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British Medical Association

Medical Ethics

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

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British Medical Association

(FOUNDED 1832)

(Member of the World Medical Association: Member of the Commonwealth Medical Association; Affiliated with the Australian, Canadian, Ceylon, Ghana, Indian, Malayan, Nigerian, Pakistan, Sarawak and Singapore Medical Associations and the Medical Associations of New Zealand, South Africa and Swaziland.)

Patron:
HER MAJESTY THE QUEEN

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MEDICAL ETHICS

(Reprinted from the Members Handbook, 1970)

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BRITISH MEDICAL ASSOCIATION
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TAVISTOCK SQUARE, LONDON, WC1H 9JP

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 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;
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.

Duties of Doctors to the Sick

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

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.

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.

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 given below:

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.

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

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 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.

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 pamphlet "Consent to Treatment" published by the Medical Defence Union contains comprehensive advice on procedures for obtaining consent.)

Organs from Cadavers

A. Consent

Consent should normally be given in the following manner:

(i) The deceased person should have given recorded positive consent in his or her lifetime.

(ii) Failing consent as in (i) the donor should be known not to

have expressed opposition, and in every case the positive consent of the next of kin should be sought. Under the existing law (Human Tissue Act, 1961—1 (2)) inquiry must also be made as to likely objection by any other relative, as this constitutes a bar. The Minister considers that "any other relative" should be interpreted in the widest sense, though it should be sufficient to make such inquiry of the nearest available relative (Circular H.M. (61) 98, para. 8). 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).)

(v) *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 Council supports the following statement by the W.M.A. (August, 1968) regarding determination of the point of death:

"This determination will be based on clinical judgement 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 judgement of the physician."

(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 (see p. 30). 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.

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

The basis of the relationship between a doctor and his patient is that of absolute confidence and mutual respect. The patient expects his doctor not only to exercise professional skill, but also to observe secrecy with respect to the information he acquires as a result of his examination and treatment of the patient. On the doctor's side an awareness of the patient's trust serves to invoke the observation of ethical standards and the need to act always in the best interests of the patient.

Professional confidence implies that a doctor shall not disclose voluntarily, without the consent of the patient, preferably in writing, information which he has obtained in the course of his professional relationship with the patient. This principle was reaffirmed by the Representative Body in 1959 in the following terms:

> **"It is a practitioner's obligation to observe the rule of professional secrecy by refraining from disclosing voluntarily without the consent of the patient (save with statutory sanction) to any third party information which he has learnt in his professional relationship with the patient.**
>
> **"The complications of modern life sometimes create difficulties for the doctor in the application of the principle, and on certain occasions it may be necessary to acquiesce in some modification. Always, however, the overriding consideration must be the adoption of a line of conduct that will benefit the patient, or protect his interests."**

The Council places the highest possible importance on the maintenance of professional secrecy, particularly in the circumstances outlined in the following resolution of the A.R.M., 1966:

> "That this meeting confirms the policy laid down by the Representative Body in 1959 and affirms also that the death of the patient does not absolve the doctor from his obligation of secrecy. Where the patient is dead or not in a position to give consent it is left to the discretion of the doctor to decide who, in the particular case, is the person competent to give such consent."

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 presiding judge, however, may overrule this contention and direct the medical witness to supply the required information. The doctor has no alternative but to obey unless he is willing to accept imprisonment for contempt of court.

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.

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, venereal diseases, attempted suicide, or concealed birth. When in doubt concerning matters that have legal implications a doctor may also wish to consult the medical defence organization of which is he a member.

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 or non-medical persons, with the result that requests are made by medical or lay officials for clinical records or other information concerning patients. The Representative Body has passed the following resolutions relating to this problem:

> 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.)
>
> 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.)
>
> The form of consent signed by or on behalf of the patient should include a statement that the patient agrees to his hospital records being made available to the medical board in order to assist them to consider and assess claims. (A.R.M. 1955.)
>
> 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.)
>
> 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, and such requests should be made to the Medical Officer of Health. (A.R.M. 1968.)
>
> 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.)

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 make it a rule to refuse to give any information in the absence of the consent of the patient or the nearest competent relative.

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 a restrictive covenant precluding practice for an agreed time in a defined area by the partner, assistant or locum tenens after the termination of the contract. Apart, however, from the legal aspect of the matter 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.

