Comhairle na
nDochtúirí Leighis

The Medical
Council

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

174.2

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Medical Council
Lynn House
Portobello Court
Lower Rathmines Road
Dublin 6

Third Edition 1989

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Constitution and Functions

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INTRODUCTION

When introducing the Mid-Term Report of the Council covering the years 1984-86, I commented:

"Many doctors still hark back to the days when, once on the Register, a doctor could proceed with equanimity, insulated to some degree from social and political pressures. Those days, if they ever really existed, are over. The pressures on members of the profession are steadily intensifying in all fields . . . The extraordinary scientific advances of recent years have brought new ethical problems and an even greater need to keep up to date. Social changes leading to major alterations in the way of life of many of our patients, and their greatly enhanced expectations, all now play a part in the daily life of the doctor."

This new Ethical Guide must be seen against that background of rapidly increasing change in Irish society. It is not the last word – other Guides will follow in the years to come. For this reason, amongst others, it is a Guide and not a Code. It arises from the need to interpret and re-define Medical Ethics to meet situations never envisaged before; the Ethics remain the same but their application must vary. Examples are the advances – if that some of them be – in the field of Reproductive Medicine seemingly leaving mankind to face the implications of the new techniques of Genetic Engineering. The profession will need to clarify its views on this. No one can foresee what changes in society and in medical practice will stem from the AIDS pandemic which confronts us. It is chastening to consider that, with all our skills, there is at present no prospect of any cure for this disease. Even greater ethical problems may arise in the future when choices have to be made on the diversion of resources to deal with it.

However, we must live in the present. Questions of advertising and relations with the media have always presented difficulties. This Guide attempts to tease out the problems somewhat further and will, hopefully, preserve that sometimes narrow line between self-advertisement and the legitimate provision of information to the community. No one should forget, however, that the profession as a whole feels very deeply about this field, and is instinctively wary of anything which seems to advance the interests of individual doctors at the expense of their colleagues.

Just as this Guide had been agreed by Council and was ready for publication a meeting, which had been postponed several times, took place with the Incorporated Law Society to discuss those problems which can arise in the provision of medical reports in possible legal proceedings. This is a constant irritant to both professions for there are rights and obligations on both sides. It is now proposed that a joint committee should be set up to review this whole area. This will, of course, be a matter for the new Council, but from our point of view the over-riding concern must be at all times the interests of those patients involved. In no circumstances should the delivery of a report be unduly delayed.

This booklet is the result of long and detailed discussion, and it is our hope that what is published now will remain relevant for some years to come, given that clarification of specific issues may become necessary from time to time. It should be studied and kept for reference by all practitioners, containing as it does the thinking of the Council on those issues which seem increasingly to affect us. Also, as one would expect, it reflects the ethos of the practising profession in Ireland.

I must thank and congratulate those who contributed to this third edition. It will be seen as one of the major achievements of the Council.

P. N. Meenan
President

Constitution and Functions

MEMBERSHIP

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.

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.

THE REGISTER

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 with the 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.

REGISTRATION

Full Registration is normally preceded by Provisional Registration which follows on primary qualification and limits practice to residence 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. Doctors who are nationals of European Community Member States and who hold formal medical qualifications awarded in Member States are entitled to apply for full registration by making application in the prescribed form and manner. Information is available from the Registrar at the Council's Office. Doctors from countries with which this country has reciprocity of registerable medical qualifications may apply for full registration.

Temporary Registration, which is limited to doctors who are not otherwise entitled to registration, enables doctors from countries outside the Community to gain experience by being employed in hospitals approved 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.

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

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.

Any certificate, prescription or other document which is required to be signed by a medical practitioner is invalid and ineffective if signed by a person who is not duly registered.

EDUCATION AND TRAINING

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 EC Directives are satisfied.

FITNESS TO PRACTISE

The Council is empowered through its Fitness to Practise Committee, to enquire 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 **Fitness to Practise**.

