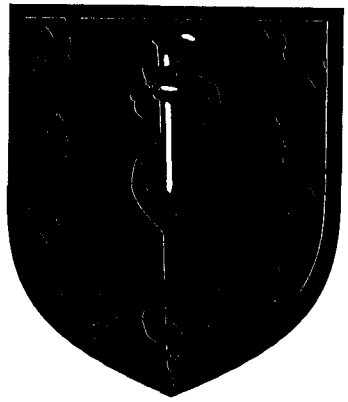
Comhairle na nDochtúirí Leighis

Medical Council

A Guide to Ethical Conduct and Behaviour



FIFTH EDITION 1998

A Guide to Ethical Conduct and Behaviour

Fifth Edition, 1998

Approved by The Medical Council, Ireland, at its meeting
on 30th June 1998 and published in Dublin, November 1998

Design, layout and film outputting by
Diskon Technical Services Ltd., Dublin 8
and printed by the Elo Press Ltd., Dublin 8.

CONTENTS

INTRODUCTION

The Medical Council exists to protect the interests of the public when dealing with members of the medical profession. It does so by supervising undergraduate education and post-graduate training, maintaining the register, regulating professional standards and by the publication of guidance to the profession on ethical issues. Doctors have been given the privilege of regulating their own professional affairs through the Medical Council; with that privilege comes the responsibility to ensure that each of these mechanisms operates in the most effective way possible.

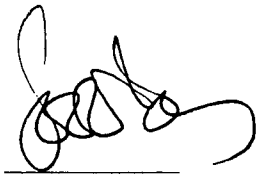
Independent decision making by doctors and their patients is a key part of how medicine operates in Ireland; the Medical Council has no wish to interfere with its effectiveness. The Ethical Guidelines are not a set of rules or a code to be consulted in order to find an answer to every difficult issue. They are a set of principles which doctors must apply in each situation, together with their judgement, experience, knowledge and skills.

The welfare of our patients is paramount. That concern may be expressed in the management of physical illness or in dealing with other issues that affect health. The doctor who provides a reasonable explanation of his or her understanding of the problems and care needed, who seeks the permission of the patient for the interventions proposed and who respects the patient's confidentiality, is unlikely to cause injury to his or her patient.

Our responsibility to follow these principles extends from the care of physical illness and psychosocial problems to health promotional activities and the management of services to patients. Doctors have a further duty to examine continuously the options available to them in the management of their patients and to analyse critically what is in the best interests of those patients.

Changing demographics, new technologies, an expanding knowledge base, pressures on the health services, and raised public expectations are all familiar reasons for the ever changing nature of medical practice. The Ethical Guidelines contain principles of medical practice which rarely change but whose application to new situations is a continuous process. For this reason, each of the Councils elected since 1979 has, on a five yearly basis, published an update of these Ethical Guidelines.

My thanks go to all the members of the Council and to the many members of the public and medical and other organisations that made submissions in relation to this re-drafting. My special thanks go to the members of the drafting sub-committee and the Ethics Committee for the commitment and dedication with which they undertook this important task.



Gerard Bury,
President

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).

SECTION A

CONDUCT AND BEHAVIOUR

1.1 TRADITION

The profession of medicine has a long and honourable tradition of service and care. Society allows doctors many privileges and it is the responsibility of doctors not to abuse these.

1.2 ETHICAL CONDUCT

In giving guidance to the medical profession about questions of ethical conduct, it is not the intention of the Council to issue a Code, but to provide a Guide by which the individual members of the profession may judge particular situations. The Council does not consider it appropriate to compile a detailed catalogue of exactly how doctors should behave in every circumstance.

1.3 INDEPENDENCE OF JUDGEMENT

Medical care must not be used as a tool of the State, to be granted or withheld or altered in character under political pressure. Doctors require independence from such pressures in order to carry out their duties. Regardless of their type of practice the responsibility of all doctors is to help the sick and injured. They must practice without consideration of religion, nationality, gender, race, politics or social standing. They must not allow their professional actions to be influenced by any personal interest.

1.4 TRUST AND PRIVILEGE

The position of trust and privilege held by doctors in the community is founded not only on technical knowledge and skill, but also on high standards of personal and professional behaviour at all times. It is the statutory duty of the Council to investigate complaints about alleged lapses from such standards.

1.5 PROFESSIONAL MISCONDUCT

Professional misconduct is conduct which doctors of experience, competence and good repute, upholding the fundamental aims of the profession, consider disgraceful or dishonourable.

1.6 COURT CONVICTIONS

Convictions in a court of criminal jurisdiction of any registered medical practitioner are notified to the Council which will investigate the circumstances involved. A doctor may not be able to avoid an inquiry by claiming that he/she was not on duty at the time of the alleged offence.

1.7 WITHDRAWAL OF SERVICES

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

SECTION B

DOCTORS AND PATIENTS

2. Responsibility to Patients

2.1 Doctors must do their best to preserve life and promote health. Once they undertake the care of patients they should ordinarily provide continuity of care for the duration of the illness. If they wish to withdraw their services, they must inform the patient and allow sufficient time for alternative medical care to be sought, **during which time clinical continuity must be maintained.** They should also provide medical information to another member of the profession when requested.

