

Comhairle na
nDochtúirí Leighis



The Medical
Council

*A Guide to Ethical Conduct
and Behaviour
and to Fitness to Practise*

Fourth Edition 1994

174

**Constitution
and Functions**

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**A Guide to Ethical Conduct
and Behaviour
and to Fitness to Practise**

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TABLE OF CONTENTS

	<i>paragraph</i>	<i>page</i>
INTRODUCTION		7-10
CONSTITUTION AND FUNCTIONS		
Membership	1	12
The Register	2	13
Registration	3	13
Provisional Registration	4	13
Full Registration	5	13
Temporary Registration	6	13-14
Retention Fee	7	14
Removal of Name from the Register	8	14
Offences in Relation to the Register	9	14
Education and Training	10	14
Fitness to Practise	11	14
ETHICAL CONDUCT AND BEHAVIOUR		
Ethical Conduct and Behaviour	12	16-17
Section A		
Responsibility to Patients	13	18
Behaviour towards Patients	14	18
Failure of Communication	15	18-19
Personal Relationships between Doctors and Patients	16	19
Section B		
Professional Responsibilities	17	20
Health Problems	18	21
Section C		
Advertising and the Media	19	22-24
Practice Signs	20	24
Clinics	21	24-25
Practice Announcements	22	25
Community Resources	23	26
Personal Standards	24	26

	<i>paragraph</i>	<i>page</i>
Prescribing	25	26
Irresponsible Prescribing	26	26-27
Convictions	27	27
Industrial Action	28	27
Section D		
Doctors in Practice	29	28
Deputising Arrangements	30	28-29
Confidentiality	31	29-32
Consent	32	32
Information	33	32-34
Certification	34	34
Specialist Referral	35	34-35
Fee Splitting	36	35
Attendance on Doctors' Families	37	35
Patient Records	38	35
Section E		
Reproductive Medicine	39	36
In-Vitro Fertilisation	40	36-37
Research on Humans	41	37
Donor Organ Procurement	42	37-38
Euthanasia	43	38
Relationships to Prisoners	44	38
Doctor Patient Relationship	45	38-39
Serious Infection	46	39-40
Investigation	47	40
Doctors with serious contagious diseases	48	40
Adoption	49	41
CONCLUSION	50	44
FITNESS TO PRACTISE		
Fitness to Practise	51	46-48

	<i>page</i>
APPENDICES	
Appendix A — In-Practice Information	49
Appendix B — Recognised Specialties	50
Appendix C — Recommendations of the Medical Council for the prescribing of controlled drugs under the Misuse of Drugs Act, 1977	51-55
Appendix D — Deputising Arrangements	56-57
Appendix E — Resolution Adopted by the 27th World Medical Assembly.	58-59
Appendix F — Medico-Legal Reports	60-61
Appendix G — The Principles Underlying In-Vitro Fertilisation	62-63
Appendix H — Declaration of Helsinki	64-68
Appendix I — Declaration of Tokyo	69-70
Appendix J — Principles of Medical Ethics in Europe	71-78

INTRODUCTION

Since the last edition of the Ethical Guide in 1989, there have been many changes in the practice of medicine ranging from high technological procedures, ethical problems relating to reproductive medicine, genetics, serious infection, advertising and in general, changes in social conditions of many of our patients. The present Guide has been revised and a new format established with numerical identifiable paragraphs to simplify referrals to the Guide. The Ethics Committee has spent a lot of time in the past year re-editing for this issue and I must compliment Professor P. Keane for his enthusiasm and diligence as Chairman of the Committee. New changes relate to data protection, donor organs, protocol on brain death, a statement on abortion, deputising arrangements, requests for medico-legal reports, in-practice information.

In Mason and McCall Smith's excellent book on the "Law and Medical Ethics" *, the introduction refers to the former television series "Your Life in their Hands", and states that though a doctor's involvement with a patient is very special, the two sides of the relationship are not always equally balanced. Just as the lawyer knows more about the law than does his client, doctors know more about medicine than do their patients. Thus it is stated that a patient's attitude is therefore divided between, on the one hand, the trust and learning of another and, on the other hand, the overall apprehension of someone who finds himself/herself in a state of anxiety and uncertainty. It is the function of medical ethics to ensure that, in such an ambivalent situation, the doctor does not abuse his/her perceived superiority.

The progress of medicine can be traced to Imhotep in Egypt in 2000 B.C. who was priest, physician and court official and who laid down rigid rules in regard to experimental treatment, and patients were not charged for visits.

In Babylon in 1000 B.C. the code of Hammurabi contained the elements of medical ethics, systems of payment and penalties for negligence.

In 500 B.C. Greek medicine really introduced medical ethics and philosophers had taken over the waning powers of the priest and introduced new standards and ideals which had been handed down as the Hippocratic Oath. This lapsed with the decline of Greek civilisation but is apparently assented to in a modified version by students at Edinburgh University.

The modern version of the Hippocratic Oath is the Declaration of Geneva which was amended in Sydney in 1968 and forms the International Code of Medical Ethics.

The Judeo - Christian era followed and during the Medieval times, the monasteries kept medicine alive until the voluntary hospital system evolved.

One could say that we as doctors are "victims of our own progress" as new ethical complexes arise from modern medical progress in medicine and surgery, and a well educated public who have an insatiable demand for medical information, expect and demand the best modes of treatment.

The public now expect high quality health care efficiently delivered at the lowest possible cost. Thus the medical profession are under constant scrutiny by the public and the media. In years past, in my generation, people endured many short comings in medical services and care, but to-day, the demand that medical care in all specialties be delivered efficiently is widespread. The recent establishment of a Patients Charter has increased the number of complaints received by the Fitness to Practise Committee. Many of these complaints, all of which are studied meticulously as potential long term High Court cases, turn out not to be the concern of the Council, but they nevertheless reflect the increasing pressure on the profession with growing disparity in the doctor patient relationship leading to the abominable practice of defensive medicine where unnecessary expensive tests are ordered with longer hospital stays and thus longer waiting lists, all to the disadvantage of the patient.

The increasing legislation coming from the European Union, the Conference des Ordres, which incorporates representatives of all EU registration authorities with observers from Sweden and Poland, has established a European Guide to medical ethics in Europe which has been accepted by all Member States and which will probably have greater influence as European integration proceeds.

The Council's recent statement on guidelines re abortion is the Council's majority view and is incorporated in this new Guide.

From the point of view of consent, ethically, doctors may always exercise their own professional judgement concerning disclosures to patients for investigative purposes.

Guidelines are included on medico-legal reports - Section D, paragraph 33.02 and Appendix F - the statement re hearsay evidence is legally correct but rarely implemented. On the matter concerning

the time-scale within which a report may be issued, the "two month" period - Appendix F - paragraph 2 - should be interpreted as meaning the report be available within a reasonable time-scale. It is my view that there may be rare personal circumstances where a doctor, who has initially treated a patient, may not wish to provide a medico-legal report and, in such a situation, the doctor then has an obligation within a reasonable period, to provide an available colleague with relevant notes. The nature/type of report should ideally be provided by the doctor who was involved in the initial treatment. The referral of patients to consultants for the purpose of compiling medico-legal reports without prior consultation with their general practitioners or consultants who initially treated the patients is to be deprecated.

Advertising continues to be a problem and grey area and the line between information and advertising is tenuous. Some members of the profession have continuously expressed liberal views on advertising by the profession while the majority wish to continue their traditional conservative opinions in this regard. As outlined, guidelines on in-practice information by general practitioners are included in the Guide. A recent document - Principles of behaviour of the doctor - advertising medical practice - is actively being considered by the Conference Internationale des Ordres in Paris and sets out very strict codes of ethics in regard to advertising by doctors. When adopted, it will be made available to all practitioners. Clinics continue to advertise but, unfortunately, the Council has no statutory powers to deal with them, and in my view the public interest would best be served by some form of licensing procedure. Doctors involved in such clinics should take very careful notice of the Guidelines in this edition.

In the changing sphere of ordinary medical practice, ethical problems will continue to occur and become more complex, but it is my view that doctors who look after their patients well, will not have ethical or disciplinary problems.

I should stress that when difficulties arise, doctors should consult their defence society or union. The Guide is not a code but merely guidelines to normal ethical behaviour. In the evolving era of many new techniques in medical practice, it is probable that the General Medical Council and our own Council, including the Royal Colleges, will seriously look at post-graduate educational standards for various specialists, and ensure that these specialists continue their education

by self-assessment programmes and thus assure the public thereof. It is also possible that a process of re-certification could be introduced to ensure that evidence of such training in various techniques has occurred. The self-regulatory functions which have been afforded to doctors by peer reviews since 1858 could be called into question as the public interest may not be well served by the failure of the profession to ensure continuing medical competence. This privilege must be seriously protected at all costs and in the interests of this independence, it is thus of utmost importance that the Council be supported by all its members and this Guide read by all doctors.

I must say a very sincere thanks to all my colleagues in the Council, particularly those who contributed so much of their valuable time in re-editing the former Guide, and hope that this new edition will serve its purpose and help doctors practise good ethical, sensible and reasonable medicine which should reflect the high standards for the profession in Ireland.



Harold Browne
President

Constitution and Functions

*Ref: McCall and Smith: "Law and Medical Ethics" 3rd Edition Butterworths

1. MEMBERSHIP

1.01 The Medical Council consists of twenty-five members appointed as follows:

- One by each of the five Medical Schools in the State.
- Two by the Royal College of Surgeons in Ireland, one representing the surgical specialties and the other jointly the specialties of anaesthetics and radiology.
- Two by the Royal College of Physicians of Ireland, one representing the medical specialties and the other jointly the specialties of pathology and obstetrics and gynaecology.
- One appointed by the Minister for Health after consultation to represent psychiatry.
- One appointed by the Minister for Health after consultation to represent general medical practice.
- Ten who are in medical practice in the State, elected by registered medical practitioners, of whom at least:
 - Two are hospital consultants other than psychiatrists;
 - One is a consultant psychiatrist;
 - One is a community physician;
 - One is in hospital practice, but not a consultant;
 - Two are general practitioners;
- Four persons appointed by the Minister, at least three of whom are not registered medical practitioners, to represent the interests of the general public.

1.02 The Council which normally meets four times each year, holds office for five years and no member may serve more than two consecutive terms. The Council elects its President and Vice-President. The Registrar is the Chief Officer of the Council.

2. THE REGISTER

2.01 The General Register of Medical Practitioners is published by the Council every five years, with annual supplements in the intervening years. It gives the name, address and qualifications of each doctor together with the registration number and date of registration. Official certificates of registration are issued. There is a statutory obligation on the doctor to display the certificate at the place where the practice of medicine is conducted.

