead patients or members of the public reasonably to believe that there is such an association."

VI. The Doctor and Commercial Undertakings

A general ethical principle is that a doctor should not associate himself with commerce in such a way as to let it influence, or appear to influence, his attitude towards the treatment of his patients. Some of the particular directions in which the danger of unethical conduct may arise are mentioned below.

Pharmaceutical Products

It is undesirable for a doctor to have a special direct and personal financial interest in the sale of any pharmaceutical preparation he may have to recommend to a patient. If such be unavoidable for any good and sufficient reason, he should disclose his interest when ordering that preparation or article. This is not held to apply to the acquisition of shares in a public company marketing pharmaceutical products.

Testimonials written by doctors on the value of proprietary products have often been abused by the manufacturers. A doctor should refrain from writing a testimonial on a commercial product unless he receives

a legally enforceable guarantee that his opinion will not be published without his consent.

Commercial Enterprises

The Central Ethical Committee disapproves of the direct association of a medical practitioner with any commercial enterprise engaged in the manufacture or sale of any substance which is claimed to be of value in the prevention or treatment of disease and which is recommended to the public in such a fashion as to be calculated to encourage the practice of self-diagnosis and of self-medication or is of undisclosed nature or composition.

The Central Ethical Committee takes a similar view of the association of a medical practitioner with any system or method of treatment which is not under medical control and which is advertised in the public press.

In neither of the above findings does the Central Ethical Committee pretend to interfere with the right of a medical practitioner to be associated (save as above) with any legitimate business enterprise.

In general, a doctor should not allow his professional status to enhance the business or, conversely, allow the business to enhance his professional status.

Reprints

The following statement has been issued by the Association of the British Pharmaceutical Industry, in agreement with the Central Ethical Committee, on the use of doctors' names in advertising material issued by pharmaceutical firms:

(*a*) *Issue of Reprints or Abstracts*

The Central Ethical Committee of the British Medical Association, having received from time to time complaints from practitioners, has given careful thought to the question of the use of the names of registered medical practitioners in promotion material put out by pharmaceutical houses.

The Committee is fully aware of the desire of a pharmaceutical house to establish authenticity for reports on its products and to support the promotion of the product in all proper ways. A possible method of achieving this is to issue a reprint or abstract of an article, bearing the name and perhaps degrees and appointment of the registered medical practitioner.

(*b*) *The Position of the Doctor*

The Central Ethical Committee has received complaints that this custom is unethical because it means that these names were being associated with the advertising and marketing of proprietary products. It appeared to the recipients of the material that the names of the authors were being placed before them unsolicited and in a prominent manner. Further it left the way open to firms, particularly of lower standing, to seize upon this method of the use of

doctors' names as a means of enhancing their business. On both these counts it is felt that the practitioner author is being placed in danger of an accusation of contravening the Notice issued by the Disciplinary Committee of the General Medical Council.

(*c*) *Reasonable Quotations*

The Central Ethical Committee raises no objection to reasonable quotations so long as they are not extensive and likewise raises no objection to reference to doctors' names in a bibliography of published works.

Whereas the Central Ethical Committee takes no objection to the mention of doctors' names in a bibliography, the Committee takes exception to the use of doctors' names in a prominent manner in promotion material, as for example at the heading of reprints or abstracts, especially when these are circulated as separate items.

(*d*) *Consultation with the Association of British Pharmaceutical Industry*

It should be emphasized that the reference to articles and abstracts is not confined to those appearing in the *British Medical Journal*, but to the medical press in general. The Central Ethical Committee of the British Medical Association, in discussing these matters with the Association of the British Pharmaceutical Industry, has not been concerned with the publishing technicalities, and the issue of reprints is, of course, a matter for the editor of the periodical.

There was discussion on the question of pharmaceutical firms acceding to requests from doctors for reprints and it was agreed that no objection should be taken to this so long as the spirit of the matter was observed and that promotional material was not used in such a way that doctors would be actively encouraged to write for reprints.

(*e*) *Export Promotion*

The further question discussed was that of promotion in foreign countries, in some of which promotion material and sales are not permitted unless supported by authentic reports bearing the writer's name and establishing the clinical uses of the products.

The Central Ethical Committee raises no objection to variations of the above policy overseas so long as the methods used conform to the custom of the country concerned.

Surgical Instruments

In the course of practice some doctors design instruments for special purposes and wish to make them available for use by their colleagues. The best method of placing an instrument on the market is to sell the interest outright to a manufacturer; this is preferable to collecting royalties. After the financial interest is renounced there is no objection to

the inventor's name being attached to the instrument if he so desires. If, however, the demand for the instrument is uncertain the manufacturer may not be prepared to buy the interest; in that case the royalty system may be used initially.