2.2 EMERGENCIES
Doctors must provide care in emergency situations unless they are satisfied that alternative arrangements have been made. They must also consider what assistance they can give in the event of a public disaster, a road traffic accident, fire, drowning or other similar occurrences.

2.3 COMMUNICABLE DISEASES
Acceptance of the risk of treating patients with communicable diseases is a time-honoured tradition of the medical profession. Should a doctor be unable to do so for medical reasons, the patient must be given an explanation and explicit arrangements made to have him or her looked after by a colleague. Failure to do this is unethical.

2.4 MORAL DISAPPROVAL
Treatment must never be refused on grounds of moral disapproval of the patient's behaviour.

2.5 CONSCIENTIOUS OBJECTION
If a practitioner has a conscientious objection to a course of action this should be explained and the names of other doctors made available to the patient.

2.6 DIFFERING SKILLS
If a doctor considers that he/she does not have the personal skills or necessary facilities to undertake a certain line of management the patient should be referred to an appropriate colleague.

2.7 PRISONERS
Prisoners who are ill must be treated in the same manner as other sick people and must not be demeaned because of their status. However, doctors have a right to take appropriate precautions if they think there is a possibility of physical violence. The Council supports the 1975 Declaration of Tokyo issued by the World Medical Association concerning torture and other cruel, inhuman and degrading punishments (see Appendix C).

2.8 DISAGREEMENTS WITH PATIENTS
If a patient and a doctor consider that they are not getting on well together, an agreement to help the patient to transfer to another practitioner may be the best way of dealing with the matter, subject to continuity of care (see paragraph 2.1).

3. Behaviour Towards Patients

3.1 IDENTIFICATION
Doctors should identify themselves to patients whom they are treating.

3.2 DIGNITY OF THE PATIENT
Patients must always be treated with dignity and respect. There is no excuse for rude and insensitive behaviour towards them or their relatives.

3.3 INFORMATION FOR PATIENTS
A request for information from a patient always requires a positive response. In general, doctors should ensure that a patient and, provided the patient agrees, family members, are as fully informed as possible about matters relating to an illness.

3.4 DETAILS OF INFORMATION
Patients do not always fully understand the information and advice given to them by doctors. They should be encouraged to ask questions. These should be answered carefully in non technical terms with or without information leaflets. The aim is to promote understanding and to encourage compliance with recommended therapy. The doctor should keep a note of such explanation and if it is felt that the patient still does not understand, it may be advisable to ask the patient's permission to speak to a relative.

3.5 Maternity Care
Registered medical practitioners who agree to undertake the antenatal and delivery care of a woman should clearly inform her at the time of booking about the arrangements for delivery.

3.6 Procedures
Patients undergoing procedures or treatment of any sort have the right to be informed as to which doctor or doctors are to be involved.

3.7 Fees
Doctors' fees should be appropriate to the service provided. Patients are entitled to ask how much a doctor is going to charge.

3.8 Second Opinion
Patients are entitled to a second or further medical opinion about their illness. Doctors must either initiate or facilitate a request for this and provide the information necessary for a satisfactory referral.

3.9 Physical Examination
Doctors should normally ask permission from a patient before making a physical examination. In the case of minors, the child's guardian should be present or should give permission for the examination.

3.10 Intimate Examination
For any intimate examination the patient, irrespective of age, is entitled to ask for a chaperone to be present. Such requests should be acceded to whenever possible.

3.11 Communication with Patients
Many complaints to the Council refer to lack of communication, or discourtesy, on the part of the doctor. Where differences have arisen between the doctor and the patient or the patient's relatives there is much to be gained and rarely anything to be lost by the expression of regret by the doctor. Doctors may have been inhibited by feeling that any such expression would amount to an admission of liability. This is not necessarily so.

3.12 Personal Relationships
Any form of sexual advance to a patient with whom there exists a professional relationship is professional misconduct. A doctor's professional position must never be used to pursue a relationship of an emotional or sexual nature with a patient, the patient's spouse, or a near relative of a patient. The practice of medicine involves a close affinity between doctors and their patients with the latter sometimes becoming emotionally dependent. Doctors should be aware of this and are urged to take special care and prudence in circumstances which could leave them open to an allegation of abuse of their position.

SECTION C

PROFESSIONAL RESPONSIBILITIES

4.1 DENIGRATION OF A COLLEAGUE

Doctors should give moral support to each other. Denigration of a colleague is never in the interest of patients and is to be avoided. When disputes arise, they should be settled as speedily as possible and without undue publicity. Differences about clinical management are best aired without rancour in the correct fora i.e. weekly or monthly clinical meetings or symposia.

4.2 A COLLEAGUE'S PRACTICE

Doctors must not deliberately damage the practice of colleagues. This obligation is particularly compelling when there has been a recent professional association.

4.3 CONSULTATION AND CO-OPERATION

Doctors should not hesitate to consult, in the patient's interest, with other doctors and to co-operate, where necessary, with other health-care professionals. However, they have a duty to satisfy themselves that people to whom they refer patients are competent.