Unless the written consent of the principal or partner or partners is obtained, a doctor who has acted as an assistant to or locum tenens for that principal or as a member of a partnership should not set up in general practice in opposition to his former principal or partner in the area of practice of that principal or partner, nor should any doctor act similarly towards another with whom he has unsuccessfully negotiated for a partnership or made enquiries thereon; to do so would be considered an unethical procedure. Even though the principal by a breach of faith may have caused *bona fide* negotiations to break down, the other doctor concerned should not start a competitive practice with him unless and until he satisfies himself, by a reference to practitioners established in the area or to the British Medical Association, that the action he contemplates is free from ethical objection. 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.

The Representative Body in 1925 considered the special position of a locum tenens and expressed its views in the following terms:

> As a locum tenens is introduced in confidence to the practice of which he/she takes charge, it must be presumed on principles of common equity that he cannot without dishonour commence practice in the neighbourhood where he has acted unless with a written consent obtained either from the practitioner whose substitute he has been or from the legal representatives of this practitioner. There may, however, be circumstances, for example, the lapse of time, which would make the strict application of this rule an unreasonable interference with the freedom of a practitioner who had

acted as a locum tenens. If any such plea for the relaxation of the rule in any individual case can be advanced, the facts should be stated to the Central Ethical Committee and the judgment of the Central Ethical Committee on this point be accepted as final.

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 to 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 (see p. 30).

A Consultant beginning practice in a particular speciality 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 speciality 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 principals 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 speciality.

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 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 un-

reasonably 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 representative 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

The examination of another doctor's patient may occasionally 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 who at the time of the application is under active* treatment by a colleague, unless he *is* personally satisfied that the colleague concerned has been notified by the patient or his representatives that his services are 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.

Notwithstanding paragraph (3) above, when a practitioner in whatever form of practice is asked for advice or treatment by a patient and has reason to believe that the patient is already under medical care and that the request is made without the knowledge of the attending practitioner, it is the duty of the practitioner so approached to urge the patient to permit him to communicate with the attending practitioner. Should the patient refuse this proposal and *if the circumstances are exceptional* the practitioner is at liberty to examine the patient and to tell the patient his findings and conclusions, but, save for any emergency which exists, he shall not accept the patient for treatment. (A.R.M. 1957.)

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.

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

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*) Consultations in venereology, either at clinics or in private.

(*e*) Overseas visitors having no family doctor in the United Kingdom.

(*f*) 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 Representative Body in 1967 resolved:

That this Meeting agrees that when a gynaecologist considers that a patient, as part of her treatment, requires contraceptive advice, and he has not been asked by her general practitioner to carry this out, he should, except in special circumstances, refer the patient back to her own doctor and not to a family planning clinic and should in any case, inform the general practitioner of his action in this matter.

In connexion with the setting up by local health authorities of family planning clinics as part of the National Health Service the Representative Body approved the following statement:

1. The right of a woman to direct access to services provided by Family Planning Clinics is both recognized and respected. These services are supplementary to those provided by family doctors, and do not replace them.

2. In many cases it is in the best interests of the woman if her own doctor is given an opportunity to express an opinion on the suitability of the proposed form of contraception.

3. These cases include all those in which the woman is under the active clinical care of a doctor at the time of attendance at the clinic, or where the indications for contraception are medical (as opposed to social).

4. In other cases the need to inform the woman's own doctor will depend upon the form of contraception which is proposed. If certain mechanical methods (e.g. diaphragm) are proposed, there is no need for prior reference to the woman's own doctor. However, if some condition is found on examination about which her own doctor ought to be informed, she should be encouraged to permit a report to be sent.

5. The woman's own doctor should always be given an opportunity to express an opinion before an oral contraceptive is prescribed or an intra-uterine contraceptive device fitted. In some cases the woman's own doctor may wish to undertake management of the case himself or to refer the case to a specialist, if appropriate.

6. It is often desirable that a cervical smear should be taken at the same time as the woman is examined at the clinic, and there is no need for prior reference to the woman's own doctor, who should, however, be informed of the result. A clinic should not accept a woman attending solely for the purpose of having a cervical smear test unless she has been referred by her own doctor (subject to any arrangements which may be made between the clinic and representatives of the medical profession locally).