Ethical Conduct and Behaviour

ETHICAL CONDUCT AND BEHAVIOUR

"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).

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.

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.

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

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.

Some Member States of the European Community have legal codes which specify ethical conduct for doctors in great detail. The Council does not consider it necessary to compile such a catalogue of behaviour where non-observance could be regarded as professional misconduct. 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.

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

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. Traditionally, in this country cases of alleged professional misconduct are examined by the peers of the practitioner concerned, with due regard to his or her constitutional rights.

SECTION A

RESPONSIBILITY TO PATIENTS

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. 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.

BEHAVIOUR TOWARDS PATIENTS

Complaints continue to be made 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.

FAILURE OF COMMUNICATION

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 written instructions to patients or relatives may help understanding and compliance.

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 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.

PERSONAL RELATIONSHIPS BETWEEN DOCTORS AND PATIENTS

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

SECTION B

PROFESSIONAL RESPONSIBILITIES

The practice of medicine is sometimes difficult and often demanding. Doctors should give moral support to each other. When disputes with colleagues arise they should be settled as speedily as possible and without undue publicity.

When considered necessary doctors should not hesitate to refer patients to colleagues, or to consult with them, but should not associate professionally with, or refer patients to, unregistered practitioners.

The Council considers that doctors have a personal and 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 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, the nursing profession, 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.

Doctors who are unable to honour commitments entered into concerning employment with hospital authorities, should inform the hospital at the earliest opportunity.

HEALTH PROBLEMS

The misuse of alcohol and other drugs is such a common contributing factor in illnesses, family problems, behaviour disorders, drug inter-reactions and accidents, that doctors must play a greater part in educating the public, both about the proper use and the danger of these drugs.

In this area an awareness of responsibility, both personal and professional, 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. The perceived misuse of alcohol or other drugs by a doctor may be grounds for the holding of an Inquiry, and a claim of not being on duty will not be grounds for avoiding an Inquiry.

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 should be given to the Fitness to Practise Committee of the Council.

A similar procedure is recommended when other forms of physical or mental ill-health, or the aging process, appear to affect seriously professional competence and responsibility to patients.

The Council is aware of the counselling service operated by the Ethical Committee of the Irish Medical Organisation. It fully supports the service which is confidential but, in doing so, wishes to make clear that the service should not be used to withold complaints to the Council when the public interest is endangered. The Council regrets that the Medical Practitioners Act, 1978, makes no provision for dealing with the sick doctor, except through disciplinary proceedings. Doctors have a responsibility to advise the Council promptly of any circumstances where a doctor's fitness to practise is in question, and when the public interest is at risk.

SECTION C

RESPONSIBILITY TO THE COMMUNITY

ADVERTISING AND THE MEDIA

The reputation of a 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.

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.

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.

Similarly, social, ethical, political or research aspects of medicine may require doctors to be identified by name, qualifications or appointments. Thus, they take personal responsibility for their views and establish the basis for them.

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.

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.

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 decision making. The Council, in putting forward the foregoing advice, will hold doctors responsible for their decisions to appear on programmes or to write articles in the non-medical press.

CLINICS

Recent years have seen a proliferation of organisations, centres or 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 remain anonymous, and to ensure that any treatment, advice or services offered, conform

to the traditional standards of the medical profession. Such doctors may be held accountable for any 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.

Any financial, or other, interest which a doctor holds in any Clinic/Private Hospital should be declared to patients who are being referred to it for investigation or treatment.

PRACTICE ANNOUNCEMENTS

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. The specialty interest of the doctor may be mentioned, provided it is within the list of specialties recognised by the Council – see Appendix A. The notice should 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.

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 as entered in the Register, telephone number and the specialty which must be one of those approved by the Council.

Illuminated surgery signs erected outside doctors' surgeries may be of assistance to the public in locating surgeries in,

for example, large housing estates. The Council recommends that doctors who favour such signs should ensure that the signs are discreet and restricted to the word "Surgery".