4.4 JUNIOR COLLEAGUES AND TRAINEES

The Council considers that doctors have a personal and professional responsibility towards junior colleagues and medical students. They should assist and advise them on the development of correct professional values, and **the courtesies, attitudes and behaviour** required when dealing with other people. Junior doctors should never be asked to perform tasks for which they are not fully competent except under the direct supervision of senior colleagues who can take over should difficulty be encountered. Senior staff must always be willing to undertake troublesome or unpleasant tasks rather than instructing juniors to do so. Delegation of duties to trainees of whatever level does not obviate the responsibility of the trainer for the actions taken.

4.5 REFERENCES

When references are requested about colleagues, honesty and fairness are essential.

4.6 PUBLIC COMMITMENTS

Doctors who accept contractual appointments or commitments from public bodies, the boards of voluntary hospitals or other medical and teaching institutions have a duty to fulfil these. If they find that they cannot do so they should ask to be relieved of them. The Council will take a grave view should such commitments be delegated on a regular basis, especially to someone of junior status.

4.7 MEDICAL RECORDS

It is in the interest of both doctors and patients that accurate records are always kept. These should be retained for an adequate period and eventual disposal may be subject to advice from legal and insurance bodies. There is no objection to patients being supplied with a report of their own medical history. Doctors are reminded of their responsibility in advising administrative authorities of the importance of medical records being stored in such a manner that they are readily accessible to clinical staff when required for patient management.

4.8 CONTINUING MEDICAL EDUCATION

Doctors must maintain competence in practice and develop a high level of awareness of advances in their own area of medicine by partaking in Continuing Medical Education (C.M.E.)/Continuing Professional Development (C.P.D.). The Council regards continuous quality improvement to be a professional responsibility for every doctor.

4.9 HEALTHCARE RESOURCES

Funds for healthcare are limited. A decision to spend money in one area may involve not having it available in another. The Council considers that doctors have a place in helping to ensure the efficient and effective use of resources and in giving advice on their allocation. Lack of facilities does not excuse failure to help patients. Doctors have an obligation to point out deficiencies to the appropriate authorities but do not have to yield to pressures for cost savings by acting against the interests of patients.

4.10 Research

Doctors engaged in research have a duty to be truthful about their results and must never make unjustified claims for authorship. They should not allow their relationship with commercial firms to influence their attitude towards the design or the results of trials.

5. Health Problems

5.1 Alcohol and Drugs

The perceived misuse of alcohol or other drugs by a doctor may be grounds for the holding of an inquiry even if the doctor claims that he/she was "off duty". The complaint that a doctor has been under the influence of alcohol or drugs is a grave charge, and may lead to erasure from the Register.

5.2 Sick Colleagues

Doctors have a further responsibility to protect the interest of the public when they become aware that the use of alcohol or other drugs is affecting the competence of a colleague. In such circumstances they should express their anxiety directly to the colleague concerned and advise that expert professional help be obtained. If such approaches fail and where the interests of patients are or may be at risk, the facts must be given promptly to the Fitness to Practise Committee. Any dereliction of a doctor's responsibility in this regard will be viewed seriously.

5.3 Physical or Mental Ill-Health

A similar procedure to paragraph 5.2 is recommended when other forms of physical or mental ill health or the ageing process appear to affect seriously a doctor's professional competence.

5.4 Doctors with Infectious Diseases

It is unethical for doctors who believe that they might be infected with a serious contagious disease (e.g. Hepatitis, H.I.V. etc.) not to seek and accept advice from professional colleagues as to how far it is necessary for them to limit their practice in order to protect their patients. Colleagues who are consulted have a dual role. They must counsel and support the doctor concerned, but they must ensure that the doctor does not pose a risk to patients and others. If such a risk exists, the Fitness to Practise Committee must be informed as soon as possible.

5.5 General Healthcare

Doctors should be aware that the practice of medicine can be demanding and that they too can suffer ill-health. If this occurs, they should seek advice and help from another doctor, rather than treating themselves.

SECTION D

DOCTORS IN PRACTICE

6. Practice Announcements

6.1 SETTING UP PRACTICE
Registered medical practitioners who are setting up practice may make announcements in the following manner:

Two discreet announcements concerning the commencement of practise, may be placed in the national and/or local press, giving the registered name of the doctor, the address of the practice, the surgery hours and the telephone number(s). If the doctor wishes to include a specialty, it must be one that is recognised by the Medical Council and the doctor must be eligible to have his or her name entered for that specialty in the Register of Medical Specialists. The announcement should only appear in the **Social and Personal** section and should not be inserted as a display notice.

6.2 NATIONAL AND LOCAL DIRECTORIES
Where doctors wish to publish the above particulars in directories it is essential that they always include their name and address as entered in the General Register of Medical Practitioners. If such information is "boxed", the box must not measure more than 45 mm. in any direction.

6.3 THE INTERNET AND OTHER MEDIA
Doctors wishing to use such techniques to make practice announcements must restrict details to those mentioned in subsections 6 and 7.

6.4 REGISTERED NAMES
Doctors must practise in the names in which they are registered. The Council registers doctors in the names in which their primary medical qualification is conferred and when a change of surname occurs, formal evidence must be furnished to enable an alteration to be made in the register (e.g. State marriage or Deed Poll certificate). Commonly used abbreviations of forenames may be submitted for entry.