7. Medical treatment, e.g. for infertility, should not be carried out at the clinic without reference to the woman's own doctor, and no case should be referred to a specialist for an opinion or for treatment without prior reference to her own doctor. (A.R.M. 1967.)

8. When practitioners acting as individuals, or collectively, prescribe an oral or an intra-uterine contraceptive they shall remain, in that respect, responsible for the future management of the patient, unless the treatment is carried out with the prior consent of the patient's own general practitioner. This shall in no way alter the normal relationship between a general practitioner and a consultant. (A.R.M. 1968.)

Sterilization

The following resolution was passed by the Representative Body in 1967:

That, as all methods of contraception appear to have their drawbacks, this meeting considers that the time is due for the medical profession to consider the question of the legality of sterilization and help to form the law by deciding its view of what the law ought to be.

If the doctor is satisfied that an operation for sterilization is in the interests of the health of the patient and that the patient has given

valid consent and understands the consequences of the operation there is, in the opinion of the Council, no ethical reason why the operation should not be performed.

As regards legal aspects, Council has received the following statement from the Medical Defence Union, with which the other defence organizations are understood to be in agreement. In the opinion of Council no further action need be taken in this connexion:

> In its 1961 Annual Report the Union expressed the view that sterilization of a husband or wife solely as a method of birth control might not be upheld by the Court. The climate of public opinion has been changing and the Council feels that a more liberal attitude to sterilization would now be taken by the Courts than might have been the case five years ago. In the case of a married patient the written consent of both the husband and wife should be obtained before the sterilization of either party is undertaken. The Union has prepared a model form of consent to an operation for primary sterilization, a copy of which will be sent on request to any member.

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 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) It 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.

Industrial Medical Officers

The Representative Body in 1961 approved the following notes for the guidance of industrial medical officers:

A doctor in industry 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 industry whether they are working whole-time or in a part-time capacity.

(A) The doctor in industry 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 medical officer of health 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 industrial appointment should be guided by the following:

1. Save in emergency, the doctor in industry 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 industry believes that the workers should consult his general practitioner, he should urge him to do so.

3. Save in emergency, the doctor in industry 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 industry to verify justification for absence from work on grounds of sickness. If the doctor in industry 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 industry 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 industry 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 industry 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 industry 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 for his professional use are 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. The Association further believes that the doctor in industry 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 on 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 13.

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 be 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 1949 the Councils of the British Medical Association and of the Pharmaceutical Society approved the following ethical principles:

(1) It is undesirable that a doctor and a pharmacist should carry on a practice from the same premises unless each practice has a separate address and there are separate means of access to the two addresses.
(2) It is undesirable that a doctor should have a financial interest in directing his patients to a particular chemist when there are other chemists in the area.
(3) In order to preserve the principle of free choice and to avoid abuse, it is undesirable that a doctor should recommend a particular chemist, or a chemist a particular doctor, unless he is specifically asked to do so by the patient.

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 1 Tilney Street, London, 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 1956 the Council drew up a report which was approved by the Representative Body to serve as a guide to the profession. This report, which is reproduced below, was revised in 1960 and 1961.

Report on Advertising and the Medical Profession

(Approved by the Representative Body 1968)

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 its functions, procedure and disciplinary jurisdiction. 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 (ix) of the Notes on certain professional offences issued by the General Medical Council.

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, but anonymity should be observed as a general principle unless the objective of identifying the doctor is apparent, paramount and justifiable in one of the following ways:

(*a*) in the interests of the general public; or
(*b*) in the interests of the medical profession; or
(*c*) as an essential part of providing authoritative information when necessary for the general public.

In these circumstances anything that could be construed as advertising of the doctor himself should be incidental and reasonably unavoidable for the attainment of the objective. Departure from the principle cannot be justified on grounds that the resulting publicity will not benefit the doctor professionally.

8. The principle of anonymity is particularly important in circumstances where the doctor is contributing frequently, as in the case of a series of programmes or articles.

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 it 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.

Public Health Medical Officers

20. Publicity is necessary in carrying out the duties of medical officers of health and other medical men who hold posts in the public health or other 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.

Re: 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.