Medical Patents

Patenting in the medical field by medical practitioners was the subject of a full enquiry by the Council in 1950. Copies of its report, entitled "Patenting in its Relation to the Medical Profession", may be obtained on application to the Secretary. Briefly the Council approved patenting in the medical field by members of the profession, provided the patent was offered and assigned to the National Research Development Corporation, whose present address is Kingsgate House, 66 Victoria Street, London, S.W.1. This assignation could ensure that the invention or discovery to which the patent related would be made available, developed and exploited in the best interests of the public.

Nursing Homes and Medical Institutions

Advertising in the lay press of nursing homes and kindred institutions, where medical advice or treatment is not provided, is a custom in which the profession has for a long time acquiesced and no objection need be taken to such advertising.

There is similarly no objection to the practice of advertising in the medical press, or in other publications primarily intended for the medical profession, institutions professing to provide medical advice or treatment. Such advertisement may include the names and qualifications of the resident and attending medical officers, but there should be no laudatory statement of the form of treatment given or the address of the consulting rooms or of the hours of a member of the medical staff at which he sees private patients.

Further, no exception need be taken to the association of registered medical practitioners with an institution for the treatment of patients by physiotherapy and electrical methods, provided the following essential conditions are strictly conformed to:

(*a*) That the institution is not in any way advertised to the lay public.

(*b*) That the treatment of all patients is under the direct control of a registered medical practitioner who accepts full responsibility for their treatment.

(*c*) That the relation between the medical officer of the institution and private practitioners conforms to usual ethical procedure between consultant and private practitioner.

If a medical practitioner has a financial interest involving his possible pecuniary gain in any institution to which he refers a patient it is desirable that he should disclose this fact to the patient.

VII. The Doctor and the General Public

Modern life brings the doctor into contact with the general public in numerous ways, both directly and indirectly, and raises for him problems of conduct unknown to his predecessors. The general public interest in medical knowledge, the dissemination of medical information through radio and television, and the press interview, all demand the exercise of the utmost caution by the doctor, whose professional standards condemn self-advertisement and publicity. In 1968 the Council drew up a report which was approved by the Representative Body to serve as a guide to the profession, and further amendments were made in 1974.

Report on Advertising and the Medical Profession

(Approved by the Representative Body in 1968 and 1974)

Attention is drawn to the statement of the General Medical Council on advertising, which appears in the pamphlet issued by the G.M.C. on "Professional Discipline". The Association is in agreement with this statement.

N.B.—Ultimate responsibility in all these matters rests with the individual concerned, but practitioners finding themselves in any difficulty in deciding upon their course of action or in doubt as to the safeguards necessary are advised to seek guidance from the Secretary of the Association.

Advertising

1. The word "advertising" in connexion with the medical profession must be taken in its broadest sense, to include all those ways by which a person is made publicly known, either by himself or by others without objection on his part, in a manner which can fairly be regarded as for the purpose of obtaining patients or promoting his own professional advantage.

2. It is generally accepted by the profession that certain customs are so universally practised that it cannot be said that they are for the person's own advantage, as, for instance, a door plate with the simple announcement of the doctor's name and qualifications. Even this, however, may be abused by undue particularity or elaboration.

Avoidance of Publicity

3. Any publicity by or on behalf of or condoned by a doctor which has as its object the personal advertisement of the doctor is highly undesirable, unethical, and in contravention of paragraph (viii) of "Professional Discipline" issued by the General Medical Council, Part II (reproduced on pages 51–53).

4. Therefore no active steps should be taken by any medical practitioner to achieve publicity as a doctor otherwise than as provided below. A doctor should take all possible steps to avoid or prevent

publicity where it can be shown to be unnecessary or to be to his advantage as a doctor.

Newspapers, Radio, Television

5. The public has a legitimate interest in the advances made in the science and art of medicine, and it is of advantage that medical information discreetly presented should reach the public through such media, both for the general instruction of the inquiring layman and for the particular purpose of "health education".

6. Great caution is necessary in public discussions on theories and treatment of disease owing to the misleading interpretation that may be put on these by an uninformed public to the subsequent embarrassment of the individual doctor and the patient. Sensational presentation should be avoided at all costs. The discussion of controversial medical matters, particularly in relation to treatment, is more appropriate to medical journals or professional societies.

7. Medical practitioners who possess the necessary knowledge and talent may properly participate in the presentation and discussion of medical or semi-medical topics through such media.

The Representative Body, in 1974, resolved:

"That a clear distinction be made between discussions solely of general principles of medicine, where no objection would be made to the naming of the doctor involved, and those discussions which result in any particular reference by that named doctor to the way in which he approached clinical problems."

8. Anonymity is particularly important in circumstances where the doctor refers to his personal management of individual clinical matters. The professional tradition of anonymity must continue in this context, in order to avoid any risk of a charge of advertising.