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 to attract new patients.

COMMUNITY RESOURCES

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, when appropriate, on their allocation. Their responsibility to the community should not conflict with their responsibility to an individual patient in their care.

PERSONAL STANDARDS

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.

IRRESPONSIBLE PRESCRIBING

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.

While such strictures may not necessarily be justified, it is well for doctors to keep constantly in mind their educational responsibilities, particularly where the use of tranquillisers, hypnotics, and antibiotics is concerned.

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. 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 investigates fully, and views seriously, 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 B.

CONVICTIONS

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 should not be able to avoid an Inquiry by claiming that he/she was not on duty at the time of the alleged offence.

INDUSTRIAL ACTION

When doctors decide to participate in an organized collective withdrawal of services they are not released from their ethical responsibilities vis-a-vis their patients. They must guarantee emergency services and also such care as may be required by those whom they are currently treating.

SECTION D

DOCTOR IN PRACTICE

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.

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.

The Council does not approve of doctors forming companies which engage in the practice of medicine.

The professional notepaper of doctors should confine itself to registrable medical qualifications held by the doctor and, where appropriate, information concerning the practice.

DEPUTISING ARRANGEMENTS

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.

Doctors who use the services of a deputising agency should satisfy themselves,

(a) that a high standard of continuing medical care for their patients is provided,

(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.

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.

It is especially important that deputising doctors should not accept the transfer of patients from the principal doctor.

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.

Doctors in single handed practice 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.

Doctors should not use deputising services to relieve them of their responsibility in the clinical care of patients, for example, by regularly using such a service for their domiciliary calls.

Whatever deputising arrangements are made by doctors, 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 C.

CONFIDENTIALITY

Confidentiality is a time honoured principle of medical ethics. There are three 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.

Medical records, both clinical and technical, must be safeguarded. 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 D. 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: Community Physicians, Occupational Physicians, Doctors employed by, and/or, acting for An Garda Síochána and the Defence Forces, Prison Medical Officers.

The following points should be borne in mind:

(i) The doctor-patient relationship should be respected at all times.

(ii) Where circumstances permit, the examinee's own personal physician should be informed.

(iii) The significance, rather than the precise details, of the medical findings should be conveyed to any third party.

(iv) Documents containing medical details should always be transmitted under confidential cover.

In order to fulfil statutory requirements it may be necessary for a doctor to provide, e.g. a community physician, with medical information which may be used for the benefit of a patient. For example, clinical details may be provided so that the payment of a financial allowance may be recommended. In such instances the community physician is not obliged to release the specific details, but may interpret them to the administrative authority concerned.

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 person examined may the employer have access to that person's medical record, and then only in specifically agreed circumstances.

An employer has not got the right to be informed of the clinical details of illness or injury without the consent of the patient. The doctor may, when assessing the nature of the particular disability,

interpret the medical findings in terms of the patient's likelihood of continuing to work.

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.

Problems may also arise for doctors who are requested by insurance companies to complete a medical report on a patient. Doctors are advised to ensure that the patient fully understands what may be involved in furnishing a medical report, and has given full consent to such a report being issued.

CONSENT

Medical intervention normally requires consent. Whether or not a person is sufficiently informed, and sufficiently free, to consent to medical investigation and treatment may be difficult to resolve. Every effort should be made to ensure that a patient understands the nature and purpose of the medical procedures involved. The Council urges special caution whenever children, prisoners, mentally ill, mentally handicapped, or unconscious persons are involved.

INFORMATION

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, medical practitioners 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.

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 interests of their

patients, to provide the necessary information to a colleague who is willing to provide a report.

In their own interests and in the interests of patients, it is essential that doctors keep accurate records of patient care.

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.

CERTIFICATION

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.

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.

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.

Certificates issued should give the full name and address of the patient, date of issue and be personally signed by doctors. The registered name and address of doctors should appear on certificates.