Extracts from the booklet issued by the G.M.C. on its functions, procedure and disciplinary jurisdiction are set out below:

DISCIPLINARY JURISDICTION AND PROCEDURE

(a) General

The Council fully realises and appreciates the high standard of professional conduct of the vast majority of doctors in this country who will never find themselves directly concerned with the Council's disciplinary jurisdiction. Yet circumstances may arise in which a doctor, perhaps through no fault of his own, may be confronted with one of the problems mentioned below, or with some difficult question bordering on such a problem—for example, in relation to the giving of certificates, or "advertising". This part of the pamphlet, therefore, provides a brief explanation of the Council's disciplinary work, together with such *general* guidance as may be given in regard to certain problems of medical ethics and conduct. *Specific* guidance in a particular set of circumstances can rarely be given by the Council, owing to its judicial functions under the Medical Act.

The Medical Act 1956 provides that if any fully or provisionally registered practitioner (1) has been convicted* of any offence by any Court in the United Kingdom or the Republic of Ireland, or (2) after due inquiry has been judged by the Disciplinary Committee of the Council to have been guilty of infamous conduct in any professional respect, the Committee may if they think fit direct that his name be erased from the Register.†

Convictions *overseas* may, if the facts warrant, give rise to a charge of infamous conduct in a professional respect.

The term "conviction" as used in this pamphlet does not include a finding or decision of an Executive Council or of the Secretary of State under the machinery of the National Health Service.

* Such convictions are reported to the Council in the normal course.

† Some changes will be introduced with effect from April 1, 1970, when the disciplinary provisions of the Medical Act 1969 will come into operation. In general the pamphlet describes the current position (January 1970).

The Council's Approach to "Infamous Conduct"; its Duty to Protect the Public

The formidable phrase "infamous conduct in a professional respect", which was first used in the Medical Act of 1858 and was retained in the Act of 1956, 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."

Lord Esher added to this definition as follows: "The question is not merely whether what the medical man has done would be an infamous thing for anyone else but a medical man to do. He might do an infamous thing which would be infamous in anyone else, but if it is not done in a professional respect it does not come within the section." Another eminent Judge has stated that the phrase means "no more than serious misconduct judged according to the rules, written or unwritten, governing the profession". In other words, it means a serious breach of medical ethics.

Under the Act the Disciplinary Committee are not called upon to punish, in any retributive sense. Their primary duty is to protect the public. "Is it in the public interest to leave this doctor on the Register?" must be the first question in their minds in difficult cases. Subject however to their overriding duty to the public, members of the Committee may and do constantly ask themselves, "What is in the best interests of the doctor himself?" Largely for this reason, as further explained below, the Council has evolved a system of placing certain offenders (especially in relation to drink and drugs) on probation for a limited period; if all goes well, the case will be discharged at the end of the period.

The Council is as concerned as the doctors themselves to avert wherever possible any need for a formal disciplinary inquiry into a doctor's conduct. Hence, it is the practice of the President and of the Penal Cases Committee (a preliminary Committee who sit in private—see pages 97 and 101) to send letters of warning to those doctors who have been convicted for the first time for, say, driving a motor-car while under the influence of drink. Similar letters may be sent in regard to such matters as serious failures to visit or treat patients, or the issue of misleading professional certificates.

Types of "Infamous Conduct"; Convictions raising Disciplinary Questions

It is not possible, and since circumstances change it never will be possible, to compile a complete list of the matters which may lead to disciplinary action on the part of the Council. The question whether any particular action or course of conduct amounts to "infamous conduct in a professional respect" is one which falls to be determined by the Disciplinary Committee after considering all the circumstances

of each individual case, including any mitigating circumstances. The gravity of any conviction, or of a sequence of convictions, has similarly to be determined in each particular case. However, in the light of the Council's experience over the last hundred years it is possible to indicate, with examples, a number of types of offence or misconduct which raise disciplinary issues:*

