BRITISH MEDICAL ASSOCIATION

Board of Science and Education Publication

Professional Standards

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BRITISH MEDICAL ASSOCIATION

PROFESSIONAL STANDARDS

A Statement prepared by a Special Panel appointed by the Board of Science and Education of the British Medical Association.

March 1972
B.M.A. House,
Tavistock Square,
London, WC1H 9JP

The Members of the Panel

The membership of the Special Panel, appointed by the Board of Science and Education, was as follows:—

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J. J. L. Ablett	Consultant Anaesthetist, United Leeds Hospitals.
J. M. Beazley	Senior Lecturer, Institute of Obstetrics and Gynaecology, University of London.
M. Crawfurd	Senior Lecturer in Medical Genetics, University of Leeds.
T. M. W. Farewell	Medical Assistant in Psychiatry, Napsbury Hospital, St. Albans.
A. G. Johnson	Senior Lecturer in Surgery, Charing Cross Hospital Medical School, University of London.
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B. N. C. Prichard	Senior Lecturer in Clinical Pharmacology and Therapeutics, University College Hospital Medical School, University of London.

Secretariat to the Board of Science and Education of the B.M.A.

Walter Hedgcock

Doreen Warner

STATEMENT OF PANEL ON PROFESSIONAL STANDARDS

INTRODUCTION

1. In April 1970 the Board of Science and Education invited a panel of younger doctors to identify areas of anxiety and conscience in medical practice. Trends in certain spheres of medical practice appeared to challege the generally accepted principles that the function of the doctor is to maintain respect for human life and the health and welfare of his patients. The Board considered it was an appropriate time for professional standards to be reviewed in the light of current knowledge and thought, and study given to the drafting of a statement of guidance for medical practice. Throughout its discussions the Panel has taken as its criterion that the medical profession must be seen to have concern for the maintenance and quality of human life and the dignity of the individual patient in the situations in which medicine is practised. The profession must be seen to be responsible for its own professional standards and competence, including its relationship with the State; the Panel has examined some of the ethical and other issues involved in medical practice and has tried to match these with guidelines for standards in the future. It has looked at traditional attitudes to evaluate the need for their perpetuation and has studied new situations to see whether they require new rules.

2. In preparing this Statement the Panel has looked again at various accepted codes — the Hippocratic Oath; the Nuremberg Code (1950) on clinical investigation; the Declaration of Geneva (1947) and the International Code of Medical Ethics based upon it; the W.M.A. Declarations of Helsinki (1964) on human experimentation, of Sydney (1968) on determination of death, and of Oslo (1970) on therapeutic abortion. It has examined these codes in the light of current problems and situations.

3. In its deliberations the Panel in no way wished to usurp the functions of the Association's Central Ethical Committee; it has in fact discussed its ideas initially with the Chairman of that Committee. The Panel has also met experts in disciplines closely associated with medicine — theology, law and sociology (see Appendix I). Whilst it does not claim that the views put forward in the following Statement reflect in every respect those of its visiting experts it hopes that the Panel's views on existing professional standards will form a useful basis on which to start discussions within the profession.

MEDICAL ETHICS

4. The understanding of and adherence to the principles of medical ethics are of the utmost importance to the profession. These principles have enabled the formation of a code of professional relationships and the Panel suggests that it would be opportune for all interested bodies within the profession to re-evaluate long held opinions in the light of current practices and procedures and to pronounce publicly their views thereon.

Teaching of Ethics

5. The teaching of medical ethics should be undertaken in the light of current knowledge and foreseeable advances. Ethics of medicine should form part of the medical curriculum. The subject must be taught and discussed in the context of medical practice throughout the doctor's undergraduate and postgraduate training. When students have reached their final clinical years and have had some practical experience it would be valuable for them to hear the views of staff working in para-medical and associated fields, such as lawyers, philosophers, theologians, sociologists, so that insight into other aspects of a common problem may be gained. It might also be considered valuable to arrange joint meetings with students from these faculties when they have reached an advanced stage of training. Seminars and discussions are preferable to more formal lectures. The aim should be to acquaint the medical student with the dilemmas facing doctors in reaching decisions in the light of current medical and social welfare practice. The Panel hopes that medical schools will consider these proposals favourably when composing their curricula and a list of subjects suggested for inclusion in a course on Medical Ethics is set out in Appendix II.