7. Practice Premises

7.1 The premises of medical practitioners should be adequate and suitable for their purpose.

7.2 SURGERY SIGNS
A professional plate and a surgery sign may be displayed at the surgery premises.

7.3 If the practice is carried on in a business premises, the doctor's name may be included in a list of the occupants of the complex.

7.4 Practice signs may exhibit the doctor's name and registrable qualifications together with the following information:
a) Days and hours of attendance.
b) Telephone numbers of the practice.
c) Particulars of an emergency service.

7.5 INFORMATION FOR THE PUBLIC
Leaflets or notices from the Faculties of the Irish College of General Practitioners about the address of a doctor's practice premises may be exhibited or distributed in places such as libraries, post-offices, health centres, citizens advice bureaux and other suitable locations. However, such information should be restricted to the particulars mentioned in paragraphs 6.1 and 7.4, and should not contain comments about the doctor's personal qualities or expertise.

7.6 IN-HOUSE INFORMATION
The Council welcomes the use of in-house information for patients. This is most suitable for display or distribution in the surgery by the doctor or ancillary staff.

7.7 LETTER HEADING
Doctors' letter heading would normally be confined to registrable qualifications. The use of other degrees such as diplomas and certificates should be limited to those issued by bodies recognised by the Council. It is wise to avoid mention of membership of various "Associations" and "Societies" which are not post-graduate qualifications and may be misleading to the public (see Appendix B).

7.8 Guidelines on practice information have been agreed with the Irish College of General Practitioners (see Appendix A).

8. Information about Patients

8.1 A request by a third party for information about a patient **for whatever reason** must be refused unless the patient has given permission.

9. Medical Reports

9.1 PROVISION OF REPORTS
Doctors have a responsibility to supply medical reports for solicitors or insurance companies on behalf of patients they have seen or treated professionally or for whom they have been responsible. However such reports should not be given without the patient's permission (see paragraph 18.10).

9.2 ACCURACY
Reports must be factual and true. They are not to be influenced by the fee or by pressure from anyone to omit some details or to embellish others, and strict accuracy must be observed. They should concentrate on the medical problem referred to and omit extraneous details.

9.3 DELAY
Undue delay in furnishing reports may amount to professional misconduct if such a delay results in the patient being disadvantaged. Normally, the report would be supplied within two months of the examination or receipt of a written request, whichever occurred last.

9.4 DISCLOSURE
Doctors are reminded that if a case in which they have been involved comes to court, they may be obliged to disclose all their notes, comments and conversations about the patient.

9.5 FEES FOR REPORTS
It is not unethical to request a fee prior to forwarding details, but to accept a fee and not provide a report is unethical.

9.6 REVENUE COMMISSIONERS
When discussing their own finances with the Revenue Commissioners, doctors should not reveal information about patients.

10. Certification

10.1 ACCURACY
Strict accuracy is essential when issuing certificates, reports and other formal documents bearing the signature of a doctor. Pressure from any source to deviate from this standard must be resisted. Initial certification, reports or other formal documents should only be issued after the doctor has seen and examined the patient.

10.2 DETAILS
Certificates, dated, would normally give the full name and address of the patient. Certificates, reports and other formal documents should have the doctor's name and address on them and the doctor should personally sign them.

10.3 PRE-SIGNED CERTIFICATES
It is not acceptable that certificates pre-signed by doctors should be filled in and handed out by those assisting them.

10.4 VALIDITY
Any certificate, prescription or other document, which requires the signature of a doctor is invalid and ineffective if signed by a person who is not a registered medical practitioner.

11. Prescribing And Irresponsible Prescribing

11.1 PRESCRIBING
A doctor should prescribe the most appropriate medicine for the patient's condition and best interest. The manner in which doctors are remunerated, or any financial interest they may have in the pharmaceutical or allied industry, must not be taken into consideration when recommending therapy for their patients.

11.2 SIGNATURE
A prescription, dated, must always be signed by the doctor who issues it. Should the need arise to prescribe a drug over the telephone, the doctor should record the call and forward the appropriate prescription to the pharmacist in a reasonable time.

11.3 INDICATIVE DRUGS BUDGETING
Doctors should be careful about how they exercise indicative drugs budgeting. They should continue to re-educate themselves on the principles of best practice and rational prescribing by referring to published guidelines and by availing of various C.M.E. activities.

11.4 DRUG ADDICTION
Doctors who wish to treat drug dependent or addicted patients must be aware of the recommendations of The Pharmaceutical Society of Ireland (October 1996), as well as those of The Irish College of General Practitioners Task Group (May 1997), and the Report of the Methadone Treatment Services Review Group (January 1998). They should only do so if they have the proper facilities and the support of the statutory and voluntary services. The Council and the Pharmaceutical Society have agreed to co-operate in the monitoring of prescribing patterns by practitioners and to investigate any evidence of irresponsible prescribing. In conjunction with the Pharmaceutical Society, the Council has issued recommendations for the prescribing of controlled drugs under the Misuse of Drugs Acts, 1977 & 1984. Doctors must be acquainted with these, and any further regulations issued in accordance with the Acts.