	Page on which further information is given
(1) *Abuse of a doctor's knowledge, skill or privileges*	
Illegal abortion.	39
Improperly purveying dangerous drugs.	40
(2) *Abuse of relationship between doctor and patients*	
Adultery with a patient.	39, 40
Improperly disclosing information obtained in confidence from a patient.	——
(3) *Disregard of personal responsibilities to patients*	
Culpable neglect in diagnosis or treatment.	40
"Covering" medical practice by unregistered persons.	41
(4) *Offences indicative of tendencies dangerous to patients*	
Offences arising out of abuse of alcohol.	40
Addiction to drugs.	40
(5) *Offences discreditable to the doctor and his profession*	
False pretences, forgery, fraud, theft, indecent behaviour, assault.	——
(6) *Issuing untrue or misleading certificates*	41
(7) *Improper attempts to profit at the expense of professional colleagues*	
Canvassing for patients.	41
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Depreciation of other doctors.	43
(8) *Abuse of financial opportunities afforded by medical practice*	
Improperly obtaining money from patients or from authorities under the National Health Service.	43
Commercialisation of a secret remedy.	44
Improperly prescribing drugs or appliances in which a doctor has a financial interest.	44
Fee-splitting.	44

* The instances given in each category have been selected in order to illustrate the issues concerned. *Neither the categories nor the instances given in these pages are exhaustive;* nor are the Disciplinary Committee prepared to accept it as a good defence that a doctor has done something against which he had received no formal warning. The doctor whose name (in the last century) was erased for keeping and exhibiting "an anatomical museum containing wax-works of a disgusting character", and the doctors who have been charged with convictions for murder, or for blackmailing a patient, could hardly expect to have received a specific warning in advance from the Council against such conduct.

(b) Notes on certain Professional Offences

Some, though not all, of the matters described below have already been mentioned in the preceding section (a).

(i) *Termination of Pregnancy*

The Council regard as a serious matter the termination of pregnancy if done in circumstances which contravene the law. A criminal conviction in the British Isles for such an offence in itself affords ground for a charge before the Disciplinary Committee.

(ii) *Adultery or other improper conduct or association with a patient or member of a patient's family*

Any doctor who commits adultery or other improper conduct or who maintains an improper association with a person with whom he stands in professional relationship at the material time is liable to disciplinary proceedings. In upholding a decision of the Disciplinary Committee, the Judicial Committee of the Privy Council have made the following comments on circumstances in which an abuse of professional relationship may arise:

> "A doctor gains entry to the home in the trust that he will take care of the physical and mental health of the family. He must not abuse his professional position so as, by act or word, to impair in the least the confidence and security which should subsist between husband and wife. His association with the wife becomes improper when by look, touch, or gesture he shows undue affection for her, when he seeks opportunities of meeting her alone, or does anything else to show that he thinks more of her than he should. Even if she sets her cap at him, he must in no way respond or encourage her. If she seeks opportunities of meeting him, which are not necessary for professional reasons, he must be on his guard. He must shun any association with her altogether, rather than let it become improper. He must be above suspicion.
>
> "It was suggested that a doctor, who started as the family doctor, might be in a different position when he became a family friend. His conduct on social occasions was to be regarded differently from his conduct on professional occasions. There must, it was said, be cogent evidence to show that he abused his professional position. It was not enough to show that he abused his social friendship. This looks very like a suggestion that he might do in the drawing-room that which he might not do in the surgery. No such distinction can be permitted. A medical man who gains the entry into the family confidence by virtue of his professional position must maintain the same high standard when he becomes the family friend."

If a doctor becomes involved in divorce proceedings, and any question of professional relationship arises for the Disciplinary Committee, any finding of fact which has been made in matrimonial proceedings in British or Irish courts must, in accordance with the Medical Act, be accepted by the Committee as conclusive evidence of the fact found.

(iii) *Disregard of personal responsibilities to patients*

In pursuance of its primary duty to protect the public, the Council may feel bound to take cognisance of a case (whether or not it has been investigated under the National Health Service machinery) in which a doctor may appear to a serious extent to have disregarded his personal responsibilities to his patients or to have neglected his professional duties, for example, by failure to visit or to provide treatment for a patient.

(iv) *Offences arising out of abuse of alcohol*

More doctors appear before the Disciplinary Committee owing to convictions arising out of an abuse of alcohol (especially when in charge of motor vehicles) than for any other single reason. At some sessions, such cases have exceeded in number all other cases put together. The large majority of cases of this nature, however, are heard by the Disciplinary Committee only after more than one conviction has been recorded against a doctor. It is customary after a first conviction for drunkenness to send to the doctor, on the instructions of the Penal Cases Committee, a warning letter in order that he may reconsider his habits and conduct. It is repeated convictions, indicating habits that may bring disrepute on the doctor and on the profession, which may lead to an inquiry before the Disciplinary Committee. At this inquiry all the convictions are liable to form the basis of the charge against the doctor.