Intra-Professional Relationships

6. It is in the best interests of the patient that the standard of intra-professional relationships is always kept at a high level. Unless there is good communication and exchange of information between doctors the patient will suffer and professional friction may be created.

7. Generally speaking, the accepted channels of referral of patients should be used, although access to any doctor should not be denied to a patient. In primary medical care, patients should normally see a consultant on referral by their general practitioner. This ensures that the appropriate selection of specialists can be made in the first instance and facilitates the co-ordination of treatment.

8. It is recognised, however, that there are circumstances when direct referral from one consultant to another may be in the patient's best interest. In these instances there should be full communication

between consultant and general practitioner; if the general practitioner is by-passed the quality of long-term care of his patients may be jeopardized.

Advertising

9. The public media have a vital educational function and the profession cannot afford not to use radio, press and television. It is recognised that an appearance on television may benefit the person concerned, but provided the appearance is not used specifically for personal advancement or gain it should not be deemed to be improper. The public image of medicine is important; badly presented programmes or poorly prepared information might prove to be not in the best interests of the patient or the profession. The aim should be to disseminate knowledge impartially and to present a balanced view. A television appearance by a member of the profession should be looked upon as a privilege not to be abused.

10. In the past, the fear that publication of information might be regarded as advertising has led to inadequate information about doctors' services being made available to the public; for example, a problem exists for patients in selecting a doctor in that detailed information is not readily available. The Monopolies Commission (H.M.S.O. 1970, Cmnd. 4463) has suggested the lifting of restrictions on advertising. The Panel considers that the removal of restrictions on individual advertising is not the best way to solve this problem; the doctor who is most successful in achieving publicity might not necessarily be the best doctor for the patient to consult.

11. In the view of the Panel there should be no need for personal advertising by individual doctors but there is a need for information to be more readily available about all general practitioners by area.

SOCIAL RESPONSIBILITY AND CONFIDENTIALITY

12. The observance of confidentiality on information obtained as a result of the doctor/patient relationship has long been a tradition of British medicine and must not lightly be discarded. If this traditional confidence is not observed then the patient may cease to confide in his doctor and the doctor/patient relationship would thus be seriously damaged. The Panel considers that the doctor must resist to the limits of the law attempts to persuade him to divulge confidential information. In this connection the Panel suggests that there is a need for research scientists to be covered by an ethical code similar to that of the medical profession in view of the increasing co-operation between research scientists and clinicians in the development of new techniques to aid patients.

13. However, the Panel appreciates that conflict may sometimes arise between the doctor's responsibility to his patient and his

responsibility to society. In certain circumstances there may come a point where the doctor feels his social responsibility outweighs his responsibility to the patient and that information should be passed to the appropriate authorities. For example, the psychiatrist is faced with a dilemma in dealing with the patient whose disordered process of thought causes him to act in a dangerous anti-social manner, especially where the doctor knows that the patient or other members of society are at risk; a similar dilemma is faced by other doctors in dealing with, for example, patients with relevant medical conditions who refuse to give up driving. The Panel is agreed that at the ethical and moral level the doctor must account, in the first instance, to his patient in accordance not only with his own conscience but also within the framework of the collective experience of his colleagues and, secondly, to the employing authority or public authority. Should a situation arise where these two responsibilities conflict and the responsibility to society is professionally judged to be paramount the patient should be clearly informed. Whichever course of action he decides upon the doctor is responsible for his own choice.