9. It is important that doctors participating in the presentation and discussion of medical matters through such media should take all steps to avoid laudatory references to their professional attainments and achievements. References to a *named* doctor being specially skilled in a particular form of treatment or specialty, or in the use of some special apparatus or the performance of some particular operation, are to be avoided wherever possible. It is necessary at all times to observe modesty concerning personal attainments and courtesy in reference to colleagues. Where a doctor's qualifications are given they should not be unduly emphasized—for example, by large or heavy type. In the case of public appearances it is advisable to acquaint the chairman, or interviewer beforehand, of the need to be circumspect in referring to professional status or attainment in any introductory remarks. This is particularly important where the press are likely to be present.

10. No correspondence with the lay public should be entered into by the doctor as a result of his presentation.

11. There is a wide range of subjects unrelated, or only remotely related, to the practice of medicine where there may well be no objection to the announcement of the name and usual designation of a doctor who is an authority on the particular subject. But there should be nothing in the announcement or presentation of the subject which could be regarded as promoting his professional advantage.

12. Presentations or discussions of medical matters through newspapers, periodicals, radio, TV, etc., the transmission of which is restricted to other countries, need not be anonymous even where contributions are frequent, provided that the presentation is not contrary to the rules of the profession in the other countries concerned.

13. Care should be taken to ensure that privately owned institutions with which the doctor is professionally associated cannot be identified in the course of the presentation whether directly or through accompanying advertisements.

Medical Attendance upon Royalty and other Prominent Persons

14. Attendance upon Royalty and other prominent persons frequently leads to the mention of doctors' names—for example, in bulletins. This is traditionally accepted as in the public interest and unavoidable.

Press Interviews

15. A practitioner should exercise the greatest caution in granting a press interview. A seemingly innocuous remark or casual aside is often open to misinterpretation and may easily form the subject of a damaging headline. This may place the practitioner in a position of embarrassment and danger. In certain circumstances it may be preferable to promise a prepared statement than to give an impromptu interview, or, if an interview be granted, to ask for an opportunity to approve the statement in proof before it is published.

16. It should be noted that the Association has authorized the appointment of an honorary press secretary in each of the Divisions. His duties include the function of acting as a link between the profession and the public, including the press, on behalf of both the Division and Headquarters, on all matters affecting the profession's relations with the public. His services could be used on all suitable occasions.

Condonation of Publicity in the Press

17. Exception cannot reasonably be taken to publication in the lay press of a doctor's name in connexion with a factual report of events of public concern. On occasion, however, in press reports, articles, or social columns, statements are made without previous

consent, commenting favourably on the professional activities or success of medical practitioners. These statements cannot fail to place the named practitioner in a critical and embarrassing situation, and should not be allowed to pass unchallenged. In every case of this type the medical practitioner involved should send a letter of protest to the editor marked "Not for publication" demanding that statements concerning his professional activities be not published in future without previous personal consent. Statements disclaiming responsibility for offending publicity should not be offered to the lay press for publication.

Reports of Social Occasions and Gatherings

18. It is usually unexceptionable for a doctor's name to be included in a report of a social occasion or gathering. The more distinguished a man the more often is his name likely to appear as an important guest at a function. Nevertheless, the name that is always occurring, sometimes in unlikely places, may well be suspect.

It is not beyond the wit of man to manage to appear prominently and frequently in sufficient places for his name to become better known than would be the ordinary sequel of a good professional reputation. Ambition may supersede conscience and modesty.

Holding of Public Office

19. It is the recognized duty of a medical man to take his share as a citizen in public life and to hold public office should he so desire, but it is essential that the holding of public office is not used as a means of advertising himself as a doctor.

Community Physicians

20. Publicity is necessary in carrying out the environmental health and certain other duties of community physicians and other medical men who hold posts in the public services. Provided that this is not used for the individual's advancement in his profession it may be rightly allowed.

Photographs

21. A practitioner's photograph appearing in connexion with an interview or an article published in the lay press on professional subjects is a most undesirable form of publicity, and every reasonable precaution should be taken to ensure that such photographs are not published.

Advertisements in the Lay Press

22. The use of the advertising columns of the lay press to publicize the professional activities of individual medical practitioners, even in the absence of a name (for example, by using a box number), is

unethical. A particularly reprehensible form of advertising of this type is the submission to the press directly or through an agent of information concerning the personal movements, vacation, or new appointments of a medical practitioner for publication in social columns.

Example of Senior Practitioners

23. There is a special duty upon practitioners of established position and authority to observe these conditions, for their example must necessarily influence the action of others.

Dangers

24. The particular dangers in each of these fields of activity are referred to in the preceding paragraphs. But in every case the guiding principles should be those of the above mentioned pamphlet issued by the General Medical Council, which lays down that a practitioner should not sanction or acquiesce in anything which commends or directs attention to his professional skill, knowledge, services, or qualifications, or deprecates those of others, or be associated with those who procure or sanction such advertising or publicity.