3. REGISTRATION

3.01 Full registration is normally preceded by provisional registration.

4. PROVISIONAL REGISTRATION

4.01 This follows the primary qualification and limits practice to those who are in residence as defined and practise in one or more approved hospitals for such period as the Council decides. After this period of training with clinical responsibility, a certificate of experience is obtained allowing the doctor to proceed from provisional to full registration.

5. FULL REGISTRATION

5.01 This normally follows on provisional registration when it is satisfactorily completed.

5.02 Full registration may be applied for by doctors who qualify under rules made by the Council under the provisions of section 27(2)(d) of the Medical Practitioners Act, 1978.

5.03 Doctors who are nationals of the Member States of the European Union and who hold formal qualifications awarded in Member States are entitled to full registration.

5.04 Graduates of universities where there is reciprocity of registrable medical qualifications between this country and the country in which the universities are located, may apply.

6. TEMPORARY REGISTRATION

6.01 Temporary registration, which is limited to doctors who are not otherwise entitled to registration, enables doctors from

countries outside the European Union to gain experience by being employed in hospitals approved of by the Council. Their medical qualifications and experience must be of a standard acceptable to the Council before temporary registration is granted. Temporary registration may be granted for an aggregate period of five years which cannot be extended.

7. RETENTION FEE

7.01 The retention of any name on the register is contingent on payment of the prescribed fee.

8. REMOVAL OF A NAME FROM THE REGISTER

8.01 Registered doctors may apply to the Council to have their names removed from the register at any time provided that no disciplinary proceedings are pending.

9. OFFENCES IN RELATION TO THE REGISTER

9.01 It is an offence for any person falsely to represent himself or herself to be a registered medical practitioner, or to **make** any false representation for the purpose of obtaining registration.

10. EDUCATION AND TRAINING

10.01 The Council has the statutory responsibility of satisfying itself as to the suitability of undergraduate medical education and training provided by recognised medical schools, and as to the standard of theoretical and practical knowledge required at the examinations for primary qualification. It must also satisfy itself as to the clinical training and experience required for the granting of a certificate of experience, and the adequacy and suitability of postgraduate education and training. In all cases the Council must see that the minimum standards specified in the relevant EU Directives are satisfied.

11. FITNESS TO PRACTISE

11.01 The Council is empowered through its Fitness to Practise Committee, to inquire into the conduct of a registered medical practitioner on the grounds of alleged professional misconduct or alleged unfitness to practise by reason of physical or mental disability. For further details see Section 51, **Fitness to Practise**.

**Ethical Conduct
and
Behaviour**

12. ETHICAL CONDUCT AND BEHAVIOUR

12.01 "It shall be a function of the Council to give guidance to the medical profession generally on all matters relating to ethical conduct and behaviour."

- Medical Practitioners Act, 1978, section 69(2).

12.02 The profession of medicine has a long and honourable tradition of service and care. It is the responsibility of each doctor to uphold this tradition and to maintain high standards.

12.03 Society allows the doctor many privileges, and with each of these goes responsibility. If these privileges are used irresponsibly, there could be little surprise if a climate of public opinion were to develop in favour of limiting professional freedom.

12.04 However, doctors should be allowed an independence of thought, judgement and action if they are to carry out their essential functions.

12.05 Medical care must not be used as a tool of the State to be granted or withheld or altered in character under political pressure. Regardless of the type of their practice, the responsibility of all doctors is to help the sick and injured. Doctors must practise without consideration of religion, nationality, race, politics or social standing. Doctors should not allow their professional actions to be influenced by any personal interest.

12.06 In giving guidance to the medical profession on questions of ethical conduct, it is not the intention of the Council to issue a Code, but to provide a Guide by which individual members of the profession may judge particular situations. The Council does not consider it feasible to compile a catalogue of behaviour where non-observance could be regarded as professional misconduct.

12.07 Professional misconduct is conduct which doctors of experience, competence and good repute consider disgraceful or dishonourable.

12.08 The Council considers that the circumstances of any individual case may be so complex and varied that the question of a doctor's fitness to practise must be considered **on the merits of the case**. In this country cases of alleged professional misconduct and unfitness to practise for health reasons are examined by members of the Council, both medical and non-medical; with due regard to the doctor's constitutional rights.

SECTION A

13. RESPONSIBILITIES TO PATIENTS

- 13.01 Rapid advances in scientific knowledge and medical technology have brought with them many new areas of ethical concern, in addition to the traditional problems considered by our predecessors. It is accepted that a doctor has a duty to keep informed of current advances in **his/her** specialty. Doctors must do their best to preserve life and promote the health of the sick person. Once doctors undertake the care of patients, they must ordinarily give continuity of care for the duration of the illness. If they wish to withdraw their services, they must inform the patient, and allow sufficient time for alternative medical care to be sought, **during which time clinical continuity must be maintained.** Doctors must attend in emergency situations unless they are satisfied that alternative care is available. Acceptance of the risk of treating patients with communicable diseases is a time-honoured tradition of the medical profession. Failure to do so is unethical and may, in certain circumstances, amount to professional misconduct.
- 13.02 Patients are entitled to a **second or further opinion** concerning their illness. Doctors should either initiate or facilitate a request for same, and provide the information necessary for a satisfactory referral.

14. BEHAVIOUR TOWARDS PATIENTS

- 14.01 Complaints continue to be made to the Council of rude and insensitive behaviour towards patients and their relatives. It would seem that patients may not always be treated with the dignity and respect due to them. The Council will take a grave view of substantiated complaints of this nature.

15. FAILURE OF COMMUNICATION

- 15.01 Patients do not always fully understand the information and advice given to them by their doctors. Patients' questions should be answered with care in non-technical terms, and efforts made at subsequent interviews to ensure that the advice has been understood and followed. Brief, clearly written

instructions to patients or relatives may help further understanding and promote **compliance** with treatment instructions.

- 15.02 The Council is concerned that many of the complaints which it receives about medical practitioners stem from a **lack of communication**, or of courtesy, on the part of the doctor concerned. Where a difference has arisen between a doctor and a patient or the patient's family, there is much to be gained and rarely anything to be lost by the doctor expressing regret if something has gone wrong. It would seem that doctors have been inhibited by a feeling that any such expression in these circumstances would amount to an admission of liability. This is not necessarily so.

16. PERSONAL RELATIONSHIPS BETWEEN DOCTORS AND PATIENTS

- 16.01 Any form of sexual advance to a patient with whom there exists a professional relationship is professional misconduct. Similarly, the Council will take a serious view of a doctor who uses **his/her** professional position to pursue a personal relationship of an **emotional or sexual nature** with a spouse or close relative of a patient. The practice of medicine often involves a close personal relationship between doctors and their patients, and patients sometimes become emotionally dependent. Doctors must be aware of such a possibility, and are urged to take special care and prudence in circumstances which could leave them open to an allegation of abuse of their position of responsibility and trust.

SECTION B

17. PROFESSIONAL RESPONSIBILITIES

- 17.01 The practice of medicine is sometimes difficult and often demanding. Doctors should give moral support to each other. **Denegration of a colleague** is never in the interests of patients and should be avoided. When disputes with colleagues arise, they should be settled as speedily as possible and without undue publicity.
- 17.02 Doctors should not hesitate to consult with colleagues and should, where necessary, co-operate with recognised paramedical professionals.
- 17.03 Doctors who delegate treatment or other procedures, must be satisfied that the colleague to whom they have delegated, is competent. Delegation implies continuing responsibility on the part of the referring doctor.
- 17.04 The Council considers that doctors have a personal and professional continuing responsibility to junior colleagues and medical students. They are obliged to transmit acquired knowledge and skills and, by word and example, to adopt and foster correct professional values, attitudes and behaviour. Doctors must also take care not to delegate tasks and responsibilities beyond the skill and experience of their juniors. It is their duty to counsel and advise them about the ethics and courtesies required in dealing with patients, relatives, nurses, paramedical or other health care professionals, and their colleagues. In particular, those involved in the teaching of medical students and junior doctors, have a special responsibility, including advice on their careers.
- 17.05 Doctors who are unable to honour commitments entered into concerning employment with hospital authorities, should inform the relevant authority in the hospital at the earliest opportunity.

18. HEALTH PROBLEMS

- 18.01 The misuse of alcohol and other drugs is such a common contributing factor in illnesses, family problems, behaviour disorders and accidents, that doctors must play a greater part in educating the public, both about the proper use and the danger of these drugs.
- 18.02 The perceived misuse of alcohol or other drugs by a doctor may be grounds for the holding of an inquiry, and a claim of being 'off-duty' will not be grounds for avoiding an inquiry. In this area, an awareness of responsibility, both from the personal and professional aspect, must be part of a doctor's code of practice. The complaint that a doctor has been **under the influence of alcohol or other drugs is a grave charge**. Legal convictions for offences committed are investigated by the Fitness to Practise Committee, and may lead to erasure from the register.
- 18.03 Since the reputation of the profession is the concern of its members, doctors have a further responsibility to protect the interests of the public, when they become aware that the abuse of alcohol or other drugs is affecting the competence of a colleague. In such circumstances, they should, either alone or in consultation with others, express their anxiety directly to the colleague concerned and, when appropriate, advise expert professional help. When such approaches fail and **patients' interests are at risk**, the facts must be given to the Fitness to Practise Committee of the Council.
- 18.04 A similar procedure is recommended when other forms of physical or mental ill-health, or the ageing process, appear to seriously affect professional competence and responsibility to patients.
- 18.05 The Council is aware of the Sick Doctor Scheme operated by the Irish Medical Organisation which it fully supports. However, when the public interest is at risk, doctors have a responsibility to advise the Medical Council where a doctor's fitness to practise for health reasons, is causing concern. The Council would **view seriously any dereliction** of a doctor's responsibility in this regard.

SECTION C

19. ADVERTISING AND THE MEDIA

- 19.01 The good name and standing of the profession as a whole and of each medical practitioner is founded on professional integrity, knowledge and skill. Self advertisement, or publicity to **enhance or promote** a professional reputation for the purpose of attracting patients, is professional misconduct.
- 19.02 Guidelines on In-Practice Information have been agreed with the Irish College of General Practitioners - see Appendix A.
- 19.03 There is widespread and increasing public interest in matters of health and sickness. It is part of the traditional duty of the medical profession to influence the quality and accuracy of information on health care. The media are legitimate and valuable means of communication between the profession and the community. Thus, there is an increasing pressure on doctors to take part in radio and television programmes and to write for the non-medical press. The Council is concerned that information to the public should be authoritative, appropriate and in accordance with general experience. Information should be **factual, lucid and expressed in simple terms**. It should not cause unnecessary public concern, or personal distress, or arouse unrealistic expectations. Unsubstantiated claims for the efficacy of therapeutic regimes, or undue emphasis on the hazards of necessary procedures, are examples which may cause distress to patients or their relatives. Doctors must never give the impression that they, or the institutions to which they are attached, have **unique or special skills or solutions** to health problems. Information should never be presented in such a way that it furthers the professional interests of the doctors concerned, or appears to attract patients to their care.
- 19.04 The Council advises that, as a general rule, doctors in clinical practice should remain **anonymous** when speaking in public on the diagnosis and treatment of illness. Exceptions to this rule may be made under the general heading of preventive medicine and health education, when it may be important to establish the special experience and authority of the communicator. Doctors should **never discuss individual case**

histories or answer enquiries about personal health problems, especially on phone-in programmes.