14. The need to maintain the confidentiality of medical records has always been recognised, but special problems arise today with the development of teamwork. There is concern over the extent to which para-medical and lay workers should have access to records while playing their full part as members of the team. Moreover, this problem is accentuated with the development of separate Departments of Social Services following implementation of the Local Authority Social Services Act 1970. The Panel has especially examined this problem and notes that while social workers have their own code of ethics in the various social work bodies it should be borne in mind that, at this stage, they have neither a nationally accepted code of ethics nor a disciplinary body. It is understood that discussions are taking place and the Panel welcomes the move to devise in the near future a nationally accepted code of ethics.

15. The medical profession must be seen to be concerned about preserving the confidentiality of records. It has an educational role to play in this respect in its relations with professions complementary to medicine and every opportunity should be taken to emphasise to all non-medical staff having access to such records and who may not be covered by an ethical code, e.g. research and service scientists, technicians, social workers, clerical officers, typists, and also voluntary workers, the need to respect confidentiality and to prevent the release of information about individuals to the Press and other members of the public. It is important to ensure that non-medical scientists fully respect confidentiality, particularly when

publishing work involving individuals. It is suggested that professional associations and trade unions might be approached with a view to the inclusion in the contracts of their members who are employed in or associated with the National Health Service a statement to the effect that they must respect the confidentiality of medical records to which they may have access.

16. The Panel recognises that in some circumstances the computerisation of medical records may be of genuine value but emphasises the importance of adequate safeguards in establishing such records. Such safeguard have been outlined in another report — "Computers in Medicine" (B.M.A: 1969).

ETHICS OF RESEARCH

17. The World Health Organisation has defined an experiment on a human being as an act whereby the investigator deliberately changes the internal or external environment in order to observe the effects of such a change. Planned clinical experimentation is essential for the progress of the mastery of disease; the alternative — unplanned evaluation — leads to the fostering of useless therapy.

18. It is important that the clinical investigator should have before him a code of conduct to guide the lines of clinical research. No code can cover every eventuality and too precise a code might impede reasonable research.

19. Recognised codes of ethical practice include the Code of Ethics of the World Medical Association (Declaration of Helsinki) and the M.R.C. Statement on "Responsibility in Investigations on Human Subjects".* The Panel has attempted to draw up some general principles in the light of which individual experiments can be considered.

20. **Basic Principles**

(i) 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.

(ii) Clinical research should be conducted only by qualified persons and under medical supervision.

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

(iv) Every clinical research project should be preceded by careful assessment of inherent risks in comparison to forseeable benefits to the subject or to others.

*M.R.C. Annual Report, 1962, Cmnd 2382, H.M.S.O.; reprinted, together with the Declaration of Helsinki, in *Brit. Med. J.*, 1964, 2 177-8.

(v) 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. In particular, it would be inadmissible to carry out research where the significant possibility of irreversible change exists.

(vi) Similar principles should be adopted by non-medical research scientists.

21. Professional Care associated with Clinical Research and Innovations

(i) In the treatment of the sick person the doctor must be free to use a new therapeutic measure if in his judgement it offers hope equal to or greater than other proven therapeutic measures of saving life, re-establishing health, or alleviating suffering.

(ii) When new and sophisticated clinical procedures or laboratory methods are introduced it is essential to ensure a high level of competence in the new methods before the procedures are offered as a clinical service. To this end the Panel would recommend that such techniques should be started in new centres only when the clinicians and laboratories concerned have gained adequate experience of their methods and the number of patients requiring them is likely to be sufficient to provide the continuing experience necessary to maintain standards.

(iii) If at all possible, consistent with patient psychology, the doctor must 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 mental incapacity the permission of the legal guardian replaces that of the patient.

(iv) 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.

22. Non-therapeutic Clinical Research

(i) 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.

(ii) The nature, the purpose, and the risk of clinical research must by explained to the subject by the doctor.

(iii) 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.

(iv) Consent should always be obtained and in cases involving major procedures this should be in writing. However, the responsibility for clinical research always remains with the research worker; it never falls on the subject, even after consent is obtained.

(v) 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.

(vi) 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 must discontinue the research if in his or their judgement it may, if continued, be harmful to the individual.