SPECIALIST REFERRAL

It is a principle accepted by Council that the overall management of a patient's health should be under the supervision and guidance of their family doctor. 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 family doctor is not convinced that such a referral is necessary.

While a specialist may decide, in certain circumstances, to accept a patient without referral from a family doctor, 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.

In certain circumstances patients are referred to hospital and a specialist by sources other than the family doctor. Here again the specialist has a duty to keep the family doctor informed, if the patient consents.

Cross referral between specialists may be necessary. The Council recommends that normally the family doctor should be informed in advance of such cross referral.

FEE SPLITTING

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

ATTENDANCE ON DOCTORS' FAMILIES

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

RETIREMENT FROM PRACTICE

Doctors who propose to retire from medical practice should give sufficient notice to their patients of their intention to do so. In this way, patients will be able to make arrangements for alternative medical care. It would be helpful to patients if doctors provided the names of colleagues who would be willing to provide this. The

decision to avail of the list, or to make alternative arrangements, is a matter for the patients themselves. It is advisable that accurate patient records should be available for transfer to doctors who take over responsibility for patients. This should be made known to patients.

SECTION E

REPRODUCTIVE MEDICINE

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.

It is important for doctors to keep abreast 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, while obeying the laws of the State, must always be guided by their own informed consciences.

Abortion is illegal in Ireland and is professional misconduct. Doctors are reminded of the legal position in Ireland concerning requests for, or advice on, termination of pregnancy.

IN-VITRO FERTILISATION

The Council approves the Guidelines promulgated by the Institute of Obstetricians and Gynaecologists of the Royal College of Physicians of Ireland. Therapeutic application of in-vitro fertilisation within this framework is acceptable. Experimentation on fertilised ova and embryos at any stage of development, or the storage or freezing of spare embryos, is unacceptable. The Guidelines of the Institute are printed as Appendix E.

HUMAN RESEARCH

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.

The Council strongly supports the formation of ethical committees in all institutions where human research is undertaken. Practitioners are advised to seek approval from an appropriate supervisory organisation before undertaking any research project involving risks to human subjects.

The Council supports the resolutions of the 18th World Medical Assembly and as revised by the 29th World Medical Assembly – see Appendix F.

DONOR ORGAN PROCUREMENT

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."

EUTHANASIA

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 actively causing the death of a person, is illegal in Ireland and is professional misconduct.

RELATIONSHIPS TO PRISONERS

The Council supports and draws attention to the 1975 declaration of Tokyo by the World Medical Organisation concerning the torture and other cruel, inhuman and degrading punishment – see Appendix G.

HIV INFECTION AND AIDS

After an initial period of doubt it now appears that the ethical considerations involved in cases of HIV infection and AIDS are covered to a very large extent, if not indeed completely, by the traditional standards of the profession.

DOCTOR PATIENT RELATIONSHIP

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 disease, is well established. However, whilst the general ethical principles may be clear, it must be conceded that their application may provide problems in individual cases, and doctors may have great difficulty in reaching informed decisions in some of these. Doctors do not have the right to refuse treatment on the ground of risk to themselves or of any moral disapproval, but may properly refer a patient to a colleague if they have a conscientious objection to a given line of treatment, or feel that they do not have the personal skills or necessary facilities to undertake it. It is unlikely that such stark choices will often arise, but practitioners if in doubt, should be ready, in the interests of their patients, to consult colleagues who have particular expertise. 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.

CONFIDENTIALITY

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 is HIV positive or suffering from AIDS, 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.

Difficulties may clearly arise if the patient, after full discussion and consideration, refuses to consent to disclosure. In this case it would seem at first sight that the patient's right to confidentiality is covered by the general ethical standards of the profession and should be respected. If mutual trust between doctor and patient has been established such a case will, hopefully, be rare. Should it arise, however, the doctor will then have to decide how to proceed, in the knowledge that the decision reached may have to be subsequently justified. If it appears 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 them. They in their turn would, of course, be bound by the general rules of confidentiality.