- 19.05 Similarly, social, ethical, political or research aspects of medicine may require doctors to be identified by name, qualifications or appointments. Thus, they must take **personal responsibility** for their views and establish the basis for them.
- 19.06 In adjudicating on complaints concerning doctors and the media, the Council will consider whether the subject of the publication - written or verbal - is of legitimate public interest, and if it has been presented in a professional manner. **Of particular importance will be whether the Council considers the benefit to the doctor to have been greater than that to the public**. It may be accepted that in certain cases the benefit to the general public will outweigh any incidental advantage to the practitioner, and that the publication was a legitimate method of giving informed and accurate information on a matter of genuine public interest.
- 19.07 It is emphasised, however, that the Council is not prepared to discard traditional practice in this field, and any doctor may be called upon to justify the reasons which prompted the publication complained of, and the circumstances surrounding its publication. If it should appear to the Council that the primary motive is **self-advertisement** for the purpose of attracting patients, a most serious view will be taken of such a derogation from accepted standards.
- 19.08 Attitudes to the educational role of doctors must be determined by the profession as a whole, and be based on tradition and experience, as well as adapting to the changing needs of the community. Doctors are encouraged to make their views known to the Council, and thus play their part in the decision-making process.
- 19.09 The Council advises that doctors in clinical practice when speaking in public, should not give the impression of **possessing special skills**, and avoid any comments that could be interpreted as **canvassing for patients**.
- 19.10 Doctors letter-heading should be confined to registrable qualifications without any elaboration in prose.

19.11 The Council, in putting forward the foregoing advice, will hold doctors responsible for their decisions in respect of their involvement with and/or participation in the media.

20. PRACTICE SIGNS

20.01 In addition to a professional plate, a doctor may exhibit one **surgery** sign. This sign may be illuminated, may be displayed at the entrance to the premises, or may be affixed to a window in the building or to the outside of the building. The dimensions of this sign must not exceed 75cm x 15cm or a suitable variation of this overall specification.

20.02 When a medical practice is carried on in a business premises, shopping complex or office block, the Council has no objection to the inclusion of the practice or the doctor's name on a conglomerate list of the complex occupants, provided it is in conformity with paragraph 20.01 above.

20.03 A doctor may indicate the location of the practice by displaying at the entrance to the premises, and also, if desired, at the entrance to the surgery within such premises, a professional plate. This plate must not exceed 35cm x 25cm in size, and may exhibit the doctor's name and registrable qualifications.

20.04 A second plate which must not exceed 40cm x 30cm, may be displayed, on which any or all of the following information can be provided:

- (a) days and hours of attendance,
- (b) the availability of an emergency service,
- (c) the practice telephone number(s).

21. CLINICS

21.01 Recent years have seen a proliferation of organisations, centres and clinics which advertise, offering treatment or advice and services connected with health and health related matters. Doctors associated with these in any way have a duty to ensure that **treatment, advice or services offered**, conform to the accepted standards of the medical profession. Such **doctors** may be held **accountable** for **publicity** engendered which

could be held to be **canvassing** for the purpose of obtaining patients. Doctors associated with private hospitals should be similarly concerned to ensure that ethical guidelines are not breached. Doctors, who fail to follow this advice, may be considered by the Council to be guilty of professional misconduct.

21.02 Financial or other interest which a doctor holds in a **clinic/private** hospital should be declared to patients who are being referred to it for investigation or treatment.

22. PRACTICE ANNOUNCEMENTS

22.01 The Council, once more, draws the attention of the profession to the need for all registered medical practitioners to insert practice announcements in the following manner:

Two discreet announcements, concerning the commencement of practice by a doctor, may be inserted in the national or local press, giving the registered name of the doctor, the address of the practice and the telephone number(s). The specialty interest of the doctor may be mentioned, provided it is within the list of specialties recognised by the Council - see Appendix B. The notice should only appear in the **Social and Personal** section and should not be inserted as a display notice. Doctors are advised that those who fail to follow this advice may be liable to disciplinary proceedings.

22.02 With regard to the publication of doctors' names in national and local directories, the Council permits the inclusion of the following factual information; the name and address of the practitioner's entered in the register, telephone number(s) and the specialty which must be one of those approved by the Council.

22.03 Suitable information concerning the practice should be available to patients. While the Council welcomes the availability of in-house information to patients, or prospective patients, on application, **it is unacceptable** that any comments should be contained on the **personal qualities or expertise** of the practitioners working in the practice. It is equally **unacceptable** that such in-house information should be used to **canvass or attract** new patients.

23. COMMUNITY RESOURCES

- 23.01 Community funds for health care are limited. A decision to spend money in one area often involves a parallel decision not to spend money in another. The Council considers that doctors have a responsibility to conserve resources and give considered advice on their allocation when appropriate.

24. PERSONAL STANDARDS

- 24.01 The medical profession's position of trust and privilege in the community is founded, not only on technical knowledge and skill, but on high standards of personal and professional behaviour at all times. It is a statutory duty of the Council to investigate complaints made by members of the public, or by the profession, about alleged lapses from these high standards.

25. PRESCRIBING

- 25.01 A doctor should prescribe the most appropriate medicine to suit the patient's condition and best interests, The manner in which doctors are remunerated must not influence the treatment they recommend for their patients.

26. IRRESPONSIBLE PRESCRIBING

- 26.01 It is frequently alleged that doctors rely too heavily on the prescription of drugs, and that more time spent in listening and counselling would be safer and more helpful to their patients. It is well for doctors to keep constantly in mind their responsibilities, particularly where the use of tranquillisers, hypnotics and antibiotics is concerned.
- 26.02 Doctors who undertake to treat drug dependent or addicted patients should be well informed on all facets of treatment. It may be wise to share the responsibility of caring for such patients with a colleague, or to refer them to specialist care. This particularly applies where the doctor is approached by a patient not previously known, seeking controlled drugs. Doctors should acquaint themselves with published protocol in treating drug dependent or addicted patients. The Council and the Pharmaceutical Society of Ireland have agreed to co-

operate in the monitoring of prescribing patterns. The Fitness to Practise Committee of the Council views seriously and investigates any evidence of **irresponsible prescribing** brought to its attention. In conjunction with the Pharmaceutical Society of Ireland and the Department of Health, the Council has issued recommendations for the prescribing of controlled drugs under the Misuse of Drugs Act, 1977. These are attached as Appendix C.

27. CONVICTIONS

- 27.01 The Council receives notification of all convictions of registered medical practitioners in the Courts, views them with concern, and will investigate the circumstances involved. A doctor will not be able to avoid an inquiry by claiming that he/she was **not on duty** at the time of the alleged offence.

28. INDUSTRIAL ACTION

- 28.01 When doctors decide to participate in an organised collective withdrawal of services, they are not released from their ethical responsibilities to their patients. They must **guarantee emergency services** and also such care as may be required by those for whom they hold clinical responsibility.

SECTION D

29. DOCTORS IN PRACTICE

- 29.01 Medical practitioners' premises should be adequate and suitable for their purpose. Doctors must practise in the names in which they are registered. The Council registers doctors in the names in which their **primary medical qualifications** are conferred, and where a change of surname occurs, e.g. on marriage, formal evidence must be furnished to enable a change to be made in the register.
- 29.02 Doctors are obliged to take every reasonable precaution to **avoid damaging the practice of colleagues**. This obligation is particularly compelling when there has been a recent professional association.
- 29.03 The Council does not approve of doctors forming companies which engage in the practice of medicine.

30. DEPUTISING ARRANGEMENTS

- 30.01 Doctors have a special responsibility to ensure, as far as lies in their control, that patients **will receive adequate professional care** from another doctor when alternative arrangements have to be made during absences.
- 30.02 Doctors who use the services of a deputising agency should satisfy themselves,
- (a) that a high standard of **continuing medical care** is provided for their patients,
 - (b) that patients are **well informed in advance** of the fact that, in certain circumstances, they will be visited by a doctor acting as a deputy for the principal doctor and,
 - (c) that **an efficient communications link** is provided between agency and deputy.
- 30.03 Doctors employed as deputies should always remember that they are acting as the professional representative of the principal doctor. House calls should be completed promptly and with courteous consideration. Relevant clinical details (diagnosis, treatment and action taken) should be transmitted promptly to the principal doctor.

- 30.04 It is especially important that **deputising doctors should not accept the transfer of patients** from the principal doctor.
- 30.05 The contractual arrangements between the principal doctor and the deputising agency, and between the agency and the doctors employed as deputies, should be carefully set out and agreed between the parties.
- 30.06 Doctors who practise on their own, should arrange with their colleagues to establish a suitable rota system, whereby each doctor is covered by another while off-duty during holidays, illness or nights off. Such arrangements would lead to better **doctor/patient** relationships.
- 30.07 Doctors should not use deputising services to relieve them of their responsibility in the clinical care of patients, for example, by regularly using such services for their domiciliary calls, without sufficient reason.
- 30.08 Whatever deputising arrangements are made by doctors, a suitable notice setting out clearly the arrangements for medical care during off-duty time should be displayed prominently in doctors' surgeries, and information sheets on deputising arrangements should be made available to patients - see Appendix D.

31. CONFIDENTIALITY

- 31.01 Confidentiality is a time-honoured principle of medical ethics. There are four circumstances when exception may be made:
- * When required by a judge in a **court of law**.
 - * When necessary to protect the **interests of the patient**.
 - * When necessary to protect the **welfare of society**
 - * When necessary to safeguard the **welfare of another individual or patient**.
- 31.02 Medical records, both clinical and technical, must be safeguarded. These records may be held in the following form:
- Hard copies in patients' charts in hospitals and these come within a Charter of Rights for Hospital Patients issued by the Minister for Health.

- Hard copies, **hand/type** written, held by registered medical practitioners - see paragraph 38.01
- Electronically stored data which requires that the users be registered with the Data Protection Agency

The Council considers it appropriate to draw attention to the dangers to confidentiality in the use of computers and electronic processing in the field of health service administration. The Council supports the resolutions of the 27th World Medical Assembly - see Appendix E.

31.03 Doctors belonging to the following disciplines may experience problems in relation to the conduct of medical examinations, and when subsequently reporting to a third party:

medical officers of health, occupational physicians, doctors employed by, **and/or** acting for An Garda Síochána, Defence Forces, prison medical officers and civil service.