General

25. After making all allowances for all those modes of publicity for which there may be some justification, there remain many instances which can be regarded as contravening the spirit of the above mentioned pamphlet issued by the General Medical Council. The Association is convinced that in taking up the attitude of determined opposition to undesirable methods of publicity it is acting in the best interests of the public as well as of the medical profession. Advertising by the profession in general would certainly destroy those traditions of dignity and self-respect which have helped to give the British medical profession its high status. The Association therefore draws the attention of the profession to the danger of these objectionable methods, and stresses the need for every member of the profession to offer a firm resistance to them.

VIII. Ethical Machinery of the B.M.A.

Disputes between Doctors

From time to time doctors working together in a practice or in the same locality find themselves at variance with one another. Friction may arise in many ways, and often quite unnecessarily. For instance, clashes of personality and temperament between doctors in neighbouring practices may magnify trifling differences into angry quarrels; the hasty acceptance from patients of rumours or uncorroborated reports of another doctor's utterances or actions may lead the practitioner to

make unjust accusations against a colleague. If animosities are allowed to fester they not only embitter local practice but also damage the reputation of the profession in the eyes of the public. It is important therefore that disputes should be resolved quickly, within the profession itself, and, whenever possible, amicably.

Most of these disputes concern relationships not governed by law but by the traditions of the profession, and harmony can best be restored by reference to some medical person of authority with extensive knowledge and experience of medical ethics and customs. To provide the profession with an adjudicating body the Association, through the Central Ethical Committee, has devised "ethical machinery" based on the experience of many years. The procedure should not be regarded as a judicial trial but as a service attempting reconciliation through impartial adjudication.

The machinery consists of the Central Ethical Committee itself, which is a standing committee of the Council, local ethical committees appointed by Divisions and Branches, and detailed uniform rules of procedure for the investigation of complaints. Normally, the local unit will investigate a complaint in accordance with the rules, but if it does not wish to deal with any specific problem reference may be made to the Central Ethical Committee.

Briefly the complainant must write to the respondent (stating the complaint in terms sufficiently specific to enable the respondent to reply) intimating that he contemplates the initiation of a complaint through the ethical machinery of the Association and inviting his reply. A copy of the letter of complaint, together with any reply, must be submitted to the Honorary Secretary of the appropriate unit of the Association. The Honorary Secretary must then send the correspondence to Head Office and obtain instructions on the steps to be taken to deal with the matter and must take no action whatever in connexion with the complaint other than that prescribed in the advice and instructions he receives from Head Office. The Association will not accept responsibility for any consequences in ethical proceedings not so referred.

Disputes between a Doctor and a Lay Person

The Association does not normally intervene in a dispute between a doctor and a non-medical person. It is prepared, however, in a dispute concerning professional fees to nominate an arbitrator, provided that both parties agree in advance to accept the arbitrator's decision.

The protection of individual medical practitioners against hostile attacks by members of the lay public is one of the functions of the medical defence organizations, whose activities are described on page 162 of the Members Handbook (1970 edition).

THE GENERAL MEDICAL COUNCIL

The functions and activities of the General Medical Council are governed by the Medical Acts of 1956 and 1969. Its main functions are to keep the Medical Register; to prescribe certain standards of medical education which the G.M.C. recommends for observance by universities and other licensing bodies; and the administration of discipline.

The booklet issued by the G.M.C. on "Professional Discipline" is reproduced below, by kind permission of the G.M.C.

PROFESSIONAL DISCIPLINE

The first part of this pamphlet describes the statutory basis and machinery of the disciplinary jurisdiction of the Council. The second part of the pamphlet deals with various forms of misconduct which have led or may lead to disciplinary proceedings.

PART I

Statutory Provisions

Disciplinary powers were first conferred on the Council by the Medical Act 1858, which established the Council and the Register. The disciplinary jurisdiction of the Council is now regulated by sections 32–38 *of the Medical Act 1956 as amended by sections 13–16 of the* Medical Act 1969. These Acts provide that if any fully or provisionally registered practitioner

(1) has been convicted in the United Kingdom or the Republic of Ireland or any of the Channel Islands or the Isle of Man of a criminal offence, or

(2) is judged by the Disciplinary Committee of the Council to have been guilty of serious professional misconduct

the Committee may if they think fit direct that his name shall be erased from the Register, or that his registration shall be suspended for a period not exceeding 12 months. The power of erasure applies also to temporarily registered practitioners.

Convictions

The term "conviction", as used in this pamphlet, applies only to a determination made by a Criminal Court in the British Isles. In considering convictions, the Disciplinary Committee is bound to accept

the finding of the Court as conclusive evidence that a doctor was guilty of the offence of which he was convicted. It is not open to a doctor to argue before the Committee that he was in fact innocent of an offence of which he has been convicted. It may therefore be unwise for a doctor to plead guilty in a Court of Law to a charge to which he believes that he has a defence. A conviction in itself gives the Committee jurisdiction even if the circumstances of the criminal offence did not involve professional misconduct. The Committee is however particularly concerned with convictions for offences which affect a doctor's fitness to practise.