11.5 IONISING RADIATION
Doctors who undertake radiation procedures for patients and who are not radiologists or nuclear medicine physicians are required to complete a course of training in radiation safety and techniques recognised by the Council. The latter will then issue a certificate permitting the doctor to carry out such procedures provided that they are undertaken in hospital practice, in the presence of a radiologist or a nuclear medicine physician or a radiographer responsible to a radiologist or a nuclear medicine physician.

11.6 Acceptance of patient referrals from non-registered practitioners for radiological consultation and investigative procedures is at the discretion of the registered doctor. At all times the safety of the patient is paramount. It is advisable that copies of all reports are sent to the patient's general practitioner provided that the patient agrees (see paragraph 13.3).

11.7 TELEMEDICINE
Doctors using this technique for diagnosis, consultation, or therapy are responsible for any advice or procedures suggested by them on the medium. In the interests of patient confidentiality, doctors must take steps to ensure that the details of such information cannot be accessed by those not entitled to see them (see paragraph 18.4).

12. Deputising and Locum Arrangements

12.1 ABSENCE
Practitioners must ensure that patients receive adequate care when alternative arrangements have to be made during absence.

12.2 THE PRINCIPAL DOCTOR
Doctors who use the services of a Deputising Agency or employ a locum should satisfy themselves that:

a) In general practice, the doctor standing in is fully registered, in good standing and of good repute.
b) In hospital practice, the doctor standing in is fully or temporarily registered, in good standing and of good repute.
c) A high standard of **continuing medical care** is provided for their patients.
d) Patients are well informed in advance that in certain circumstances they will be seen by a doctor acting as a deputy for their own practitioner.
e) An efficient communications link is provided by the Agency and the locum doctor at all times.
f) Sufficient information is available for the locum to do his/her work adequately (see paragraph 4.7).

12.3 CONTRACTUAL ARRANGEMENTS
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.

12.4 Responsibility for Care
Doctors should not use long term deputising facilities to relieve them of their continuing responsibility for the clinical care of patients.

12.5 Rota Arrangements
Whatever deputising and rota arrangements are made by doctors, a suitable notice setting out clearly the procedure for medical care during off duty time should be displayed prominently in the doctor's surgery and telephone answering facilities made available for patients.

12.6 The Deputising Doctor
Doctors employed as deputies are reminded that they are acting as a professional representative of the principal doctor. Calls should be answered as promptly as possible and with courtesy. Clinical details should be transmitted directly to the principal doctor as soon as is feasible. Contractual arrangements must always be fulfilled.

12.7 Transfer
It is especially important that deputising doctors do not seek to attract patients wishing to transfer from the principal doctor.

12.8 Standard of Care
In general, patients expect locum cover to be of the same standard that they receive from their own doctor. It is particularly important in hospital practice that cover for absence is provided by someone similarly qualified wherever possible. The regular use of trainees or junior staff to cover the duties of the principal doctor or a consultant could be considered to be professional misconduct.

13. Consultant Referral

13.1 The Council accepts the principle that the overall management of a patient's health should be under the supervision and guidance of a general practitioner. However, patients have a right to seek another opinion and requests for these should be accepted sympathetically and facilitated, even if the general practitioner is not convinced that such a referral is necessary.

13.2 Referral
A consultant should not normally accept a patient without referral from a general practitioner even if he/she has seen that patient in the past.

13.3 Consultants' Responsibility
Referring doctors should supply appropriate information for the consultation. Irrespective of the mode of referral, consultants have a duty to inform the patient's general practitioner as well as the referring doctor of the findings and recommendations unless the patient expressly forbids this. In the latter case the consultant is responsible for total care of the patient until the treatment is completed and another doctor takes over responsibility.

13.4 Inappropriate Referral
If a consultant considers that a patient has been inappropriately referred or should have visited some other specialist, he or she would normally send the patient back to the general practitioner with a suitable letter.

13.5 Cross Referral
In exceptional cases, cross referral between consultants may be necessary but the general practitioner must be kept informed about the patient.

13.6 Hospital Consultation
When general practitioners refer patients to hospital they expect them to be seen during the course of their management by a doctor of consultant or equal status. It is not acceptable for them to be cared for entirely by junior medical staff.

13.7 Fee Splitting
This practice is against the interests of patients and is professional misconduct.

14. Clinics

14.1 Financial Interest
A doctor who has a financial interest in a private clinic, hospital or any institution to which he/she is referring patients for investigation or therapy, has a duty to declare such an interest to patients.

14.2 Standards
Doctors associated with clinics must make certain that the services offered conform to the accepted standards of the medical profession. They are reminded that they have a duty to ensure that ethical guidelines are not breached and that they can be held responsible for unethical advertising by private clinics and hospitals.

15. The Media and Advertising

15.1 EDUCATING THE PUBLIC

Doctors have an important part to play in educating the public in medical matters and in disseminating medical knowledge. However, doctors must not imply that they have unique solutions to health problems. Nor should they use health-promoting publicity to attract patients to their care or to enhance or to promote their own professional reputation. Doctors are reminded that if they work in a clinic that makes claims about special expertise not found elsewhere they will be held responsible for such claims being made.