The following points should be borne in mind, taking due note of paragraph 31.01:

- (i) The doctor-patient relationship should be respected at all times.
- (ii) Where circumstances permit, the examinee's own personal doctor should be informed.
- (iii) The significance, rather than the precise details, of the medical findings should be conveyed to any third party with the patient's consent only.
- (iv) Documents containing medical details **should always** be transmitted under confidential cover.
- (v) Medical information obtained by a doctor in the process of patient examination should always be used for the betterment of that patient.

31.04 A doctor should, when assessing the nature of the particular disability, **interpret the medical findings** in terms of the patient's likelihood of continuing to work, if requested to do so. An employer has not got the right to be informed of the clinical details of illness or injury without the consent of the patient.

31.05 In order to fulfil statutory requirements it may be necessary for a doctor to provide a medical officer of health, for example, with medical information which may be required so that the payment of a financial allowance may be recommended. In such instances, the public health physician is not obliged to release the specific details, but may interpret them to the administrative authority concerned with the patient's consent.

31.06 Similarly, an occupational physician may present to an employer the significant aspects of a medical condition which the physician may discover as the result of an examination. **Only with the consent** of the patient examined, may the employer have **access to that patient's medical record**, and then only in specifically agreed circumstances.

31.07 Special problems will arise when a doctor finds that a patient is suffering from a communicable disease. Here, the real or potential risk to public health must be carefully assessed, and the doctor must have strict regard to the **statutory obligations** in the matter of **reporting** such a case.

31.08 Problems may also arise for a doctor who is requested by an insurance company to complete a medical report on a patient. A doctor is advised to ensure that the patient fully understands what may be involved in furnishing a medical report, and that the contents may change **his/her** insurance. With that knowledge, the patient has to give full consent to the issuing of such a report.

31.09 An insurance policy represents a contract between the company involved and the person seeking insurance. It is well recognised that failure to disclose any material fact renders the contract void.

31.10 An insurance company may request a **medical report** on a patient who has **died**. Such a report can only be issued by the deceased's doctor with the full consent of the next-of-kin. Even though the patient is deceased, the medical records still remain confidential. Death of a patient does not absolve a doctor from this obligation.

31.11 Identifiable **audio-visual** or photographic recording of a patient or relatives of a patient, must only be undertaken with

the informed consent of the patient, the patient's parent, guardian, or representative as appropriate. Such record or recording must not be used or shown for any purpose other than that for which appropriate permission has been obtained.

31.12 Doctors should have due regard to the provisions of the legislation on data protection.

32. CONSENT

32.01 Medical intervention requires consent. Every effort should be made to ensure that a patient understands the nature and purpose of the medical procedures involved. Whether or not a patient is sufficiently informed, and sufficiently free, to consent to medical treatment may be difficult to resolve. A patient's **right to refuse** to give consent to treatment should be respected and **documented**, provided that the patient is able to exercise that judgement.

X 32.02 The Council urges **special caution wherever children, mentally ill, mentally handicapped or unconscious patients are involved**. In the case of the unconscious patient, consent could be implied or presumed on the grounds that if the patient were conscious, the patient would probably consent to the saving of **his/her** life. Where a patient is otherwise impaired and unable to give consent, that consent for immediate or life saving treatment may be presumed and treatment administered. A doctor needs to consider the question of **parental/guardian** consent and information when consulted by a patient below the age of majority. A doctor **cannot assume** he/she is safe in ignoring the **parental/guardian** interest.

33. INFORMATION

33.01 A request for information by a patient always requires a positive response. A request by a third party for information about a patient should be refused unless consent has been given. In general, doctors should ensure that patients and, with their consent, members of the family concerned, are as fully informed as possible about matters relating to the illness.

33.02 Doctors may be requested by the patient or the patient's solicitor to provide medical reports on the patient whom they have treated. A doctor has a moral professional responsibility to supply this report when so requested by his or her patient or the solicitor acting as the patient's agent - see guidelines at Appendix F.

33.03 Independent medical examination of a plaintiff is an established practice in litigation. Doctors are advised that questions and discussions between a defendant's doctor and the plaintiff should be confined only to establishing the nature and extent of the injuries and discussion generally should be limited to a minimum. It is both appropriate and expedient that questions to be raised by the defendant's doctor should be directed to the plaintiff's doctor. Only where it is essential should any questions be directed to the plaintiff.

33.04 In their own interests and the interests of patients, it is essential that doctors keep **accurate records** of patient care. These records should be retained for a period subject to advice from legal and medical insurance bodies.

33.05 The Council advises that a registered medical practitioner who agrees to undertake the ante-natal care and delivery of a patient should clearly inform the patient, at the time of booking, of the arrangements for her delivery.

33.06 Doctors have been requested by the revenue commissioners to show records which consist of patients' names and addresses and in some instances, clinical information. It has been established from the revenue commissioners, that it is not normal practice to request doctors to furnish a list of their patients. In regard to confidentiality, there are two significant safeguards for taxpayers which apply to all revenue personnel. Confidentiality of information is enshrined as a fundamental principle in the taxpayers' Charter of Rights and all Inspectors of Taxes, on appointment, make a declaration in accordance with the provisions of schedule 17 of the Income Tax Act, 1967, and that this declaration imposes a statutory obligation on them as regards the confidentiality of information they come across in the course of their work. The Council has noted in correspondence with the revenue commissioners that it is

not their practice to request doctors to furnish a list of their patients and that the Council shares their view on this ethical matter. Refer to Confidentiality - see Section 31.

34. CERTIFICATION

- 34.01 The Council takes a serious view of the important matter of the issue of certificates, reports and other formal documents bearing a doctor's signature. Great care is necessary to see that **strict accuracy** is observed. Pressure from any source to deviate from this standard must be resisted.
- 34.02 It is **not acceptable** that certificates, **pre-signed** by doctors, should be filled in and handed out by those assisting them. Such a practice, if brought to the attention of the Council, may lead to disciplinary proceedings.
- 34.03 It is essential that doctors, having seen and examined the patient, should personally sign and date each certificate, report or other formal document issued under their name.
- 34.04 Certificates issued should give the full name and address of the patient, date of issue and be personally signed by doctors. The registered names and addresses of doctors should appear on certificates.
- 34.05 Any certificate, prescription or other document, which is required to be signed by a doctor, is invalid and ineffective if signed by a person who is not duly registered.

35. SPECIALIST REFERRAL

- 35.01 It is a principle accepted by the Council that the overall management of a patient's health should be under the supervision and guidance of the patient's general practitioner. However, patients have a **right to seek another opinion** and requests for these should not be discouraged but should be accepted sympathetically, even if the general practitioner is not convinced that such a referral is necessary.
- 35.02 While a specialist may decide, in certain circumstances, to accept a patient without referral from a general practitioner, **he/she** has a duty to inform the latter of the findings and recommendations unless the patient expressly withholds consent. In such circumstances, the specialist is responsible for

total care of the patient until the treatment is completed and another doctor takes over responsibility.

- 35.03 In certain circumstances patients are referred to hospital or a specialist by sources other than the general practitioner. Here again, the specialist has a duty to **keep the general practitioner informed**, if the patient consents.
- 35.04 Cross referral between specialists may be necessary. The Council recommends that normally the general practitioner should be informed of such cross referral.

36. FEE SPLITTING

- 36.01 This practice is against the patient's interests and is professional misconduct.

37. ATTENDANCE ON DOCTORS' FAMILIES

- 37.01 It is not considered advisable that doctors should treat, or issue prescriptions or certificates for members of their families, except in special circumstances.

38. PATIENT RECORDS

- 38.01 Doctors who propose to **retire** from medical practice should give sufficient notice to their patients of their intention to do so. It would be helpful to patients if doctors provided the names of colleagues who would be willing to provide medical care. The decision to avail of the list, or to make alternative arrangements, is a matter for the patients themselves. It is advisable that copies of accurate patient records, or summaries of the medical knowledge therein, should be available for transfer to **doctors** who take over responsibility for patients. In the event of doctors not wishing to transfer files to other doctors, the original doctors are obliged to convey by way of letter or other means, **medical information** concerning their patients to nominated doctors, with the patients' consent. The same guidelines apply in the dissolution of a practice.

SECTION E

39. REPRODUCTIVE MEDICINE

- 39.01 In an age of changing social, economic, political and philosophical attitudes, the implications of scientific discoveries in the field of reproductive medicine present many new problems.
- 39.02 It is important for doctors to keep informed of these developments which may have an important bearing on many aspects of patient care. These include family planning, infertility, sterilisation, artificial insemination and the prevention of congenital handicap. In this whole area of conflicting attitudes, doctors, when **counselling and treating** all patients with understanding and empathy, while obeying the laws of the State, must always be guided by their own informed consciences.
- 39.03 It has always been the tradition of the medical profession to preserve life and health. Situations arise in medical practice where the life **and/or** health of the mother or of the unborn, or both, are endangered. In these situations it is imperative ethically that doctors shall endeavour to preserve life and health. This is in accordance with the International Code of Ethics where the English text states: "A doctor must always bear in mind the obligation of preserving human life" and the Declaration of Geneva which in 1983 stated "**I WILL MAINTAIN** the utmost respect for human life from its beginning even under threat and I will not use my medical knowledge contrary to the laws of humanity".
- 39.04 While the necessity for abortion to preserve the life or health of the sick mother remains to be proved, it is unethical always to withhold treatment beneficial to a pregnant woman, by reason of her pregnancy.
- 39.05 Departure from these principles in practice may leave the doctor open to a charge of professional misconduct.

40. IN-VITRO FERTILISATION

- 40.01 The Council approves the Guidelines promulgated by the Institute of Obstetricians and Gynaecologists of the Royal

College of Physicians of Ireland and therapeutic application of in-vitro **fertilisation** within this framework to married couples is acceptable. The **Guidelines of the Institute** are printed as Appendix G.

41. RESEARCH ON HUMANS

- 41.01 Many factors are involved in this difficult area. One is the possible benefit of the proposed procedure to the patient. Another relates to the adequacy of the patient's consent. Yet another concerns the potential risks concerned with the research procedure involved, and the competence of the patient to assess these and give well-informed consent to the proposed procedure.
- 41.02 The Council strongly supports the formation of ethical committees in all institutions where research on humans is undertaken. Practitioners are advised to seek approval from an appropriate supervisory organisation before undertaking any research project involving risks to human subjects.
- 41.03 The Council supports the resolutions and draws attention to the Declaration of Helsinki adopted by the 18th World Medical Assembly and as revised by the 29th World Medical Assembly - see Appendix H.