The treatment of a patient by a doctor under the influence of drink has led to a disciplinary charge.

(v) *Abuse of Dangerous or Scheduled Drugs*

Disciplinary proceedings may become necessary as a result of a breach of the Dangerous Drugs Regulations, or of some other offence committed in order to gratify a doctor's own addiction; or a doctor may have been convicted for driving or being in charge of a motor vehicle when under the influence of a drug. Charges have also been based on the treatment of a patient by a doctor alleged to be under the influence of drugs.

In addition to such cases arising out of a doctor's own addiction to drugs, disciplinary proceedings have been taken in cases in which a doctor is alleged to have purveyed drugs to persons otherwise than in the course of bona fide treatment.

(vi) *Untrue or misleading certificates and other professional documents*

Doctors engaged in general practice are especially familiar with the problems that may arise in regard to the issue of certificates, reports, and other documents signed in a professional capacity. Such certificates are repeatedly required of doctors, for example in the National Health Service, or in relation to birth, illness, death or cremation, or for the purpose of excusing attendance in the courts or in public or private employment.

Doctors are expected by the Council to exercise the most scrupulous care in issuing such documents, especially in relation to any statement that a patient has been examined on a particular date. Any doctor who gives in his professional capacity any certificate or kindred document containing statements which he knows, or ought to know, to be untrue, misleading, or otherwise improper, brings himself within the scope of the Council's disciplinary jurisdiction.

(vii) "*Covering*", *i.e. assisting unregistered persons to practise Medicine*

Relations with persons performing functions relevant to Medicine, Surgery, and Midwifery

Any doctor who knowingly enables or assists a person, not duly qualified and registered as a medical practitioner, to practise Medicine or to treat patients in respect of matters requiring medical or surgical discretion or skill, becomes liable to disciplinary proceedings.

The foregoing statement is not to be regarded as affecting or restricting 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 specialised 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 patient.

It will be understood that no doctor should enable any uncertified person to attend a woman in childbirth, save in urgent necessity or under the personal supervision of a doctor.

(viii) *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 organisations which canvass, may lead to disciplinary proceedings.

Disciplinary proceedings may also result from 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. The Council has also taken action in cases where doctors, whether singly or by arrangement with other doctors, have issued National Health Service prescriptions to patients who were being treated as private patients.

(ix) *Advertising; depreciation of other doctors*

(1) 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.

(2) 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 organisations 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.

(3) 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 organisations with which a doctor is associated or by which he is employed.

(4) 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 5 below).

(5) 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.

"It must be recognised that professional medical men may be amply justified in publishing books and articles and in publishing them in their own names. By their writings they may be making invaluable contributions to medical science and to learning. They may be disseminating useful knowledge. They may be helping their fellow practitioners. They may be advantaging a wider public. It must however be recognised that by their writing they may inevitably and indeed justifiably attract notice. This may redound to their professional and to their pecuniary advantage. It may well be that in some cases a hope that some legitimate meed of personal advancement will result may find its place amongst the motives in writing and may be the spur to command the industry that the task may require. But after this has been said it can definitely be said that within the profession the line between the kind of publication that is unobjectionable and the kind that is objectionable should present no difficulties of recognition for any reasonable practitioner.

"Examples may be given. 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'."

(6) Disciplinary proceedings have on occasion arisen out of the depreciation of the professional skill, knowledge, services or qualifications of another doctor or doctors.

(x) *Improper Financial Transactions*

(1) Questions of infamous conduct have arisen in regard to 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.

(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. The Council has also taken cognisance of cases in which 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 erasure, (a) the commercialisation of a secret remedy, (b) improperly prescribing drugs or appliances in which a doctor has a financial interest, and (c) arrangements for fee-splitting, under which one doctor would receive part of the fee paid by a patient to another doctor.

(c) Committee Procedure

The Earlier Stages of the Proceedings

Convictions of doctors are reported to the Council by the Police authorities, apart from minor motoring offences and other trivial matters. In cases of *conduct* as distinct from convictions, any information or complaint must be supported by one or more statutory declarations (that is, sworn statements) unless it is made on behalf of a Government Department, Executive Council or Medical Council of some country overseas, or by some other body or person "acting in a public capacity".* Convictions are referred in due course to the Penal Cases Committee, who usually meet in April and October. In cases of conduct, unless it appears to the President that the matter need not proceed further, the doctor concerned is invited to submit an explanation, which is also placed before the Committee.