15.2 INFORMATION FOR THE PUBLIC

Information given to the public should be expressed in factual and lucid terms. It must never cause unnecessary public concern or personal distress nor should it raise unrealistic expectations.

15.3 INDIVIDUAL CASES

Identifiable case histories must not be referred to when speaking in public or when answering enquiries about personal health problems especially on "phone-in" programmes.

15.4 PUBLISHING A NAME

If a doctor's name is mentioned when talking to or writing in the media on social, ethical, political, or research aspects of medicine, he/she must take personal responsibility for the views expressed and establish the basis for them.

15.5 ADJUDICATION

In adjudicating on complaints concerning doctors in the media, the Council will consider whether the benefit to the doctor has been greater than that to the public and whether there has been an element of self advertisement or a claim of possession of special skills, either of which could be interpreted as canvassing for patients. In all circumstances benefit to the patient must outweigh any incidental advantages to the practitioner concerned. Self advertisement, or publicity to enhance or promote a professional reputation for the purpose of attracting patients is professional misconduct.

Sub-sections 6, 7, 14, and 15 refer to all forms of communication including Radio, Television, the Cinema, the Internet etc.

16. Attendance on Doctors' Families

16.1 Except for simple illnesses, it is not considered advisable for doctors to treat or to issue prescriptions or certificates for themselves or for members of their families.

17. Change of Practice, Retirement or Death

17.1 CHANGE OF PRACTICE

If a patient wishes to attend another practitioner, a request from the patient for a summary of the medical history to be sent to the new doctor should be acceded to.

17.2 RETIREMENT

Doctors who propose to retire from medical practice or to reduce their workload would normally give notice to their patients of their intention to do so. It would be helpful if they could also provide the names of colleagues willing to supply medical care, and have accurate copies of clinical records to hand over if the patient so wishes. Even if a doctor does not want to transfer entire files to another practitioner, he/she is obliged to supply a summary of the patient's history and management to a doctor nominated by the patient. The same guidelines apply in the dissolution of a practice or where a doctor feels, for whatever reason, that he/she cannot continue to care any longer for a particular patient.

17.3 WILLS

It may be helpful for doctors to provide in their will for the transfer of medical records to those who are to take over the care of their practice, should patients request this from the executor to the estate.

SECTION E

CONFIDENTIALITY AND CONSENT

18. Confidentiality

18.1 Confidentiality is a time-honoured principle of medical ethics. It extends after death and is fundamental to the doctor/patient relationship. While the concern of relatives and close friends is understandable, the doctor must **not** disclose information to any person without the consent of the patient.

18.2 THIRD PARTY INFORMATION
Sometimes it may be necessary to obtain information about a patient from a third party e.g. a relative. This information is also governed by the same rules of confidentiality as in paragraph 18.1.

18.3 EXCEPTIONS TO CONFIDENTIALITY
There are four circumstances where exception may be made in the absence of permission from the patient:

1) When ordered by a Judge in a **Court of Law**, or by a Tribunal established by an Act of the Oireachtas.
2) When necessary to protect the interest of the patient.
3) When necessary to protect the welfare of Society.
4) When necessary to safeguard the welfare of another individual or patient.

18.4 MEDICAL RECORDS
All medical records in whatever format and wherever kept, must be safeguarded. Doctors are responsible for ensuring that other health professionals and ancillary staff working with them maintain confidentiality at all times and are aware of the dangers implicit in the use of computers, electronic processors, mobile and portable telephones, the Internet, facsimiles, videos, medical photography, and other similar or related equipment. The Council supports the statement on the use of computers in medicine based on resolutions of the 27th World Medical Assembly as amended by the 35th.World Medical Assembly, Venice, 1983.

18.5 REGISTERS OF ILLNESSES
With the increasing importance of audit in medicine and the necessity for evidence based medicine it is important for doctors to remember that where registers of specific illnesses are being kept, the principles of confidentiality must be adhered to and that results from research projects should protect patient anonymity.

18.6 SPECIAL SITUATIONS
Doctors belonging to the following disciplines may encounter difficulties with medical examinations and subsequent reporting to a third party:- doctors in Public Health, occupational physicians, prison medical officers, doctors employed by or acting for An Garda Siochana, the Defence Forces and the Civil Service.

The following points should be kept in mind taking due note of paragraph 18.1.

1) Before commencing such examinations, the doctor should explain the nature, context and reporting implications of the examination and should have agreement from the patient before proceeding.
2) The doctor patient relationship must be respected at all times.
3) The examinee's personal doctor should be informed, provided that agreement is obtained.
4) The significance, **rather than the precise details**, of the medical findings should be conveyed to any third party and then only with the patient's consent.
5) Documents containing medical details should always be transmitted under confidential cover.

18.7 A doctor, when assessing the significance of a particular disability, should interpret the medical findings in terms of the likelihood of the patient continuing to work, if requested to do so. **An employer does not have the right to be informed of the clinical details of illness or injury without the consent of the patient.**

18.8 In order to fulfil statutory requirements it may be necessary for a practitioner to provide a doctor in Public Health Medicine with medical information which may be essential if the payment of a financial allowance is to be recommended. In such instances, the public health physician is not obliged to release the specific details, but may interpret them to the administrative authority concerned, with the patient's consent.