23. **Safeguards**

The best safeguard would appear to be along the lines recommended by a Committee of the Royal College of Physicians (1967):* "The planning and conducting of clinical investigations demand skill, experience, and judgement. Difficult ethical problems occasionally arise and even the most experienced workers would often welcome the opinion and advice of their peers.

The competent authority — for example, Board of Governors, Medical School Council, Hospital Management Committee, or equivalent body in non-medical institutions — has a responsibility to ensure that all clinical investigations carried out within its hospital or institution are ethical and conducted with the optimum technical skill and precautions for safety. This responsibility would be discharged if, in **medical institutions** where clinical investigation is carried out, it were ensured that all projects were approved by a group of doctors, including those experienced in clinical investigation. This group should satisfy itself of the ethics of all proposed investigations. In **non-medical institutions** or wherever clinical investigation — that is, any form of experiment on man — is conducted by investigators with qualifications other than medical, the supervisory group should always include at least one medically qualified person with experience in clinical investigation".

24. The Panel strongly recommends that all hospitals be encouraged to establish ethical research committees or groups of doctors as envisaged by the R.C.P. Committee, but is concerned that neither the Department of Health nor any other body has responsibility for ensuring that such committees are established.

25. Moreover, with the increase of research in general practice,

*Supervision of Ethics of Clinical Investigations in Institutions, Report of a Committee of Royal College of Physicians, 1967, *Brit. Med. J.*, 3, 430.

particularly with drug trials, there is a need for responsible ethical committees to consider any proposed research before it is undertaken in order to afford the utmost protection for the patient and the doctor and thus seek to avoid hazards which might arise. The Panel recommends that committees or groups of doctors be established for research in general practice, the exact mechanism to be agreed between the interested bodies concerned.

RECENT DEVELOPMENTS IN MEDICAL PRACTICE

26. The Panel has discussed the undermentioned subjects which are particularly exercising the profession at the present time.

Conception and Sex Education

27. The medical profession should retain responsibility for provision of advice on agents which influence fertilisation and subsequent development, and for the prescription of drugs in this field.

28. The behaviour of society has changed much in the last decade particularly in relation to sexual behaviour. It is the experience of doctors that many young people have had little or no relevant sex education. The Panel would strongly support any moves which would make sex education more meaningful and readily available. A more responsible attitude towards the use of contraceptive methods and a greater awareness of the health hazards which can arise from irresponsible sexual behaviour, such as emotional illness and the contraction of venereal diseases, must be engendered. The Panel would support greater publicity of available sources of advice including the use of television.

Abortion

29. Since the advent of the Abortion Act 1967 there has been an increase in the number of notified abortions; the increase has greatly exceeded official expectations. This has given rise to serious medical, ethical and professional difficulties. Another Panel of the Board of Science and Education is looking into the working of the Act and has prepared evidence for the Committee appointed by the Secretary of State for Social Services and the Secretaries of State for Scotland and Wales, under the Chairmanship of Mrs. Justice Lane, to review the operation of the Act and to make recommendations.

Fetal Abnormality

30. At present the number of terminations for suspected congenital or inherited physical or mental defect is small (in 1969, 1,102 cases out of a total of 54,157 abortions). This number is likely to increase as developments in pre-natal diagnosis of congenital or inherited

defect develops, for example amniocentesis, fetoscopy and ultrasonography. Further, patients might be advised to become pregnant even though it were known that they carried a gene which was likely to produce abnormalities in their children and at the same time be offered the termination of their pregnancy should it be established, using the newer methods of antenatal diagnosis, that their unborn child was in fact adversely affected. A high level of competence in the techniques of pre-natal diagnosis of inherited defect together with a complete understanding of the ethical principles involved will be required if these procedures are to be acceptable.

BIOLOGICAL ADVANCEMENT

31. Recent advances in technical developments in biology — especially genetic developments, some of which sound futuristic in the extreme but may become technically possible within the next few years — raise new ethical problems. At the present time there is no supervisory body to review such developments in relation to their implications for the ethics of medical practice, but the Panel welcomes the recent appointment by the Board of Science and Education of a Panel on Biological Standards and Technological Developments to watch the position.