A finding or a decision of an Executive Council or other authority under the National Health Service does not amount to a conviction for these purposes. A charge of serious professional misconduct may however, if the facts warrant, be made in respect of conduct which has previously been the subject of proceedings within the National Health Service or before an overseas court or medical council; or in respect of conduct of which a doctor has been found guilty by a British Criminal Court but placed on probation or discharged conditionally or absolutely.

The Meaning of "Serious Professional Misconduct"

The expression "serious professional misconduct" was substituted by the Medical Act 1969 for the phrase "infamous conduct in a professional respect" which was used in the Medical Act 1858. The phrase "infamous conduct in a professional respect" was defined in 1894 by Lord Justice Lopes as follows:

> "If a medical man in the pursuit of his profession has done something with regard to it which will be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the General Medical Council, if that be shown, to say that he has been guilty of infamous conduct in a professional respect."

In another judgment delivered in 1930 Lord Justice Scrutton stated that:

> "Infamous conduct in a professional respect means no more than serious misconduct judged according to the rules, written or unwritten, governing the profession."

In proposing the substitution of the expression "serious professional misconduct" for the phrase "infamous conduct in a professional respect" the Council intended that both phrases should have the same significance.

The Disciplinary Committee and the Penal Cases Committee

The composition of the Disciplinary Committee is governed by the Medical Acts. The Committee is elected annually by the Council and consists of 19 members. These include the President of the Council,

who is Chairman, at least two lay members and at least six of the elected members of the Council. In all proceedings the Disciplinary Committee is advised on questions of law by a Legal Assessor who is usually a Queen's Counsel and must be a barrister, advocate or solicitor of not less than 10 years' standing. The Committee normally sits in public and its procedure is closely akin to that of a court of law. Witnesses may be subpoenaed and evidence is given on oath. Doctors who appear before the Committee may be and usually are legally represented.

The Penal Cases Committee is a smaller committee, also elected annually. It sits in private and on the basis of written evidence and submissions determines which cases should be referred for inquiry by the Disciplinary Committee.

Rules of Procedure

All disciplinary proceedings are governed by rules of procedure made by the Disciplinary Committee, after consultation with representative medical organisations, and approved by the Privy Council. The current rules were made in 1970 and are printed by H.M. Stationery Office as Statutory Instrument 1970 No. 596. Other rules govern the functions of the Legal Assessor and the procedure for appeals to the Judicial Committee of the Privy Council.

Proceedings: The Earlier Stages

Disciplinary cases are of two kinds—those arising from a conviction of the doctor in the courts and those where a doctor is alleged to have done something which amounts to serious professional misconduct.

Convictions of doctors are reported to the Council by the police and other authorities and, unless relating to minor motoring or other trivial offences, are automatically referred to the Penal Cases Committee. In cases where serious professional misconduct is alleged, before any proceedings can be instituted an information or complaint must be received, and, unless it originates from the Solicitor to the Council or from a Government Department, Executive Council or other official body, must be supported by one or more statutory declarations (that is, statements declared in a prescribed form before a Commissioner for Oaths). A complaint or information is initially considered by the President or by another member of the Council so authorised by the President. Unless the matter is considered so trivial or irrelevant to the question of serious professional misconduct that it need proceed no further, the doctor is informed of the allegations made against him and is invited to submit a written explanation. If the doctor submits an explanation, this may include evidence in answer to the allegations. His explanation is then placed before the Penal Cases Committee when they consider the complaint or information against him.

Warning Letters

Not every conviction or allegation of professional misconduct necessitates an immediate reference to the Disciplinary Committee for formal inquiry, although repeated offences may do so. It is the usual practice to send warning letters to a doctor who has been convicted for the first time of offences such as driving a motor car when under the influence of drink, or whose professional conduct appears to have fallen below the proper standards, in order that the doctor may reconsider his habits and conduct.

Inquiries before the Disciplinary Committee

As already mentioned the Disciplinary Committee is bound to accept the fact that a doctor has been convicted as conclusive evidence that he was guilty of the offence of which he was convicted. Provided therefore that a doctor admits a conviction, proceedings in cases of conviction are concerned only to establish the gravity of the offence and to take due account of any mitigating circumstances. In cases of conduct however the allegations, unless admitted by the doctor, must be *strictly proved by evidence*, and the doctor is free to dispute and rebut the evidence called. If the facts alleged in a conduct charge are found by the Committee to have been proved, the Committee must subsequently determine whether, in relation to those facts, the doctor has been guilty of serious professional misconduct. Before taking a final decision the Committee invites the doctor or his legal representative to call attention to any mitigating circumstances and to produce testimonials or other evidence as to character. The Committee takes account of the previous history of the doctor.