18.9 In like manner, an occupational physician may present to an employer the significant aspects of a medical condition which the physician may discover as the result of an examination. **Only with the consent of the patient, may the employer have access to the medical records of that patient**, and then only in specifically agreed circumstances.

18.10 Insurance Reports
A doctor, asked by an insurance company to complete a medical report on a patient, must ensure that this is not issued without the consent of the patient. Patients who enquire should be informed that such reports will be read by non-medical personnel.

18.11 The Deceased Patient
If an insurance company requests a report on a patient who has died, the report may only be issued by the doctor of the deceased with permission from the next of kin or the executors to the estate. The medical records of a dead person remain confidential and death does not absolve a doctor from the obligation of confidentiality.

18.12 Communicable Disease
If a doctor finds that a patient is suffering from a communicable disease, the potential risk to public health and others must be carefully assessed. The doctor will have to have strict regard to the statutory obligations in the matter of reporting such a case. Where others may be at risk if not aware that a patient has a serious infection, a doctor should do his/her best to obtain from the patient permission to tell them, so that medical, nursing and paramedical personnel may better treat and manage the patient and everyone who comes into contact with the patient may take appropriate precautions.

18.13 Refusal to Disclose Communicable Disease
If the patient refuses consent to disclosure, the Council considers that those who might be at risk of infection while treating the patient, should be informed of the risk to themselves. They in turn would, of course, be bound by the general rules of confidentiality.

18.14 If a spouse or partner is thought to be at risk, the doctor should strongly seek the patient's permission for disclosure. If this is refused, depending on the circumstances of the illness, the doctor is justified in informing the spouse or partner.

18.15 Recording
Identifiable audio-visual or photographic recordings of a patient, or relatives of a patient, may only be undertaken with informed and appropriate consent. Such records must not be used or shown for any purpose other than that for which permission has been obtained (see paragraph 21.2).

18.16 Legislation
Doctors should have due regard to the provisions of the legislation on Data Protection and on Freedom of Information.

19. Consent

19.1 It is reasonable for a doctor to assume that, when consulted by a patient, tacit consent is given to carrying out appropriate investigations and therapy, but every effort should be made to ensure that a patient understands the nature and purpose of proposed medical procedures. Difficulty in achieving this may be overcome by asking the person concerned if they would like the doctor to speak to a relative at the same time. People have the right to refuse consent for investigation or treatment. Their decision should be respected and documented. A note should also be made as to whether the doctor felt the patient was capable of exercising such a judgement.

20. Special Situations and Consent

20.1 The Unconscious Patient
Consent may be implied or assumed on the grounds that if the patient were conscious they would consent to their life being saved, and the health of medical and paramedical staff being safeguarded. Should there be subsequent litigation, any investigations undertaken may or may not have to be made available to the courts, but in no circumstances is this to be taken into consideration during the **initial** management.

20.2 The Violent Patient
A doctor asked to examine a violent patient is under no obligation to put him/herself in danger but should attempt to persuade the person concerned to permit an assessment as to whether any therapy is required.

20.3 The Mentally Ill
If the doctor is in any doubt as to the patient's capacity to consent it is advisable to seek specialist opinion as well as discussing the matter with parents, guardians, or relatives.

20.4 The Mentally Handicapped
The doctor should attempt to obtain consent but, depending on the degree of handicap, may have to consult with the patient's parents or guardians, and, in particularly difficult cases to obtain a second opinion.

20.5 Children
Children are as entitled to considerate and careful medical care as are adults. If the doctor feels that a child will understand a proposed medical procedure, information or advice, this should be explained fully to the child. Where the consent of parents or guardians is normally required in respect of a child for whom they are responsible, due regard must be had to the wishes of the child. The doctor must never assume that it is safe to ignore the parental/guardian interest.

21. Teaching and Consent

21.1 Students
Medical students must be identified by name, and must obtain permission from patients before examining them. It is advisable to limit the number of students examining any one patient. Doctors should not allow school-children or other inappropriate persons to become involved in the clinical care of patients.

21.2 Visual Records
The taking of photographs or videos for instructional purposes also requires permission. As far as possible these should be done in such a manner that a third party cannot identify the person concerned (see paragraph 18.15). If the patient is identifiable, he or she should be informed about the security, storage, and eventual destruction of the record.

22. Research and Consent

22.1 It is essential that written consent be obtained if patients are to be involved in clinical trials. The aims and methods of the proposed research, together with any potential hazards or discomfort, should be explained to the patient.

22.2 Anonymity
Research results must always preserve patient anonymity unless permission has been given by the patient to use his or her name.

22.3 Refusal
Refusal to participate in research must not influence the care of a patient in any way.

22.4 Special Circumstances
In those who are too young or too incapacitated, as well as the mentally ill or unconscious person, consent to take part in research may be unobtainable. Research is best avoided unless it can be shown to be relevant and potentially beneficial to the patient and there is no objection from parents or relatives.

22.5 Research Committees
All institutions which undertake research should have Research Ethics Committees. Doctors are advised always to submit proposed projects to such Committees.