42. DONOR ORGAN PROCUREMENT

- 42.01 Where **brain death** has been diagnosed, it is important that the consultant or the most senior non-consultant doctor should approach relatives with sensitivity and compassion when requesting donor organs. For the purpose of diagnosis of brain death, doctors should draw up for their hospital, guidelines that are in keeping with current medical practice.
- 42.02 The Council endorses Articles 13, 14 and 15 of the Principles of Medical Ethics in Europe:

Article 13

"In a case where it is impossible to reverse the terminal processes leading to the cessation of a patient's vital functions which are being artificially maintained, doctors will satisfy

themselves that death has occurred, taking account of the most recent scientific data. At least two doctors, acting individually, should take meticulous steps to verify this situation and record their findings in writing. They should be independent of the team which is to carry out the transplantation."

Article 14

"Doctors removing an organ for transplantation may give particular treatment designed to maintain the condition of that organ."

Article 15

"Doctors removing organs for transplantation should take all practicable steps to satisfy themselves that the donor had not expressed an opinion, or left instructions, on the matter either in writing or with his/her family."

43. EUTHANASIA

43.01 Where death is imminent, it is the doctor's responsibility to take care that a patient dies with dignity and with as little suffering as possible. Euthanasia, which involves **deliberately causing the death** of a patient, is professional misconduct and is illegal in Ireland.

44. RELATIONSHIPS TO PRISONERS

44.01 The Council supports and draws attention to the 1975 Declaration of Tokyo by the World Medical Association concerning torture and other cruel; inhuman and degrading punishment - see Appendix I.

45. DOCTOR PATIENT RELATIONSHIP

45.01 The principle that doctors should not make distinctions between their patients and should accept the risks which may be attached to treating patients with infectious diseases, is well established.

45.02 However, whilst the general ethical principles may be clear, it must be conceded that their application may present problems in individual cases, and doctors may have great difficulty in reaching informed decisions in some of these.

45.03 Where a risk to the patient or the doctor or both exists, the doctor may not wish to participate in the patient's management but must refer the patient to an appropriate colleague. Similarly, if a doctor has a conscientious objection to a given line of treatment, or feels that he/she does not have the personal skills or necessary facilities to undertake it, he/she must refer the patient to an appropriate colleague. **Treatment must never be refused** on the grounds of moral disapproval of the patient's behaviour.

45.04 The key to a proper doctor/patient relationship in this field - as in all others - is mutual trust based on an open exchange of information.

46. SERIOUS INFECTION

46.01 In any given case when it appears that others - spouses, those close to the patient, other doctors and health care workers - may be at risk if not informed that a patient has a serious infection, the doctor should discuss the situation fully and completely with the patient laying particular stress, in the case of other medicals or paramedicals, on the need for them to know the situation so that they may, if required, be able to treat and support the patient. In the case of spouses, or other partners, similar considerations will apply, and the doctor should endeavour here also to obtain the patient's permission for the disclosure of the facts to those at risk.

46.02 Difficulties may clearly arise if the patient, after full discussion and consideration, **refuses to consent to disclosure**. If mutual trust between doctor and patient has been established such a case will, hopefully, be rare. In this case, it is covered by the general ethical standards of the profession and should be respected. Should permission be refused, however, the doctor will then have to decide how to proceed, in the knowledge that the decision reached, may have to be justified subsequently. Should it appear that the welfare of other health workers may be properly considered to be endangered, the Council would not consider it to be unethical if those who might be at risk of infection, whilst treating the patient, were to be informed of the risk to themselves. They in their turn would, of course, be bound by the general rules of confidentiality.

46.03 In the exceptional circumstances of spouses or other partners being at risk, the need to disclose the position to them might be more pressing, but here again the doctor should urgently seek the patient's consent to disclosure. If this is refused, the doctor may, given the circumstances of the case, consider it a duty to **inform the spouse or other partner.**

46.04 Doctors involved in the diagnosis and treatment of HIV infection or AIDS must endeavour to ensure that all paramedical and ancillary staff, e.g. in laboratories, fully understand their obligations to maintain confidentiality at all times.

47. INVESTIGATION

47.01 From an ethical aspect, it is reasonable for a doctor to presume that when consulted by a patient, tacit consent is given to carrying out those diagnostic tests that the doctor considers necessary for the purpose of a diagnosis.

48. DOCTORS WITH SERIOUS CONTAGIOUS¹ INFECTIOUS DISEASES

48.01 It is clearly unethical for doctors who consider that they might be infected with a serious contagious disease e.g. Hepatitis B and HIV infection, not to seek diagnostic testing. If the test is positive, they should then put themselves in the hands of professional colleagues for treatment and counselling. **Doctors should be advised on how far it is necessary for them to limit their professional practice in order to protect their patients, and they should follow this advice.** Colleagues who have been consulted have therefore a dual role. They must counsel and support the doctor concerned. It is equally important that they **ensure** that their advice is followed and that the doctor concerned is not a risk to others. The Council would take a **serious view of the breach** of such advice and in this regard, the attention of doctors is drawn to Section B, paragraph 18 - Health Problems.

49. ADOPTION

49.01 The legal position in relation to the placing of children for adoption should be noted. The only bodies that are entitled to arrange adoptions are the registered adoption societies and the health boards. Doctors are advised that pregnant women thinking about adoption, should be encouraged by them to **contact an adoption agency** for professional counselling. It should be emphasised that counselling by an adoption agency imposes no obligation to choose adoption.

Conclusion

50. CONCLUSION

- 50.01 This brief review of ethical behaviour and medical practice is the fourth publication by the Council updating its advice to the profession. It is anticipated that in response to requests and advice from the profession and the community, as well as changing social needs and scientific advances, further guidelines will be required from time to time. Thus, the Council would hope to maintain consistent but evolving ethical guidelines by consensus.
- 50.02 In publishing this Ethical Guide, the document entitled "Principles of Medical Ethics in Europe" has been included as Appendix J. This was prepared and published by the Conference Internationale des Ordres et des Organismes d'Attributions Similaires, Paris. The document sets out the most important principles intended to influence the profession and the conduct of doctors, in whatever branch of medicine, in their contacts with patients, with society and between themselves. The Council, in its statutory responsibility of giving advice generally to the profession on all matters relating to ethical conduct and behaviour, fully supports the document.

**Fitness
to
Practise**

51. FITNESS TO PRACTISE

- 51.01 The Medical Practitioners Act, 1978, lays down the disciplinary procedures governing the profession. These encompass not only the alleged offences but also the methods of adjudication.
- 51.02 The Act provides that if any registered medical practitioner is convicted in the State of an offence triable on indictment (or convicted elsewhere of a similar offence) the Council may decide that **his/her** name should be erased. There are **three grounds** which can lead to erasure of a doctor's name from the register. These are proved allegations of professional misconduct, unfitness to engage in the practice of medicine by reason of physical or mental disability and failure to pay an annual retention fee.
- 51.03 The procedures are administered by the Fitness to Practise Committee (hereinafter called the Committee), set up under Part V of the Act. No set number of members is specified but the majority must be elected members of the Council. All must be members of the Council, at least one of them shall be a lay person appointed by the Minister, and its Chairman may not be either the President or Vice-President. It is this Committee which considers an application (or carries out an inquiry in the event of that being necessary) into the professional conduct of a registered medical practitioner or into the fitness of a practitioner to practise by reason of physical or mental disability. The **application for such an inquiry** may be made by the Council itself, or by any person. All complaints about practitioners are fully considered. Should the Committee decide that there is not sufficient cause to warrant an inquiry, it so informs the Council. The latter may, having considered the matter, agree and decide that no further action should be taken. However, it has the power to overrule the Committee and to direct it to hold an inquiry notwithstanding.
- 51.04 There are therefore two situations in which an inquiry may be instituted - either the Committee has itself decided that the facts alleged constitute a prima facie case for holding one, or by direction of the Council.

- 51.05 The medical practitioner who is the subject of an inquiry has a right to know the identity of the complainant and the nature of the complaint.
- 51.06 In the conduct of the inquiry, the Committee has very wide powers - those of the High Court - in compelling the attendance of witnesses, examining them under oath and compelling the production of documents. The Registrar or some other person presents the evidence and the practitioner has the right to know the evidence which it is proposed to consider, to be present and to be represented. On completion of the inquiry, the Committee formally reports to the Council. **The medical practitioner is afforded the opportunity to appear** before the Council and be heard prior to the Council making a decision as to its powers under the Act.
- 51.07 If the Committee has found the practitioner to have been guilty of professional misconduct or to be unfit to practise because of physical or mental incapacity, the Council may decide that the name should be erased from the register or from the register of medical specialists*. Alternatively, it may decide that registration may not have effect for a specified period in either register which effectively means suspension for a given length of time.
- 51.08 The Council does not, however, proceed directly to erasure or suspension and by virtue of this, there are considerable safeguards for the practitioner. The practitioner must be informed of the Council's decision and may apply to the **High Court within twenty-one days** for its cancellation. There are procedures set out to ensure that there will be no undue delay in such an application. Alternatively, if no application has been made to the High Court by the practitioner, the Council must itself apply for confirmation of the decision. The Court may cancel the decision or confirm it. If it is confirmed, the Court issues an Order confirming the decision of the Council to erase the name of the practitioner or to suspend effective registration - see 51.11 overleaf.

* The Register of Medical Specialists is not yet established.

- 51.09 After an inquiry has been held and the Committee has reported, the Council may, instead of erasure or suspension, retain the practitioner's name on the register, attaching "such conditions as it thinks fit" to its remaining there. An application to the High Court is also available in this instance. Finally, following an inquiry and report from the Committee, the Council may advise, admonish or censure the practitioner.
- 51.10 The Council has the further power to apply to the High Court, if it considers it as a matter of urgency in the public interest to do so, for an immediate Order suspending the registration of any practitioner for a specified period. Such an application is made in private.
- 51.11 It is important to know that in all instances involving erasure or suspension, the matter is considered by the High Court on an application either of the practitioner or of the Council, and that the Council does not erase or suspend the name until directed to do so by the High Court. If professional misconduct is under consideration at the hearing, the Court may also admit evidence from "any person of standing in the medical profession as to what is professional misconduct" - a further safeguard for the practitioner. On the other hand, the Council (and only the Council), may at any time restore the name of any person which has been erased or suspended, and may attach such conditions, as it sees fit, to restoring the name.
- 51.12 The findings of the Committee and the decision of the Council on its report will not be made public without the consent of the practitioner concerned, unless the practitioner has been found guilty of professional misconduct or unfit to practise medicine because of physical or mental disability.

APPENDIX A
(reference Section C, paragraph 19.02)

IN-PRACTICE INFORMATION

1. The Irish College of General Practitioners and its faculties are permitted to inform the public, at a national level, about general practitioner services on behalf of all general practitioners as a group.
2. The Irish College of General Practitioners and its faculties are permitted to inform the public concerning general practitioner services on behalf of all practitioners in a particular area, in the local media and in premises such as; Post Offices, Citizen Advice Centres, Libraries, Universities, Regional Technical Colleges, Schools, Factories etc.
3. No individual doctor is permitted to advertise nationally or locally in any form of public media on a personal basis, save as in 7 below.
4. In relation to qualifications, only registrable medical qualifications are permitted.
5. In-house information to patients or prospective patients should be available but confined to surgery premises. Such information may be in the form of leaflets, posters, other displays. Special procedures may be specified.
6. The individual doctor may direct-mail patients of the practice, those who have attended the practice within the previous three years, with material which is limited to recall, prevention and screening.
7. Two discreet notices are permitted, in the press, in relation to the establishment of a practice, change of location or personnel change. Information in relation to surgery hours is permitted in relation to public holidays or duty rotas.
8. The practice of having doctors' names in the Yellow Pages and local telephone directories is approved. Information should be confined to a doctor's name, address, telephone number(s) and registrable medical qualifications.