Artificial Insemination

32. Artificial insemination is condemned by some religious bodies but, apart from specific religious objection, there does not appear to be any general ethical objection to artificial insemination by the husband (A.I.H.). It raises problems of adequate assessment of couples which are beyond the scope of this Panel.

33. Artificial insemination by a donor (A.I.D.) raises greater problems. It is indicated where the husband is normal apart from azoospermia, or where there is a serious risk of transmission of genetic defect. A minority of the members of the Panel could not accept this as an ethical procedure; other members thought it acceptable in certain circumstances, with the husband's consent as at present. The need for expert clinical assessment is of the utmost importance. Since the Panel discussed this question it has noted the the Board of Science and Education has set up a Panel to look into the medical aspects of artificial insemination.

In Vitro Fertilisation

34. Co-operation from patients with problems of infertility will allow clinical experimental research to be undertaken which is designed to help with problems of infertility and also present a deeper understanding of the processes of conception. It is most important that such patients be given detailed explanations of the

full procedure and implications before any experimentation involving in vitro fertilisation is undertaken. An undertaking should be given to use only the husband's spermatozoa in the fertilisation of the ova obtained by laparoscopy, and until more information is available the Panel considers that it would be unethical to use a foster uterus.

35. It has been envisaged that it may become practicable to diagnose certain fetal abnormalities in fertilised ova at the stage at which they could be implanted in the mother's uterus. If such techniques are perfected without damaging ova, screening for fetal abnormality in this way might be preferable to termination at 16 weeks.

36. The Panel sees no objection to experimental research so far carried out involving the culture of human fertilised ova, but considers that the implications of this field of research should be kept under review.

37. At present there is no legislation governing experimental work which involves in vitro fertilisation. Whilst it is important to keep the options on development in this field as wide as possible, safeguards governing this work should be established and it is hoped that the Panel on Biological Standards and Technological Developments of the Board of Science and Education will help to provide guide lines for research workers, both medical and non-medical.

Applied Genetics

38. The Panel envisages that a number of techniques, such as predetermination of sex and production of chimaeric individuals by genetic engineering may become feasible in the future. Such developments would need to be kept under careful review by a supervisory body to be established by the profession so that the overriding consideration would be the wellbeing of the potential future child.

Genetic Counselling

39. Eugenic measures are usually divided into two types — positive, aimed at encouraging the selection of advantageous genes, and negative, aimed towards the elimination of harmful genes. Positive eugenics raises considerable social and biological problems; any such developments would be an appropriate matter for consideration by the supervisory body to which reference has already been made.

40. Negative eugenics can be achieved, to a certain degree, through genetic counselling. Reliable tests are being developed to detect carriers for recessive diseases. The ethical problems raised here are — firstly, if the doctor has information, should he pass it to the patient or the parents; secondly, whether tests should be offered to

other members of the family; thirdly, whether the profession should actively encourage a positive approach to screening for carrier status; fourthly, whether a national register or local registers of those carrying genes for inherited disorder should be considered?

41. In the Panel's view the divulgence of knowledge is a clinical decision; the doctor must strike a balance between the trauma of giving information, and the trauma of allowing parents to have an abnormal child. The genetic counsellor's responsibility, like that of any other doctor, is to his patient. Any form of preventive medicine involves the doctor in taking the initiative rather than waiting for the patient to approach him. This is already undertaken for immunisation procedures and there could be no ethical objection to extending it to the prevention of genetic disorder. Relatives at risk should be offered advice through their own family doctor. More people at risk could be identified through a genetic register drawing on hospital, community medical services and general practitioner sources of information. The development of a genetic register raises administrative and ethical aspects which need full consideration. Provided that there were adequate built-in safeguards to avoid misuse such a register would enable a great many more people at risk to obtain genetic advice than do so at present. Population screening for carriers is impracticable for most diseases because of technical difficulties and the rarity of most recessive disorders. As soon as a quick, simple and reliable method for the diagnosis of carriers of the gene for cystic fibrosis of the pancreas becomes available population screening of school leavers should be offered for this one disease. The incidence is about 1 in 2,000 live births, or possibly higher and between 1/20 and 1/25 of the population are carriers. The carriers themselves, their parents and their family doctors could then be informed. Such a programme might obviate the necessity for neonatal screening for affected children except where both parents were known carriers.