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, in all the circumstances of the case, consider it a duty to inform the spouse or other partner.

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

TESTING FOR HIV INFECTION

Difficulties have arisen in this area mainly because of a tendency on the part of some practitioners to carry out testing for HIV infection without the informed consent of the patient. In some cases the tests have been carried out as part of multiple screening, but on occasion specific testing has been done without the patient's knowledge and, therefore, consent. Quite apart from the ethical considerations involved the result of the testing may place the doctor in a most invidious position. Such investigations should be carried out only with the patient's knowledge and full and informed consent, following discussion between the doctor and the patient.

In dealing with children and those who cannot give valid consent further difficulties may arise when parental consent to testing has been withheld. It will be for the doctor concerned in such a case to judge whether the best interests of the child require that the test be carried out without parental consent. Obviously, such a decision may have to be justified but it may well be, when the facts have been considered, that the doctor has acted in accordance with recognised ethical principles.

DOCTORS WITH AIDS

It is clearly unethical for doctors who consider that they might be infected with the HIV virus not to seek diagnostic testing. If the test is positive they should then put themselves in the hands of professional colleagues for treatment. They should also seek advice on how far it may be 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.

TESTING FOR INSURANCE PURPOSES

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. Doctors should counsel patients of the implications of testing for HIV antibodies and inform them that it would be quite improper for the doctor not to assist in full disclosure of all the relevant facts.

CONCLUSION

This brief review of ethical behaviour in medical practice is the third publication by the Council up-dating 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.

In publishing this Ethical Guide, the Document entitled Principles of Medical Ethics in Europe" has been included as Appendix H. 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

FITNESS TO PRACTISE

The Medical Practitioners Act, 1978 introduced major changes into the disciplinary procedure governing the profession. These encompass not only the alleged offences but also the methods of adjudication.

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 name should be erased. The long established phrase "infamous conduct in a professional respect" now becomes "professional misconduct" and two new reasons for possible erasure are laid down. The first involves fitness to engage in the practice of medicine by reason of physical or mental disability. The other arises from the fact that an annual retention fee is now payable and that failure to pay this will result in erasure.

The new 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 application for an inquiry into the professional conduct of a registered practitioner, or into his fitness to practise for health reasons, and which actually carries out the inquiry. The application for an inquiry may be made by the Council itself or by "any person." In practice, 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 also the power to overrule the Committee and to direct it to hold an inquiry notwithstanding.

There are therefore two situations in which an inquiry may be instituted – either by direction of the Council, or if the Committee has itself decided that the facts alleged constitute a prima facie case for holding one.

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 reports to the Council.

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 or that registration may not have effect for a specified period. Effectively, this means suspension for a given length of time.

The Council does not, however, proceed directly to erasure or suspension. 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 may itself apply for confirmation of the decision. The Court may cancel the decision or confirm it. If it is confirmed the Court may order the Council to erase the name of the practitioner or to suspend effective registration.

These are considerable safeguards for the practitioner, but the Council has also been given greatly expanded disciplinary powers. 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 but may attach "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.

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.

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.

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 and mental disability.

Appendices

Appendix A

RECOGNISED SPECIALTIES

Anaesthetics

Cardiology

Child and Adolescent Psychiatry

Clinical Pharmacology and Therapeutics

General Surgery

Neurological Surgery

Ophthalmology

Orthopaedic Surgery

Otolaryngology

Paediatric Surgery

Plastic Surgery

Microbiology

Morbid Anatomy and Histopathology

Occupational Medicine

Paediatrics

Radiotherapy

Communicable Diseases

Community Medicine

Dermatology

Endocrinology & Diabetes Mellitus

Gastroenterology

General (Internal) Medicine

General Practice

Geriatrics

Thoracic Surgery

Urology

Haematology

Psychiatry

Diagnostic Radiology

Respiratory Medicine

Rheumatology

Tropical Medicine

Venerology

Obstetrics and Gynaecology

Chemical Pathology

Clinical Immunology

Nephrology

Neurology

Appendix B

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;