Approved by the Medical Council at its statutory meeting on 4th March, 1992, and published in Dublin, March 1992.

✓ = Recognised in *Amendment* via *Specialist Stat's* at 1/1

on *Combined list*

- Genito-Urinary medicine
- Medical Genetics
- Nuclear medicine
- Neurophysiology
- Palliative medicine
- Rehabilitation Medicine
- Biochemistry
- ~~Paediatrics~~
- Neonatology
- Cardiac

APPENDIX B
(reference Section C, paragraph 22.01)
RECOGNISED SPECIALTIES

- ✓ Accident and Emergency
- ✓ Anaesthetics
- General Practice
- Medical:
 - ✓ Cardiology
 - ✓ Clinical Pharmacology and Therapeutics
 - ✓ Communicable Diseases
 - Community Medicine
 - ✓ Dermatology
 - ✓ Endocrinology and Diabetes Mellitus
 - ✓ Gastroenterology
 - ✓ General (Internal) Medicine
 - ✓ Geriatrics
 - ✓ Nephrology
 - ✓ Neurology
 - Occupational Medicine
 - ✓ Oncology
 - ✓ Paediatrics
 - ✓ Respiratory Medicine
 - ✓ Rheumatology
 - Tropical Medicine
 - Venereology
- ✓ Obstetrics and Gynaecology
- Pathology:
 - ✓ Chemical Pathology
 - ✓ Clinical Immunology
 - ✓ Haematology
 - ✓ Microbiology
 - ✓ Morbid Anatomy and Histopathology
- Psychiatry:
 - ✓ Child and Adolescent Psychiatry
 - ✓ Psychiatry
- Radiology:
 - ✓ Diagnostic Radiology
 - ✓ Radiotherapy
- Surgical:
 - ✓ General
 - ✓ Neurological
 - ✓ Ophthalmology
 - Oral and Maxillo-Facial
 - ✓ Orthopaedics
 - ✓ Otolaryngology
 - ✓ Paediatrics
 - ✓ Plastic Thoracic - *Cardiac*³
 - ✓ Urology

APPENDIX C
(reference Section C, paragraph 26.02)
RECOMMENDATIONS

of the Medical Council for the prescribing of controlled drugs under the Misuse of Drugs Act, 1977

1. Practitioners must ensure that all prescriptions for controlled drugs are written in the format specified in the Misuse of Drugs Regulations. Incorrectly written prescriptions cannot lawfully be dispensed by pharmacists.
2. Practitioners and pharmacists in each area should reach an understanding about prescribing and dispensing controlled drugs. On the basis of such understanding pharmacists should be in a position to meet the legitimate needs of patients promptly.
3. Practitioners should not treat patients from outside their practice areas for addiction problems by prescribing controlled drugs. Practitioners are advised to refer such patients to recognised drug treatment centres.
4. Patients should be discouraged from moving from pharmacy to pharmacy with prescriptions for controlled drugs.
5. A practitioner who has patients referred from a drug treatment centre for continuation of treatment, with the patient's consent, should discuss the likely treatment regime with the patient's pharmacist.
6. Doctors should report problems in the prescribing of controlled drugs to the Medical Council.

Issued on behalf of the Medical Council and the Pharmaceutical Society of Ireland, January 1987.

MISUSE OF DRUGS ACT 1977

NOTES ON THE MISUSE OF DRUGS REGULATIONS 1979

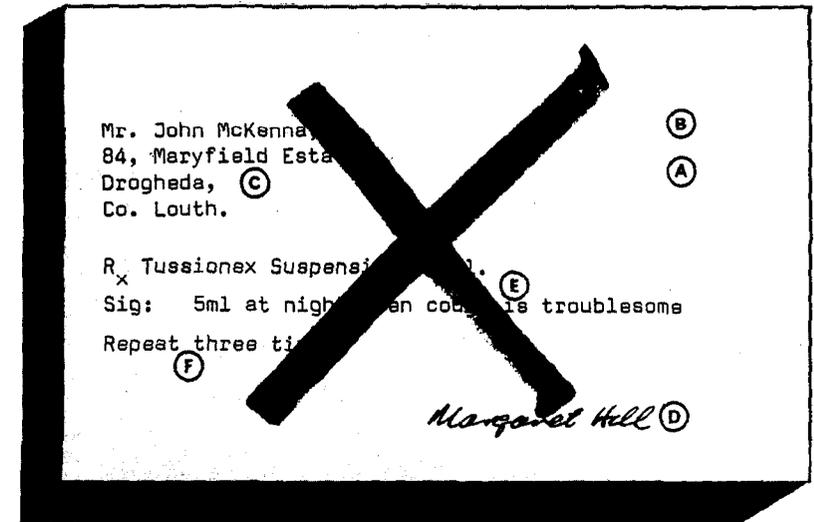
It is unlawful for a practitioner to issue, or for a pharmacist to dispense, a prescription for a Schedule 2 or 3 drug unless it complies with the following requirements:

The prescription must:

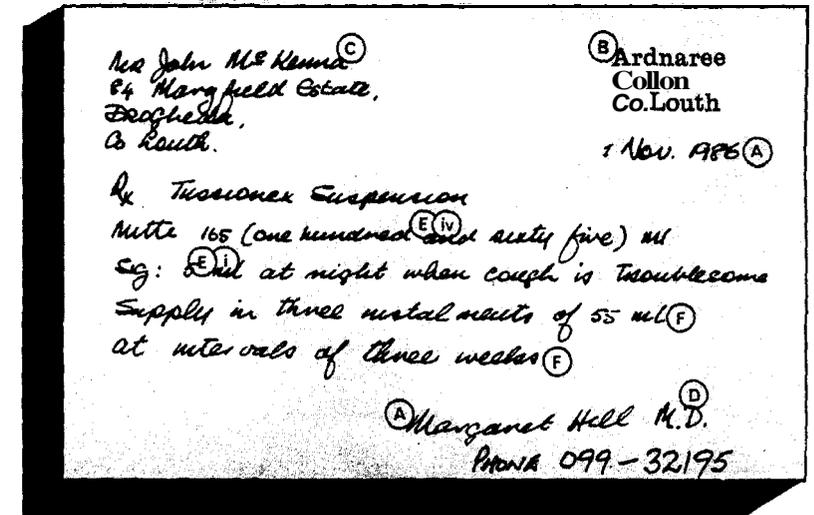
- A** be in ink and signed by the practitioner with his/her usual signature and dated by him/her.
- B** except in the case of a health prescription (G.M.S.), specify the address of the person issuing it.
- C** specify (in the prescriber's handwriting) the name including given name, and address of the person for whose treatment it is issued.
- D** state that the person issuing it, is a registered medical practitioner, and have a telephone number at which the practitioner may be contacted.
- E** specify (in the prescriber's handwriting) (i) the dose to be taken, (ii) the form in the case of preparations, (iii) the strength (when appropriate) and (iv) in both words and figures, either the total quantity of the drug or preparation or the number of dosage units to be supplied.
- F** in the case of a prescription for a total quantity intended to be dispensed by instalments, specify the amount of the instalments and the intervals at which the instalments may be dispensed.

Note: The practitioner must also be satisfied as to the identity of the person for whose treatment the prescription is being issued.

INCORRECT



CORRECT



NOTE: INCORRECTLY WRITTEN PRESCRIPTIONS ARE ILLEGAL.

A LIST OF THE MOST COMMON CONTROLLED DRUGS

SCHEDULE 2

Class of Controlled Drug	Proprietary Products
Cocaine	
Codeine	
Dexamphetamine	
Dextromoramide	Palfium
Dihydrocodeine	DF 118, DHC Continus
Dipipanone	Diconal
Fentanyl	Sublimaze
Alfentanyl	
Hydrocodone	Tussionex
Hydromorphone	Dilaudid
Levorphanol	Dromoran
Medicinal Opium (which includes Papaveretumfand)	Ornnopon
Opium Tincture BP)	
Methadone	Physeptone
Morphine	Cyclimorph, Morstel SR, MST Continus, Sevredol
Pethidine	
Pholcodine	
Phenoperidine	Operidine
Quinalbarbitone	Seconal, Tuinal

SCHEDULE 3

Amylobarbitone	Sodium Amytal
Phenobarbitone	----
Penteramine	Duromine
Flunitrazepam	Rohypnol
Temazepam	Normison, Euhypnos
Diethylpropion	Apisate, Tenuate, Dospan
Mazindol	Teronac
Meprobamate	Equagesia, Eauavil
Pentazocine	Fortral, Foatagesic

NOTE: The stricter rules for writing prescriptions do not apply to the following:

- (i) preparations containing not more than 0.1% of Cocaine or 0.2% of Morphine (each calculated as base):
- (ii) preparations (other than injections) containing not more than 10mg per dosage unit of dihydrocodeine (calculated as base) or in undivided preparations containing not more than 1.5 per cent:
- (iii) preparations containing not more than 100 mg per dosage unit of phenobarbitone (calculated as base).

APPENDIX D
(reference Section D, paragraph 30.08)

DEPUTISING ARRANGEMENTS

A. Responsibilities of Principal Doctors

(By "principal doctor" is meant the medical practitioner, who on payment of a fee, engaged the service of a deputy doctor.)

- (i) To avail of the services of a deputy does not absolve a principal doctor of final responsibility for his/her patients. Thus a principal doctor who contracts for the service of a deputy must ensure that this course of action does not in any way lessen the quality of medical care he/she is under obligation to provide for his/her patients.
- (ii) In arranging for deputising services to be provided, a principal doctor should satisfy himself/herself that the lines of communication offered are, as far as possible, foolproof. It is essential that the communication system should be one hundred per cent reliable - and this is particularly so at night.
- (iii) Principal doctors have a responsibility to ensure that their patients are well informed of the deputising arrangements. Patients should be advised that under certain circumstances they may be visited in their homes, in response to a call, by a doctor whom they have never seen before. (It is quite possible that the principal doctor may not have met the deputy.)
- (iv) Doctors working under contract in the General Medical Service have responsibilities towards their patients and towards the health board. The routine off-loading of GMS patients onto the deputy doctor is to be deplored and should be avoided.