Survival of the Handicapped

42. Another dilemma raised by medical advances is that in certain instances new treatments enable physically or mentally handicapped patients to survive whilst failing to alleviate the handicap. Such situations are frequently encountered in the fields of paediatrics and geriatrics as well as in the treatment of accident surgery. The decision as to what is best in the interests of the patients must be left to the clinical judgement of the physicians and surgeons.

ORGAN TRANSPLANTATION

43. The Panel has looked at some of the ethical problems raised by developments in the transplantation of organs and supports the

statement of the B.M.A. Council on the Ethics of Transplantation (B.M.A. Members' Handbook 1970) which it welcomes as a reasonable and comprehensive statement.

EUTHANASIA

44. The Panel has studied and commends the report on the Problems of Euthanasia prepared by a special panel of the Board of Science and Education (B.M.A. 1971) which concludes that "euthanasia cannot be accepted by the medical profession".

PROFESSIONAL RESPONSIBILITY

45. Through its discussions — the Panel has met thirteen times during the past two years — an ever recurring subject of discussion has been professional responsibility. The Panel has noted with great interest that the members of the associated disciplines of theology, the law and sociology who kindly commented on its work were intensely interested in this subject. It became apparent that guidance in professional responsibility could best be provided by a body appointed by the profession and answerable only to the profession. Every profession should be self critical in order to reach and maintain the highest standards and cannot permit others to dictate to it in this field. If this critical role is not accepted the profession may quickly lose its status and face intervention from other interested bodies and possibly the State.

46. At present the only body having responsibilities in this field is the General Medical Council, a statutory body set up by Parliament under the Medical Acts in the interests of the public. Its main functions are to keep the Medical Register, to prescribe certain standards of medical education which it recommends for observance by universities and other licensing bodies, and the administration of discipline. It has no statutory obligations to the profession. At the present time, though it deals with medical education and professional conduct, the General Medical Council has no power to:

(i) establish continuing standards of competence or to supervise them;
(ii) supervise standards of postgraduate training and education;
(iii) monitor continuing competence of those already on the Register;
(iv) examine disciplinary cases other than those referred to it.

47. The Panel suggests that the General Medical Council in trying to serve two masters, the public and the profession, finds itself in some difficulties. It suggests that the G.M.C. might be replaced by two bodies, one which it calls the "Public Body" which would concern itself principally with the registration of medical practitioners; and a "Professional Body" which would undertake all

responsibilities concerned with professional qualification, the maintenance of standards of undergraduate and postgraduate medical education and medical practice and would advise the Public Body of the qualifications of those who apply to be placed on the Medical Register.

48. **The Public Body**

The purposes of the Public Body would be:

(i) to safeguard the interests of the public;

(ii) to maintain a Register of those recognised by the Professional Body as suitable to be included on the Medical Register.

The Public Body would safeguard the public by receiving and evaluating complaints and by examining the records of legal penalties incurred by registered medical practitioners. Matters which it thought to be of a strictly professional nature would be referred to the Professional Body for its advice and recommendations.

49. **The Professional Body**

The Professional Body would concern itself with standards of postgraduate and undergraduate education and the maintenance of ethical standards of practice. The overriding principle must always be that such questions should be the concern of the Professional and not the Public Body. There are three ways in which such a body could be established:

(i) solely by the profession

(ii) set up by the profession but recognised by statute, with rights given by regulation to be consulted

(iii) created by statute and given powers by that statute.

Only the third type of body would be legally capable of carrying out in toto the functions which the Panel suggests should be invested in it. These functions are outlined below:

(*a*) to maintain and supervise standards of undergraduate and postgraduate education.