The primary duty of the Disciplinary Committee is to protect the public. In any case the Committee must therefore first consider whether the public interest requires it to remove the doctor's name from the Register, or to suspend his registration. Subject however to this overriding duty to the public the Committee considers what is in the best interests of the doctor himself. Largely for this reason the Council has evolved a system of postponing judgment, especially in relation to offences arising from abuse of drink or drugs, in order that the doctor may satisfy the Disciplinary Committee that he is able to conduct himself properly and to overcome any addiction to alcohol or drugs. In severe cases of addiction, however, the Committee may consider it necessary to order suspension while the doctor undergoes treatment.

Powers of the Disciplinary Committee at the Conclusion of an Inquiry

At the conclusion of any inquiry in which a doctor has been proved to have been convicted of a criminal offence, or is judged to have been guilty of serious professional misconduct, the Disciplinary Committee must decide on one of the following alternative courses:

(1) To admonish the doctor and conclude the case;
(2) To place the doctor on probation by postponing judgment;
(3) To direct that the doctor's registration shall be suspended for a period not exceeding 12 months; or
(4) To direct erasure.

Postponement of Judgment

In any case where judgment is postponed, the doctor's name remains on the Register during the period of postponement. When postponing judgment to a later meeting the Committee normally intimates that the doctor will be expected before his next appearance to furnish the names of professional colleagues and other persons of standing to whom the Council may apply for information, to be given in confidence, concerning his habits and conduct since the previous hearing. The replies received from these referees, together with any other evidence as to the doctor's conduct, are then taken into account when the Committee resumes consideration of the case. If the information is satisfactory, the case will then normally be concluded. If however the evidence is not satisfactory, judgment may be postponed for a further period, or the Committee may direct suspension or erasure.

Suspension of Registration

If a doctor's registration is suspended, the doctor ceases to be entitled to practise as a registered medical practitioner during that period. When a doctor's registration has been suspended the Committee may, after notifying the doctor, resume consideration of his case before the end of the period of suspension and then if they think fit may extend the original period of suspension or order erasure. Before resuming consideration of the case in such circumstances the Committee may, as when postponing judgment, ask the doctor to give the names of referees from whom information may be sought as to his habits and conduct in the interval. This information will be taken into account when the Committee resumes consideration of the case, and only if there is evidence that the doctor has not conducted himself properly, or if he is addicted to drink or drugs and has not responded to treatment, is the Committee likely to order further suspension or to direct erasure.

Erasure

Whereas suspension can be ordered only for a specified period, a direction to erase remains effective unless and until the doctor makes a successful application for the restoration of his name to the Register. Such an application cannot be made until at least 10 months have elapsed since the original order took effect.

Appeal Procedure and Immediate Suspension

When the Committee has directed that a doctor's name shall be erased or that his registration shall be suspended, the doctor has 28 days

in which to give notice of appeal against the direction to the Judicial Committee of the Privy Council. During that period, and, if he gives notice of appeal, until the appeal is heard, his registration is not affected unless the Disciplinary Committee have made a separate order that the doctor's registration shall be suspended forthwith. The Committee may make such an order if it is satisfied that to do so is necessary for the protection of members of the public or would be in the best interests of the doctor. There is a right of appeal against an order for immediate suspension to the High Court (in Scotland, the Court of Session), but such an appeal, whether successful or not, does not affect the right of appeal to the Judicial Committee of the Privy Council referred to above.

Restoration to the Register after Disciplinary Erasure

Applications for restoration may legally be made at any time after 10 months from the date of erasure. If such an application is unsuccessful, a further period of at least 10 months must elapse before a further application may be made. The names of many doctors which have been erased have subsequently been restored to the Register, after an interval. An applicant may, and normally does, appear in person before the Disciplinary Committee, and may be legally represented. The Committee determines every application on its merits, having regard among other considerations to the nature and gravity of the original offence, the length of time since erasure, and the conduct of the applicant in the interval.

PART II

Convictions and Forms of Professional Misconduct which may lead to Disciplinary Proceedings

This part of the pamphlet sets out certain kinds of offences and of professional misconduct which have in the past led to disciplinary proceedings by the Council. The Disciplinary Committee and the Penal Cases Committee must proceed as judicial bodies. The pamphlet is thus not a complete code of professional ethics, nor can it specify all offences which may lead to disciplinary action.

The question whether any particular course of conduct amounts to serious professional misconduct, and the gravity of any conviction, are matters which fall to be determined by the Disciplinary Committee after considering the evidence in each individual case. Doctors desiring detailed advice on questions of professional conduct arising in particular circumstances are advised to consult a medical defence society or professional association who are prepared to give advice on such matters; it is rarely possible for the Council to give such advice, having regard to its judicial function.

The following paragraphs describe the more common types of offence or misconduct which have in the past been regarded as grounds for disciplinary proceedings. In most cases the gravity of the offence or misconduct will be readily apparent. In other cases however such as advertising, doctors may sometimes experience difficulty in deciding on the proper course in a particular set of circumstances, and the sections concerned have been amplified to indicate some of the principles which in the opinion of the Council are relevant in each field.