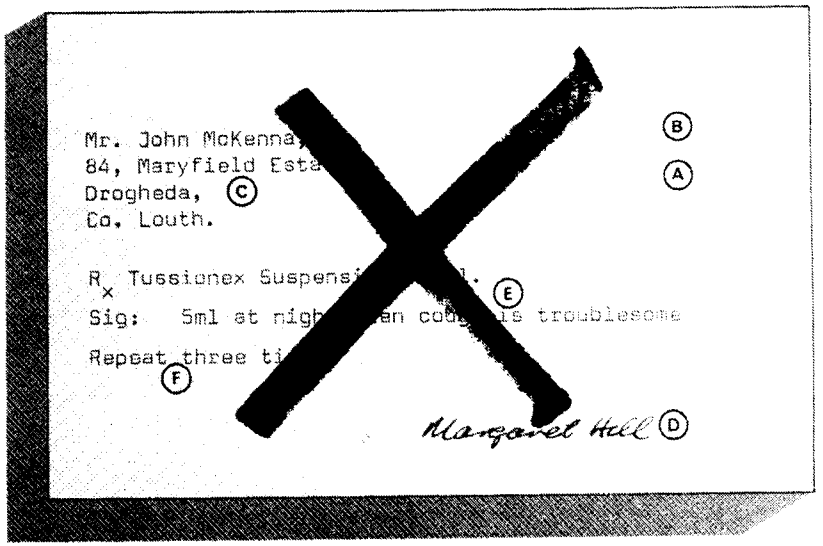
C specify (in the prescriber's handwriting) the name and address of the person for whose treatment it is issued or, if issued by a registered veterinary surgeon, the name and address of the person to whom the drug is to be delivered;

D state whether the person issuing it is a registered medical practitioner, registered dentist or registered veterinary surgeon;

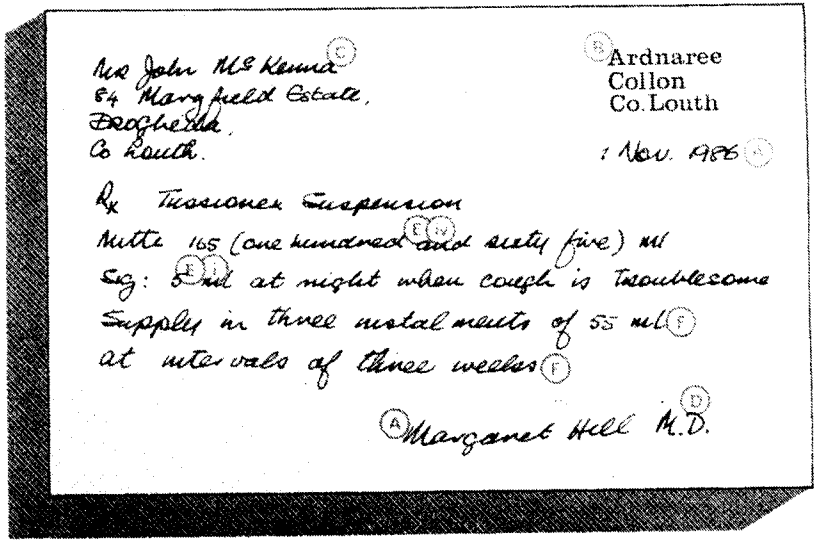
E specify (in the prescriber's handwriting) (i) the *dose* to be taken, (ii) the *form* in the case of preparations, (iii) the *strength* (when appropriate) and (iv) in both words and figures, either the *total quantity* of the drug or preparation or the *number of dosage units* to be supplied;

F in the case of a prescription for a total quantity intended to be dispensed by instalments, specify the quantity, the number of instalments, and the intervals to be observed when dispensing.