(*b*) to examine problems of professional concern, including those referred to it by the Public Body. It is envisaged that it would examine such matters as, for example, public complaints and reports of legal infringements by members of the profession; establishment of comparable standards for all doctors practising in the United Kingdom, whether they qualify here or overseas; or the effect which entry into the Common Market might have upon the practice of medicine.

(*c*) to consider the need for the establishment of methods for monitoring continuing competence to practise. The Panel recognises that this is a new concept which will meet considerable resistance within the profession, but considers that it is the

collective responsibility of the profession to ensure that each member maintains an acceptable standard of competence and that there should be safeguards against deterioration due to mental or physical ill health. This function is clearly the responsibility of the profession and should not be allowed to pass into the hands of the State.

Implications of the above proposals

50. The General Medical Council would cease to exist being replaced by two bodies, a Public or Registering Body and a Professional Body.

51. In the hospital service a voluntary early warning system exists whereby the behaviour and competence of colleagues may be confidentially reported to Hospital Management Committees for consideration. It is recognised that this system does not work uniformly throughout the country but has nevertheless established some precedent for the principle put forward in paragraph 49, sub-paragraph (*c*) above.

52. There is no comparable system at present applicable to general practice where the doctor is an independent contractor and there are still many single handed general practitioners working in some degree of isolation. The Professional Body would have to concern itself with this situation.

53. The Panel is anxious that the profession should control and be seen to control its own standards without the intervention of other agencies. It has set out the courses which in its view are open to the profession in order to maintain high professional standards and offers these for consideration.

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APPENDIX I

In preparing the Statement on Professional Standards the Panel discussed its ideas with:

C. H. H. Butcher	Hempsons, London, Solicitors to the B.M.A.
M. R. Draper	Registrar, General Medical Council.
R. G. Edwards	Reader in Physiology, Physiological Laboratory, University of Cambridge.
J. S. Happel	General Practitioner, Alresford, Hants. *and* Chairman of the Central Ethical Committee, B.M.A.
Bernard Hargrove	Senior Lecturer, Faculty of Laws, University College, London.
The Rev. Canon Ronald H. Preston	Professor of Social and Pastoral Theology, University of Manchester.
P. C. Steptoe	Senior Consultant Obstetrician and Gynaecologist, Oldham and District Hospital Group.
Richard M. Titmuss	Professor of Social Science and Administration, London School of Economics and Political Science.
K. F. Urwin	Director of Social Services, London Borough of Camden.

APPENDIX II

TEACHING OF MEDICAL ETHICS

The Panel suggests that the following subjects and questions be included in a course of seminars on Medical Ethics for clinical medical students:—

1. **Introduction** — what are ethics? — ethics and etiquette — historical perspectives — Hippocrates to Nuremberg — why have ethical codes? (Sections 1 - 8).
2. **Responsibility** — the nature of responsibility — to whom? — conflicts of responsibility — the patient or society? — advertising (Sections 9 - 16; 45 - 53).
3. **Confidentiality** — its purpose — when should it be broken? — problems of medical records (Sections 12 - 16).
4. **Definitions of death** — transplantation and its problems (Section 43).
5. **Control of Life I** — artificial insemination — in vitro fertilisation — conception — abortion (Sections 27 - 30; 32 - 37).
6. **Control of Life II** — euthanasia and care of the dying (Section 44).
7. **Medical Research I** — importance of safeguards — normal volunteers — consent — therapeutic and non-therapeutic research (Sections 17 - 23).
8. **Medical Research II** — drug trials, especially in general practice — ethical committees (Sections 24 - 25).
9. **Advances in Genetics** — genetic counselling — pre-natal diagnosis — hereditary and sex linked defects — the problem of the right action when knowledge has been obtained (Sections 38 - 42).
10. **The Individual Doctor's Conscience** — should a doctor's personal beliefs influence his medical practice?

Published by the British Medical Association,
B.M.A. House, Tavistock Square, London WC1
Printed by J. E. C. Potter & Son Ltd., Stamford, Lincs.