(i) Disregard of personal responsibilities to patients

In pursuance of the Council's primary duty to protect the public, disciplinary proceedings may be instituted in any case in which a doctor may appear to a serious extent to have disregarded his personal responsibility to his patients or to have neglected his professional duties, for example by failure to visit or to provide treatment for a patient. Many cases of this kind which are reported to the Council have already been investigated under the National Health Service machinery, but cases which have arisen in other ways may also be considered.

(ii) Abuse of alcohol

In the opinion of the Council convictions for drunkenness, or other offences arising from abuse of alcohol (such as driving a motor car when under the influence of drink), may indicate habits which may be a danger to a doctor's patients and are discreditable to the profession. After a first conviction for drunkenness a doctor may expect to receive a warning letter. Further convictions of such a nature may lead to an inquiry before the Disciplinary Committee at which all the convictions are liable to form the basis of the charge.

A doctor who treats patients or performs other professional duties while under the influence of drink is liable to disciplinary proceedings.

(iii) Abuse of controlled drugs

Disciplinary proceedings have been taken in cases in which a doctor has been found to have prescribed or supplied drugs of addiction or dependence otherwise than in the course of bona fide treatment.

Disciplinary proceedings have also been taken against doctors convicted of offences involving drugs which were committed in order to gratify the doctor's own addiction, or where a doctor has been convicted for driving or being in charge of a motor vehicle when under the influence of a drug or has treated patients when under the influence of drugs.

(iv) Termination of pregnancy

The Council regard as a serious matter the termination of pregnancy if done in circumstances which contravene the law. A criminal con-

viction in the British Isles for such an offence in itself affords ground for a charge before the Disciplinary Committee.

(v) Abuse of professional position in order to further an improper association or commit adultery

The Council has always taken a serious view of a doctor who *abuses his professional position* in order to further an improper association or to commit adultery with a person with whom he stands in professional relationship.

In an inquiry before the Disciplinary Committee, if a doctor is shown to have been found guilty of adultery in divorce proceedings in the High Court in the United Kingdom or the Republic of Ireland, such finding must, in accordance with the Medical Acts, be accepted by the Disciplinary Committee as conclusive evidence of the fact found.

(vi) Abuse of professional confidence

Disciplinary proceedings have been taken where it is alleged that a doctor has improperly disclosed information which was obtained in confidence from or about a patient.

(vii) Offences involving dishonesty, indecency or violence

Disciplinary proceedings have been instituted against doctors convicted of criminal deception (obtaining money or goods by false pretences), forgery, fraud, theft, indecent behaviour or assault. A particularly serious view is taken of such offences if committed in the course of a doctor's professional duties or against his patients or colleagues.

(viii) Advertising: Depreciation of other doctors

(1) The tradition that doctors should refrain from self-advertisement has long been accepted by the medical profession. In the opinion of the Council advertising is incompatible with the principles which should govern relations between members of the profession, and could be a source of danger to the public. A doctor who was successful at achieving publicity might not in fact be the most appropriate doctor for a patient to consult. In extreme cases advertising might raise hopes of a cure which then proved illusory.

(2) The professional offence of advertising may arise from the publication (in any form) of matter commending or drawing attention to the professional skill, knowledge, services, or qualifications of one or more doctors, when the doctor or doctors concerned have instigated or sanctioned such publication primarily or to a substantial extent for the purpose of obtaining patients or otherwise promoting their own professional advantage or financial benefit.

(3) Advertising may also be considered to occur if a doctor knowingly acquiesces in the publication (in any form) by other persons of matter which commends or draws attention to his own professional attainments or services, or if a doctor is associated with or employed by persons or organizations which advertise clinical or diagnostic services connected with the practice of medicine. In determining in either set of circumstances whether professional misconduct has occurred, it is relevant to take into account

(*a*) the extent, nature and object of the publicity; and
(*b*) the question whether the arrangements had served to promote the doctor's own professional advantage or financial benefit.

(4) Advertising may arise from notices or announcements displayed, circulated, or made public by a doctor in connection with his own practice, if such notices or announcements materially exceed the limits customary in the profession. Questions of advertising may also arise in regard to reports or notices or notepaper issued by companies or organizations with which a doctor is associated or by which he is employed.

(5) The question of advertising may also arise in a number of other contexts, such as books by doctors, articles or letters or other items written by or about them in newspapers or magazines, and talks or appearances by doctors on broadcasting or television. In such cases the identification of a doctor need not *in itself* raise a question of advertising, but such a question may arise from the nature of the material printed or spoken (compare paragraph (6) below).