INCORRECT



CORRECT



NOTE: INCORRECTLY WRITTEN PRESCRIPTIONS ARE ILLEGAL.

A LIST OF THE MOST COMMON

CONTROLLED DRUGS

SCHEDULE 2

Class of Controlled Drug	Proprietary Products
Amphetamine	
Cocaine	
Codeine	
Dexamphetamine	Dexedrine, Durophet
Dextromoramide	Palfium
Dihydrocodeine	DF 118
Dipipanone	Diconal
Fentanyl	Sublimaze, Thalamonal
Hydrocodone	Dimotane DC, Tussionex
Hydromorphone	Dilaudid
Levorphanol	Dromoran
Medicinal Opium (which includes Papaveretum and Opium Tincture BP)	Omnopon
Methadone	Physeptone
Methylphenidate	Ritalin
Morphine	Cyclimorph, MST Continus, Nepenthe
Pethidine	Pethilan, Pethilorfan
Pholcodine	
Phenoperidine	Operidine

SCHEDULE 3

Amylobarbitone	Amytal, Tuinal
Pentobaritone	Nembutal
Phenobarbitone	—
Quinalbarbitone	Seconal (Tuinal)

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

1. Preparations containing amylobarbitone, pentobarbitone or phenobarbitone (their salts etc.) when compounded with another active substance or substances none of which is a controlled drug.
2. Preparations containing not more than 120mg. of phenobarbitone per dosage unit or not more than 2.5% in the case of liquids.
3. Mixtures containing not more than 0.1% of Cocaine.
4. Mixtures containing not more than 0.2% of Morphine.
5. Codeine Phosphate Tablets.
6. Dihydrocodeine Tablets (DF 118).

Appendix C

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 provided by a deputising agency.)

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 by an agency a principal doctor should satisfy himself/herself that the lines of communication offered by the agency are, as far as possible, foolproof. This requirement applies especially to the radio link. 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 patient and toward the Health Board. The routine off-loading of GMS patients onto the deputy doctor of an agency 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 physician.

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 To avoid disputes with patients, (and indeed with principal doctors). A recurring cause of such disputes is the question of the collection of fees by deputy officers. 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 sees in the course of his/her deputising work.

C. Most Commonly Occurring Complaints

i Calls not done at all by deputy.

ii Deputy unreasonably late in arriving to complete a home visit.

iii Disputes over receipt or non-receipt of messages, (a) from principal doctor to deputising agency, and (b) from agency to deputy.

iv Reports not sent to principal doctor.

v Report sent late to principal doctor.

vi Disputes over collection of fees by deputy.

vii Patient complaints to principal doctor of rudeness on part of deputy.

viii Principal doctor complaints that deputy prescribed wrong treatment, (rare complaint).

ix Protracted delays on the part of principal doctor in paying the agency fees, (and those of the deputy).

D. The Administration of a Medical Deputising Service

In theory it would be of advantage if a deputising service were administered by a doctor. Even if this is not possible the following considerations might be examined.

I The essence of a medical deputising service is that ethical principles must apply and be practised at all times, and that there should be no bending before commercial expediency (the profit motive) at the cost of the ethical approach.

II Whatever the administrative procedures adopted in the operation and control of a deputising agency, the basic

requirements of medical confidentiality should never be placed at risk. In particular this applies to the transmission of reports.

III There should always be a stand-by arrangement in force, whereby a replacement deputy can be called into service should the rostered doctor be unable to fulfil his arranged tour of duty.

IV Deputies should not be requested to cover for more doctors (or over greater geographical distances) than can be managed with reasonable ease. Neglect of this principle will inevitably result in delays in completing house calls.

V A thoroughly reliable communications system must be provided. Normally this means satisfactory radio communication between the headquarters of the deputising service and the deputising doctors on duty. The system should be such that the deputy can be reached by radio wherever he/she is during his/her tour of duty. A proper service must be available to ensure that the communication equipment is kept in satisfactory order.