B. Responsibilities of Deputies

- (i) To act always in the knowledge that they are providing medical care on behalf of a principal doctor.
- (ii) To be conscious of the fact that their presence in a patient's home is unwelcome as it is unexpected. On arrival at a house

on a call, the deputy should announce who he/she is, and indicate why he/she is there instead of the family doctor.

- (iii) To carry out home visits as expeditiously as possible following receipt of the call.
- (iv) To convey to the principal doctor as quickly as possible, and by whatever means available, a report containing the essential details of the home visit (for example, a tentative, if not a complete diagnosis, treatment given, advice offered etc.). If an emergency admission to hospital has been required, the principal doctor must be told about this as promptly as possible.
- (v) A recurring cause of disputes is the question of the collection of fees by deputy doctors. When private medical card schemes are in force (e.g. in certain State and semi-state organisations, and in some private firms) fee collecting by the deputy (or even a discussion about it) may give offence. Great care is required.
- (vi) To complete a house call as politely and courteously as possible and to avoid making any uncomplimentary or critical remarks about the family doctor, or other professional colleagues, or of members of associated professions (nurses, pharmacists etc.).
- (vii) A deputy may be in general practice on his/her own, his/her deputising duties being part-time. Such a deputy should not entice away from a principal doctor the patients whom he/she sees in the course of his/her deputising work.

APPENDIX E
(reference Section D, paragraph 31.02)

RESOLUTION ADOPTED BY THE 27th
WORLD MEDICAL ASSEMBLY - MUNICH, GERMANY 1973

Medical Data Banks

MEDICAL SECRECY

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

Whereas: The confidential nature of the patient-doctor relationship is regarded by most doctors as extremely important and is taken for granted by the patient; and

Whereas: There is an increasing tendency towards an intrusion of medical secrecy:

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

Computers in Medicine

"Be it resolved that the 27th World Medical Assembly—

- (1) draw the attention of the people of the world to the great advances and advantages resulting from the use of computers and electronic data processing in the field of health, especially in patient care and epidemiology;
- (2) request all national associations to take all possible steps in their **countries** to assure that medical secrecy, for the sake of the patient, will be guaranteed to the same degree in the future as in the past;

- (3) request member countries of W.M.A. to reject all attempts having as a goal legislation authorising any procedures to electronic data processing which could endanger or undermine the right of the patient for medical secrecy;
- (4) express the strong opinion that medical data banks should be available only to the medical profession and should not, therefore, be linked to other central data banks; and
- (5) request Council to prepare documents about the existing possibilities of safeguarding legally and technically the confidential nature of the stored medical data."

**APPENDIX F
(reference Section D, paragraph 33.02)**

MEDICO-LEGAL REPORTS

(Agreed with the Incorporated Law Society and approved by the Medical Council, 1992)

1. Request for Medico-Legal Reports:

A patient's doctor has a moral and professional responsibility to supply a medico-legal report on request from the patient's solicitors as failure to comply **may lead to a patient being deprived of benefits to which he/she may be entitled.** Failure to discharge this responsibility in the interest of a patient, will result in the Council taking a grave view of substantiated complaints of this nature. In this respect, the over-riding concern must be at all times the interests of the patient involved and in no circumstances should the delivery of a report be unduly delayed. Attention is drawn to the paragraph in Section D entitled "Information" (ref. pages 28/29 of A Guide to Ethical Conduct and Behaviour and to Fitness to Practise, Third Edition 1989 approved and published by the Medical Council, Dublin, March 1989) wherein it is stated "Doctors may be requested by the legal profession to provide medical reports on patients whom they have treated. There may be no legal obligation on them to furnish such reports but, if they are unwilling to do so, they are required, in the interest of their patients, to provide the necessary information to a colleague who is willing to provide a report". The Council wishes to state that this advice is forthwith withdrawn because of the rule against hearsay. Hearsay evidence is in general inadmissible because the truth of the words cannot be tested by cross examination and also because of their nature the words themselves do not have the sanctity of the oath.

2. Reasonable time to issue a Medico-Legal Report:

Under ordinary circumstances, it is reasonable to expect that a medico-legal report normally will be provided within two

months after the examination or the receipt of the request, whichever occurred last. The solicitor requesting the report should be notified of any unavoidable delay beyond this two month period.

3. Nature/Type of Report:

A medico-legal report should be objective, the content should be confined to relevant professional matters and supply the information required to facilitate the patient in seeking his/her entitlements. In this context, the doctor should not assume the role of advocate either for or against any person's position, regardless of his/her inclinations. Subjective and extraneous remarks are therefore inappropriate in a medico-legal report.

A doctor who has previously examined or treated a patient is obliged to provide a medico-legal report in respect of the examination or treatment or both when requested to do so by the patient's solicitor. However, a doctor is free to decline to make a medico-legal assessment of a condition for which that doctor has not previously examined or treated the patient.

4. Amount of Fee:

A practitioner is free to charge a fee for a medico-legal report which is reasonable and not excessive in relation to the services performed.

APPENDIX G
(reference Section E, paragraph 40.01)

INSTITUTE OF OBSTETRICIANS AND GYNAECOLOGISTS
THE PRINCIPLES UNDERLYING IN-VITRO FERTILISATION

1. It is accepted that the method of in-vitro fertilisation (IVF) is a significant advance for the treatment of certain cases of human infertility.
2. The method is most suitable for treatment of women who have a **normal** uterus and produce healthy eggs, but have damaged, diseased or absent fallopian tubes. The latter condition will prevent eggs from passing from the ovary to the uterus. Without IVF, the possibility of achieving a pregnancy in such cases with severe **tubal** problems is remote.
3. IVF may be used to treat other cases of infertility such as impaired **sperm** function and unexplained infertility. This has led to the use of IVF in a larger percentage of cases of infertility.
4. In IVF human eggs are obtained from the ovary. The eggs are incubated with sperm so that fertilisation can occur outside the woman's body (in-vitro).
5. After fertilisation, the embryo is then transferred to the mother's uterus.
6. In practice, the methods of obtaining the eggs, the culture outside the mother's body and the transfer of the developing embryos to the uterus, must be carried out by experienced clinical and laboratory personnel under carefully controlled conditions.
7. It is common and accepted practice to transfer more than one embryo to the mother as this enhances the successful pregnancy rate.
8. In order to recover more than one egg, drugs are usually given to the woman to stimulate the ovaries to produce several eggs.
9. When multiple embryos are replaced, multiple pregnancies may result.

10. A couple who undergo an IVF treatment cycle could expect a successful pregnancy rate of between 10% and 20%.
11. There is no evidence that IVF results in an increased risk of abnormalities in babies.
12. In IVF pregnancies there is an increased risk of abortion, ectopic pregnancy and premature labour.

The following guidelines should be adhered to by doctors practising IVF:

1. Couples must be appropriately counselled, understand the method and give informed consent prior to embarking on IVF.
2. All fertilised embryos produced by IVF should be replaced, optimally this should be three in any treatment cycle.
3. **Sperms and** eggs from the consenting couple will be used on all IVF procedures.
4. IVF is a clinical technique used for the treatment of selected cases of human infertility; in no circumstances should it be used to produce or store human embryos for research purposes.

These guidelines update the previous guidelines of 1983.

15th April, 1992

APPENDIX H
(reference Section E, paragraph 41.03)

DECLARATION OF HELSINKI

Recommendations guiding medical doctors in biomedical research involving human subjects.

Adopted by the 18th World Medical Assembly, Helsinki, Finland, 1964, and as revised by the 29th World Medical Assembly, Tokyo, Japan, 1975.

INTRODUCTION

It is the mission of the medical doctor to safeguard the health of the people. His or her knowledge and conscience are dedicated to the fulfilment of the 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 declares that, "Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest".

The purpose of biomedical research involving human subjects must be to improve diagnostic, therapeutic and prophylactic procedures and the understanding of the aetiology and pathogenesis of disease.

In current medical practice most diagnostic, therapeutic or prophylactic procedures involve hazards. This applies a fortiori to biomedical research.

Medical progress is based on research which ultimately must rest in part on experimentation involving human subjects.

In the field of biomedical research a fundamental distinction must be recognised between medical research in which the aim is essentially diagnostic or therapeutic for a patient, and medical research, the essential object of which is purely scientific and without direct diagnostic or therapeutic value to the person subjected to the research.

Special caution must be exercised in the conduct of research which may affect the environment, and the welfare of animals used for research must be respected.

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 every doctor in biomedical research involving human subjects. They should be kept under review in the future. 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.

I. BASIC PRINCIPLES

1. Biomedical research involving human subjects must conform to generally accepted scientific principles and should be based on adequately performed laboratory and animal experimentation and on a thorough knowledge of the scientific literature.
2. The design and performance of each experimental procedure involving human subjects should be clearly formulated in an experimental protocol which should be transmitted to a specially appointed independent committee for consideration, comment and guidance.
3. Biomedical research involving human subjects should be conducted only by scientifically qualified persons and under the supervision of a clinically competent medical person. The responsibility for the human subject must always rest with a medically qualified person and never rest on the subject of the research, even though the subject has given his or her consent.
4. Biomedical research involving human subjects cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.
5. Every biomedical research project involving human subjects should be preceded by careful assessment of predictable risks in comparison with foreseeable benefits to the subject or to others. Concern for the interest of the subject must always prevail over the interests of science and society.

6. The right of the research subject to safeguard his or her integrity must always be respected. Every precaution should be taken to respect the privacy of the subject and to **minimise** the impact of the study on the subject's physical and mental integrity and on the personality of the subject.
7. Doctors should abstain from engaging in research projects involving human subjects unless they are satisfied that the hazards involved are believed to be predictable. Doctors should cease any investigation if the hazards are found to outweigh the potential benefits.
8. In publication of the results of his or her research, the doctor is obliged to preserve the accuracy of the results. Reports of experimentation not in accordance with the principles laid down in this Declaration should not be accepted for publication.
9. In any research on human beings, each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. He or she should be informed that he or she is at liberty to abstain from participation in the study and that he or she is free to withdraw his or her consent to participation at any time. The doctor should then obtain the subject's freely-given informed consent, preferably in writing.
10. When obtaining informed consent for the research project the doctor should be particularly cautious if the subject is in a dependent relationship to him or her or may consent under duress. In that case the informed consent should be obtained by a doctor who is not engaged in the investigation and who is completely independent of this official relationship.
11. In case of legal incompetence, informed consent should be obtained from the legal guardian in accordance with national legislation. Where physical or mental incapacity makes it impossible to obtain informed consent, or when the subject is a minor, permission from the responsible relative replaces that of the subject in accordance with

national legislation.

12. The research protocol should always contain a statement of the ethical considerations involved and should indicate that the principles enunciated in the present Declaration are complied with.