(6) In upholding a decision of the Disciplinary Committee the Judicial Committee of the Privy Council have stated some principles which, though enunciated in relation to books and articles, may be regarded as of general application:

"The Disciplinary Committee were entitled to have regard to the content of the written material, the form in which it was written, and the selected media for its publication in forming conclusions as to what were the purposes which animated the writer. *The Committee were entitled to consider whether a desire to give information about a subject and to direct attention to such subject could have been achieved without directing attention to the personal and unique performances and abilities of the writer.*

* * * *

"On the one side of the line there might be a book or an article which is an exposition of a particular subject either written as a text-book for medical students or practitioners or written impersonally in order to give information to the general public. No exception could be taken to such publication. As an example on the other side of the line there might be a book or an article an essential theme of which is the praise and commendation of the skill and abilities of the

writer himself with an express or implied suggestion that his successes in dealing with cases show that potential patients would do well to have recourse to him. That would be 'advertising'."

(7) The depreciation of the professional skill, knowledge, services or qualifications of another doctor or doctors may also lead to disciplinary proceedings.

(ix) Canvassing and related offences

Canvassing for the purpose of obtaining patients, whether done directly or through an agent, and association with or employment by persons or organizations which canvass, may lead to disciplinary proceedings.

Disciplinary proceedings may also result from other improper arrangements calculated to extend a doctor's practice. These include improper arrangements for the transfer of patients to a doctor's National Health Service list, without the knowledge and consent of the patients, or in a manner contrary to the National Health Service Regulations; and arrangements whereby doctors, whether singly or together with other doctors, have issued National Health Service prescriptions to persons who were being treated as private patients.

(x) Untrue or misleading certificates and other professional documents

Doctors are relied upon to issue certificates for a variety of purposes for example of incapacity to work through illness or injury, on the assumption that the truth of the certificates can be accepted without question. In some cases the certificates are required to include a statement that a patient has been examined on a particular date.

Doctors are expected to exercise care in issuing certificates and kindred documents, and should not include in them statements which the doctor has not taken appropriate steps to verify. Any doctor who in his professional capacity gives any certificate or similar document containing statements which are untrue, misleading or otherwise improper, renders himself liable to disciplinary proceedings.

(xi) Improper delegation of medical duties to unregistered persons: Covering

A doctor who improperly delegates to a person who is not a registered medical practitioner duties or functions requiring the knowledge and skill of a medical practitioner, or who assists such a person to treat patients as though that person were a registered medical practitioner, is liable to disciplinary proceedings.

The foregoing statement is not intended to restrict in any way (*a*) the proper training of medical and other bona fide students or (*b*) the proper employment of nurses, midwives and other persons trained to perform specialized functions relevant or supplementary to medicine, surgery

and midwifery, provided that the doctor concerned exercises effective supervision over any person so employed and retains personal responsibility for the treatment of the patients.

(xii) Improper financial transactions

(1) Allegations that a doctor has improperly demanded or accepted fees from a patient under the National Health Service, contrary to the Regulations of the Service, may be regarded as raising a question of serious professional misconduct.

(2) Disciplinary proceedings may also result when a doctor knowingly and improperly obtains from an Executive Council or hospital authority any payment to which he was not entitled, or when a general practitioner under the National Health Service has improperly issued prescriptions to patients on his dispensing list.

(3) The Council has also viewed with concern, or regarded as a ground for disciplinary action (*a*) improperly prescribing drugs or appliances in which a doctor has a financial interest, (*b*) arrangements for fee-splitting, under which one doctor would receive part of a fee paid by a patient to another doctor, and (*c*) the commercialization of a secret remedy.

CONCLUSION

It must be emphasized that the categories of misconduct described above cannot be regarded as exhaustive, since from time to time with changing circumstances the Council's attention is drawn to new forms of professional misconduct. Any abuse by a doctor of any of the privileges and opportunities afforded to him, or any grave dereliction of professional duty or serious breach of medical ethics, may give rise to a charge of serious professional misconduct.

SUPPLEMENTARY INFORMATION

THE MEDICAL REGISTER

The Registered Addresses of Doctors

The Council requires from time to time to write to every doctor on the Register. Under the Medical Act 1969 registered doctors are required to pay an annual fee for the retention of their names on the Register. Every doctor from whom a fee is due is sent a notice of the fact, and a reminder if he fails to pay the required fee. Failure to respond to these communications could lead to the erasure of the doctor's name from the Register. The Medical Acts also enable the Registrar of the Council to inquire of any registered doctor, at his registered address, whether the address is still correct: and if no reply is received within six months, the Registrar may erase the doctor's name from the Register.

It will therefore be seen that it is very important for every doctor, in his own interest, to provide the Council at all times with an address

which will afford an effective channel of communication with him, so that letters sent by the Council will reach him without delay. In particular, overseas doctors who are in practice in the United Kingdom are strongly advised to give the Council an address in the United Kingdom (rather than a permanent address abroad) and to ensure that changes in address are promptly notified to the Council.

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