VI Agencies should avoid employing doctors to carry out the duties of a deputy in an area in which the deputy has set up practice.

VII The contractual arrangements between principal doctors and the agency should be carefully set out and agreed between both parties.

VIII The employment of deputising doctors should be as the result of careful selection based on interviews. Doctors chosen for this work should be adequately experienced and of high personal character.

IX All deputising doctors should be fully registered, and should hold valid membership of a medical protection organisation. The employing agency should satisfy

itself on this point before engaging a doctor for duty as a deputy.

X Considerations should be directed towards whether a deputising doctor and the agency should enter into an arrangement supported by a written contract.

Appendix D

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

Medical Data Banks

MEDICAL SECRETARY

"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 WMA 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 E

STATEMENT

IN-VITRO FERTILISATION

The Council, by a majority decision, approved the following statement:

"The Council approves the guidelines promulgated by the Institute of Obstetricians and Gynaecologists of the Royal College of Physicians of Ireland. Therapeutic application of In-Vitro Fertilisation within this framework is acceptable. Experimentation on fertilised embryos at any stage of development, or the storage or freezing of spare embryos is unacceptable."

The Medical Council,
8, Lower Hatch Street,
Dublin 2.

December, 1985.

INSTITUTE OF OBSTETRICIANS AND GYNAECOLOGISTS

IN-VITRO FERTILISATION

The Executive Council have discussed in-vitro fertilisation (IVF) and have prepared the following statement which explains the principles underlying IVF and provides guidelines for those who may undertake this practice in Ireland.

(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 in these circumstances may be the appropriate treatment for about 5% of infertile couples.

(4) Recent claims that IVF may be used to treat other causes of infertility such as reduced or defective sperm have still to be confirmed but if substantiated, could lead to the use of IVF in a larger percentage of cases of infertility.

(5) The principles of IVF is that a ripe human egg is extracted from the ovary shortly before it would have been released naturally. The egg is mixed with the semen of the woman's husband so that fertilisation can occur outside the fallopian tube (in vitro).

(6) The fertilised egg (embryo) once it has started to divide is then transferred to the mother's uterus.

(7) In practice, the methods of recovery of the egg, the culture outside the mother's body and the transfer of the developing embryos to the uterus must be carried out under very carefully controlled conditions.

(8) It is common and accepted practice to transfer more than one embryo to the mother as this greatly enhances the successful pregnancy rate.

(9) In order to recover more than one egg drugs may be given to the mother to stimulate the ovaries to produce several ripe eggs in one cycle.

(10) If multiple embryos are implanted they may result in a multiple pregnancy.

(11) The success rate of fertilisation in vitro is usually at least 75%. In spite of apparently satisfactory transfer of embryos to the potential mother in cases of successful fertilisation the confirmed clinical pregnancy rate is only between 10 and 20%. It can thus be concluded that about 80% of transferred embryos are lost. It is anticipated that improved transfer procedures will in the foreseeable future improve pregnancy rates in IVF. However it must also be appreciated that a very great number of embryos, perhaps 50 to 60% are lost at this early stage of pregnancy in natural conception in the human.

(12) There is no evidence to suggest that IVF results in an increased risk of abnormalities in babies.

Doctors should adhere to the following guidelines when practising IVF:

(1) The technique of IVF should be offered to married couples who have been appropriately counselled, understand the method and give informed consent.

(2) All fertilised embryos produced by IVF should be replaced in the potential mother's uterus.

(3) Only sperms and eggs from the consenting couple will be used in all IVF procedures.

(4) It is emphasised that 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.

Appendix F

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 fulfillment 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 G

THE WORLD MEDICAL ASSOCIATION, INC.
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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 H

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
In the course of his professional practice a doctor undertakes to give priority to the medical interests 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.

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

Moral and Technical Independence
ARTICLE 5
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
The practice of medicine entails in all circumstances constant respect for the 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 processes 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.