In cases both of conviction and of conduct, it is for the Penal Cases Committee to decide whether an inquiry need be held by the Disciplinary Committee, who normally meet in May and in November. If the Penal Cases Committee decide against the holding of an inquiry, it is open to them to send a warning letter to the doctor, as mentioned on pages 94 and 97.

The Disciplinary Committee

The full membership of the Committee is nineteen, including two laymen, but the majority of cases are heard by nine members only. The Committee normally sit in public, and their procedure is closely akin to that of Courts of Law. Witnesses may be subpoenaed, and evidence is given on oath. Doctors who appear before the Committee in answer to charges, whether based on convictions or allegations of infamous conduct, may be, and usually are, legally represented. **The Committee are bound by law to accept a conviction as conclusive evidence that the doctor was in fact guilty of the offence; it is not open to a doctor to contend at this stage that he was in fact innocent of the offence of which he was convicted, or that he was convicted only because he had pleaded guilty in order to avoid publicity or for some other reason.** The circumstances of a criminal offence need not involve professional misconduct, but the conviction in itself gives the Committee full jurisdiction.

* This expression includes officers of Government Departments, local authorities and public authorities, Judges and officers attached to Courts, and the Solicitor to the Council.

In cases of conduct, evidence as to the facts may be adduced by both parties. If the facts are found by the Committee to have been proved to their satisfaction, they must subsequently determine whether, in relation to those facts, the doctor has been guilty of infamous conduct in a professional respect.

Alike in cases of conviction and of conduct in which the facts have been found proved, the Disciplinary Committee have to decide on the merits of the case between several possible courses of action. Before taking a final decision, they invite 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 may decide to conclude the case without erasing the name of the doctor (this does not prevent them from expressing concern at the facts which have been disclosed), or they may place the doctor on probation by postponing judgment for a specified period, or they may direct erasure. In the last event, the name will be erased after twenty-eight days unless in the interim the doctor appeals to the Judicial Committee of the Privy Council against the decision of the Disciplinary Committee.

Of the 359 doctors whose names were erased in 1900–1969 on disciplinary grounds, 98 were erased for adultery or improper conduct with a patient, 64 for procuring illegal abortion or miscarriage, 61 for offences connected with drink or drugs, 30 for advertising or canvassing, 31 for fraud, false pretences or analogous matters and 75 on other grounds.

(d) Restoration to Register after Disciplinary Erasure

Applications for restoration may legally be made at any time after ten months from the date of erasure. If such an application is unsuccessful, a further period of at least ten 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 determine 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.

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 may be asked to pay an annual fee for the retention of their names on the Register. It is intended to send to every doctor from whom a fee is due a notice of the fact, and a reminder if he fails to pay the required fee. Ultimately, however, 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.

Restoration of a name to the Register after erasure under Section 3 of the Medical Act 1969

(i.e. through failure to answer official communication from the General Medical Council)

1. Section 3 of the Medical Act 1969, which substantially reproduced similar provisions in section 15 of the Medical Act, 1858, contains the following sub-sections:

"(4) It shall be the duty of the Registrar to keep the register correct in accordance with the provisions of the Act of 1956, this Act and regulations made by the General Council, to erase the names of persons who have died, and from time to time to make the necessary alterations in the addresses, qualifications and other registered particulars of registered persons.

"(5) The Registrar may, by letter addressed to any registered person at his address on the register, inquire whether he has changed his address and, if no answer is received to the inquiry within six months from the posting of the letter, may erase from the register the entry relating to that person."

2. Regulations made by the Council provide that (unless the President shall otherwise direct) the Registrar shall not restore to the Principal List or to the Overseas List of the Register of Medical Practitioners any name which has been removed therefrom under the foregoing provisions unless

(1) the person whose name has been so removed makes application, in writing, in the appropriate form set out in the Schedule to the Regulations,

(2) the application is supported by such fee or fees, if any, as prescribed in the Regulations.

Copies of the appropriate form may be obtained from:

THE REGISTRAR,
GENERAL MEDICAL COUNCIL,
44 HALLAM STREET,
LONDON, W1N 6AE

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