II. MEDICAL RESEARCH COMBINED WITH PROFESSIONAL CARE (CLINICAL RESEARCH)

1. In the treatment of the sick person, the doctor must be free to use a new diagnostic and therapeutic measure, if in his or her judgement it offers hope of saving life, re-establishing, health or alleviating suffering.
2. The potential benefits, hazards and discomfort of a new method should be weighed against the advantages of the best current diagnostic and therapeutic methods.
3. In any medical study, every patient - including those of a control group, if any - should be assured of the best proven diagnostic and therapeutic method.
4. The refusal of the patient to participate in a study must never interfere with the doctor-patient relationship.
5. If the doctor considers it essential not to obtain informed consent, the specific reasons for this proposal should be stated in the experiment protocol for transmission to the independent committee (1,2).
6. The doctor can combine medical research with professional care, the objective, being the acquisition of new medical knowledge, only to the extent that medical research is justified by its potential diagnostic or therapeutic value for the patient.

III. NON-THERAPEUTIC BIOMEDICAL RESEARCH INVOLVING HUMAN SUBJECTS (NON CLINICAL BIOMEDICAL RESEARCH)

1. In the purely scientific application of medical research carried out on a human being, it is the duty of the doctor to remain the protectors of the life and health of that person on whom biomedical research is being carried out.
2. The subjects should be volunteers - either healthy persons or patients for whom the experimental design is not related to the patient's illness.
3. The investigator or the investigating team should discontinue the research if in his/her or their judgement it may, if continued, be harmful to the individual.
4. In research on man, the interest of science and society should never take precedence over consideration related to the wellbeing of the subject.

**APPENDIX I
(reference Section E, paragraph 44.01)**

**THE WORLD MEDICAL ASSOCIATION, INC.
13, Chemin du Levant, 01210 Ferney-Voltaire, France**

DECLARATION OF TOKYO

Guidelines for Medical Doctors concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment.

As adopted by the 29th World Medical Assembly, Tokyo, Japan, October, 1975.

PREAMBLE

It is the privilege of the medical doctor to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patient. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

DECLARATION

1. The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.
2. The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened.
4. A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective, or political shall prevail against this higher purpose.
5. Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgement should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.
6. The World Medical Association will support, and should encourage the international community, the national medical associations and fellow doctors to support the doctor and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

APPENDIX J
(reference Conclusion, paragraph 50.02)

PRINCIPLES OF MEDICAL ETHICS IN EUROPE
(Translated from the original French Text)

(Prepared by the Conference Internationale des Ordres et des Organismes d' Attributions Similaires)

This document sets out the most important principles intended to influence the professional conduct of doctors, in whatever branch of practice, in their contacts with patients, with society and between themselves. It also refers to the privileged position of doctors, upon which good medical practice depends. The Conference has recommended to its constituent regulatory bodies in each member state of the European Communities that they take such measures as may be necessary to ensure that their national requirements relating to the duties and privileges of doctors vis-a-vis their patients and society and in their professional relationships conform with the principles set out in this document, and that there is provision within the framework of their national law for the effective implementation of these principles.

ARTICLE 1

The doctor's vocation is to safeguard man's physical and mental health and relieve his suffering, while respecting human life and dignity with no discrimination on the grounds of age, race, religion, nationality, social status or political opinions or on any other ground, whether in peace time or in war time.

Undertakings by the Doctor

ARTICLE 2

X In the course of his professional practice a doctor undertakes to give priority to the medical interest of the patient. The doctor may use his professional knowledge only to improve or maintain the health of those who place their trust in him; in no circumstances may he act to their detriment.

ARTICLE 3

In the course of his professional practice a doctor must refrain from imposing on a patient his personal philosophical, moral or political opinions.

Enlightened Consent
ARTICLE 4

Except in an emergency, a doctor must explain to the patient the expected effects and consequences of treatment. He will obtain the patient's consent, particularly when his proposed course of action presents a serious risk.

X The doctor may not substitute his own definition of the quality of life for that of his patient.

Moral and Technical Independence
ARTICLE 5

X Both when giving advice and when giving treatment, a doctor must bring to bear the full range of his professional freedom and the technical and moral circumstances which permit him to act in complete independence.

The patient should be informed if these conditions are not met.

ARTICLE 6

When a doctor is working for a private or public authority or when he is acting on behalf of a third party, be it an individual or institution, he must also inform the patient of this.

Professional Confidentiality
ARTICLE 7

The doctor is necessarily the patient's confidant. He must guarantee to him complete confidentiality of all the information which he may have acquired and of the investigations which he may have undertaken in the course of his contacts with him.

The death of a patient does not absolve a doctor from the rule of professional secrecy.

A doctor must respect the privacy of his patients and take all steps necessary to prevent the disclosure of anything which he may have learned in the course of his professional practice.

Where national law provides for exceptions to the principles of confidentiality, the doctor should be able to consult in advance the Medical Council or similar professional organisation.

ARTICLE 8

Doctors may not collaborate in the establishment of electronic medical data banks which could imperil or diminish the right of the patient to the safely protected confidentiality of his privacy. A nominated doctor should be responsible for ethical surveillance in the case of every computerised medical data bank.

Medical data banks must have no links with other data banks.

Standards of Medical Care
ARTICLE 9

The doctor ought to have access to all the resources of medical knowledge in order to utilise them as necessary for the benefit of his patient.

ARTICLE 10

He should not lay claim to a competence which he does not possess.

ARTICLE 11

He must call upon a more experienced colleague in any case which requires an examination or method of treatment beyond his own competence.

Care of the Terminally Ill
ARTICLE 12

X The practice of medicine entails in all circumstances constant respect for life, the moral autonomy and the free choice of the patient. However, the doctor may, in the case of an incurable and terminal illness, alleviate the physical and emotional suffering of the patient by restricting his intervention to such treatment as is appropriate to preserve, so far as possible, the quality of a life which is drawing to its close. It is essential to care for the dying patient right to the end and to take such action as will permit the patient to retain his dignity.

Removal of Organs
ARTICLE 13

In a case where it is impossible to reverse the terminal processes leading to the cessation of a patient's vital functions which are being artificially maintained, doctors will satisfy themselves that death has occurred, taking account of the most recent scientific data

At least two doctors, acting individually, should take meticulous steps to verify that this situation has occurred, and record their findings in writing.

They should be independent of the team which is to carry out the transplantation.

ARTICLE 14

Doctors removing an organ for transplantation may give particular treatment designed to maintain the condition of that organ.

ARTICLE 15

Doctors removing organs for transplantation should take all practicable steps to satisfy themselves that the donor had not expressed an opinion or left instructions on the matter either in writing or with his family.

Reproduction
ARTICLE 16

The doctor will furnish the patient, on request, with all relevant information on the subjects of reproduction and contraception.

ARTICLE 17

It is ethical for a doctor, by reason of his own beliefs, to refuse to intervene in the process of reproduction or termination of pregnancy or abortion by suggesting to the patients concerned that they consult other doctors.

Experimentation on Humans
ARTICLE 18

Progress in the field of medicine is based on research which may not be undertaken without experimentation which has a direct bearing on humans.

ARTICLE 19

Details of all proposed experimentation involving patients must first be submitted to an ethical committee which is independent of the research team for opinions and advice.

ARTICLE 20

The free and informed consent of any person who is to be involved in a research project must be obtained after he has first been sufficiently informed of the aims, methods and expected benefits as well as the risks and potential problems, and of his right not to take part in experiments (or other research) and to withdraw from participation at any time.

ARTICLE 21

The doctor may not link biomedical research with medical treatment, with a view to developing medical knowledge, except insofar as that biomedical research is justified by a potential diagnostic or therapeutic aid which will be relevant to his patient.

Torture and Inhuman Treatment
ARTICLE 22

A doctor must never attend, take part in or carry out acts of torture or other kinds of cruel, inhuman or degrading treatment for any reason (crime, charges laid, beliefs), whatever the situation, including cases of civil or armed conflict.

ARTICLE 23

A doctor must never use his knowledge, his competence or his skills for the purpose of facilitating the use of torture or any other cruel, inhuman or degrading procedure for any purpose whatsoever.

The Doctor and Society

ARTICLE 24

In order to accomplish his humanitarian duties, every doctor has the right to legal protection of his professional independence, in times of peace as in times of war.

ARTICLE 25

It is the duty of a doctor, whether acting alone or in conjunction with professional organisations, to draw the attention of society to any deficiencies in the quality of health care or in the professional independence of doctors.

ARTICLE 26

Doctors must be involved in the development and the implementation of all collective measures designed to improve the prevention, diagnosis and treatment of disease. In particular, they must provide a medical contribution to the organisation of rescue services, particularly in the event of public disaster.

ARTICLE 27

They must participate, so far as their competence and available facilities permit, in constant improvement of the quality of care through research and continual refinement of methods of treatment, in accordance with advances in medical knowledge.

Relationships with Professional Colleagues

ARTICLE 28

The rules of professional etiquette were introduced in the interest of patients. They were designed to prevent patients becoming the victims of dishonest manoeuvres among doctors. The latter may, on the other hand, legitimately rely on the recognised professional qualifications of their colleagues.

ARTICLE 29

The doctor called upon to treat a patient already under the care of a colleague must endeavour to establish a professional link with that other doctor in the interest of the patient, unless the patient objects.

ARTICLE 30

It is not contrary to professional etiquette for a doctor to inform the competent professional regulatory authorities of any serious lapses from the rules of medical ethics and good professional practice of which he is aware.

Publication of Findings

ARTICLE 31

A doctor must give priority to the professional journals in offering for publication any discoveries that he may have made or conclusions that he may have drawn from his scientific studies which are relevant to diagnosis or treatment. He must submit his findings in the appropriate form for review by his colleagues before releasing them to the lay public.

ARTICLE 32

Any exploitation by way of advertisement of a medical success to the profit of an individual or of a group or institution is contrary to medical ethics.

Continuity of Care

ARTICLE 33

A doctor, whatever his specialty, has a duty to give emergency treatment to any patient in immediate danger, unless he is satisfied that other doctors will provide this care and are capable of doing so.

ARTICLE 34

The doctor who agrees to give care to a patient undertakes to ensure continuity of care when necessary with the help of junior doctors, locums or medical colleagues with appropriate skills.

Freedom of Choice
ARTICLE 35

The patient's freedom to choose a doctor constitutes a fundamental principle of the patient-doctor relationship. The doctor must respect, and make sure that others respect, the patient's freedom of choice. The doctor, for his part, may refuse to treat a particular patient, unless the patient is in immediate danger.

Withdrawal of Services
ARTICLE 36

When a doctor decides to participate in an organised, collective withdrawal of services, he is not released from his ethical responsibilities vis-a-vis his patients to whom he must guarantee emergency services and such care as is required by those currently being treated.

Fees
ARTICLE 37

In setting his fees, the doctor will take account, in the absence of any contract or of individual or collective agreement on the rate of fees, of the importance of the service which has been given, any special circumstances in a particular case, his own competence and the financial situation of the patient.