22.6 Declaration of Helsinki
The Council supports the resolutions and draws attention to the Declaration of Helsinki adopted by the 18th World Medical Assembly and revised by the 48th World Medical Assembly.

23. Organ Transplantation and Consent

23.1 A doctor involved in organ transplantation has duties towards both donors and recipients.

23.2 Brain Death
Brain death should be diagnosed, using currently accepted criteria, by at least two independent and appropriately qualified clinicians, who are also independent of the transplant team.

23.3 Living Donors
Living donors should be counselled as to the hazards and problems involved in the proposed procedures, preferably by an independent physician.

23.4 PAYMENT
Payment of any sort, apart from incidental expenses, should not be a factor in the ultimate decision made about organ donation.

24. Inability to Communicate and Consent

24.1 For the seriously ill patient who is unable to communicate or understand, it is desirable that the doctor discusses management with the next of kin or the legal guardians prior to reaching a decision about the use or non-use of treatments **which will not contribute to recovery from the primary illness.** The Council reiterates its view that access to nutrition and hydration remain one of the basic needs of human beings, and all reasonable and practical efforts should be made to maintain both of them.

25. The Dying Patient

25.1 Where death is imminent, it is the responsibility of the doctor to take care that the sick person dies with dignity, in comfort, and with as little suffering as possible. Deliberately causing the death of a patient is professional misconduct.

SECTION F

REPRODUCTIVE MEDICINE

26.1 In this rapidly evolving and complicated area the Council reminds doctors of their obligation to preserve life and to promote health. The creation of new forms of life for experimental purposes or the deliberate and intentional destruction of human life already formed is professional misconduct.

26.2 GENE MANIPULATION
As scientific technology advances it may be possible to manipulate genes in gametes (i.e. sperm or ova). If such work has as its aim the improvement of health it may be ethical. However, if the intention is not so directed or is the creation of embryos **for experimental purposes** it would be professional misconduct.

26.3 FROZEN SPERM AND OVA:
ARTIFICIAL INSEMINATION BY DONOR (A.I.D.)
There is no objection to the preservation of sperm or ova to be used subsequently on behalf of those from whom they were originally taken. Doctors who consider assisting with donation to a third party must have regard to the biological difficulties involved, and pay meticulous attention to the source of the donated material. Doctors who fail to counsel both donor and recipient thoroughly about the potential social, medical and legal implications of such measures and the possible consequences for the would be parents and their baby could face disciplinary proceedings.

26.4 IN-VITRO FERTILISATION (I.V.F.)
Techniques such as I.V.F. should only be used after thorough investigation has failed to reveal a treatable cause for the infertility. Prior to fertilisation of an ovum, extensive discussion and counselling is essential. Any fertilised ovum must be used for normal implantation and must not be deliberately destroyed.

26.5 THE CHILD IN UTERO
The deliberate and intentional destruction of the unborn child is professional misconduct. Should a child in utero suffer or lose its life as a side effect of standard medical treatment of the mother, then this is not uneth-

ical. Refusal by a doctor to treat a woman with a serious illness because she is pregnant would be grounds for complaint and could be considered to be professional misconduct.

26.6 ADOPTION

Doctors should remember that in cases of proposed adoption there are several parties involved all of whom need continued support and counselling. Pregnant women who are considering giving up their babies for adoption should be helped to contact a registered adoption agency (details of these may be obtained from the Adoption Board).

CONCLUSION

This Guide is based on previous Guides to Ethical Conduct and Behaviour because the principles which engendered them in the first place have not changed, despite the fact that the practices to which they apply have altered as Medicine has developed. It is not possible to outline how doctors should behave in every given circumstance but an attempt has been made, through the use of extensive paragraphing, to enable the ready assessment of how ethical principles might impinge on a particular area of practice. It is hoped that doctors can consult the Guide easily and it is also hoped that should they be asked questions about ethical matters, they will have no difficulty in finding the appropriate section.

The Council is most grateful to those bodies and individuals who took the time and trouble to respond to its request for contributions and suggestions during preparation of the Guide. These have been acknowledged individually, even if they have not been incorporated into the publication.

From time to time the Council will issue additional guidance as required and it is expected that in the future, with changes in medical practice, there will be a need for the compilation of further Guides.

The Council considers it important that the medical profession aspires to the highest possible standard of behaviour and practice amongst its members. There are numerous examples in history, even up to the present day, where doctors have allowed themselves to behave or have been forced to behave, in a manner which has led to the mistreatment and degradation of the very people they are meant to serve. It is to be hoped that this will never occur in Ireland and that this Guide will help to maintain the honourable tradition of service which has always been expected from doctors in this country.

APPENDIX A

(reference Section D, paragraph 7.8)

In-Practice Information

1. The Irish College of General Practitioners and its faculties are permitted to inform the public, at national level, about general practitioner services on behalf of all general practitioners as a group.

2. The Irish College of General Practitioners and its faculties are permitted to inform the public concerning general practitioner services on behalf of all practitioners in a particular area, in the local media and in premises such as: Post Offices, Citizen Advice Centres, Libraries, Universities, Regional Technical Colleges, Schools, Factories etc.

3. No individual doctor is permitted to advertise nationally or locally in any form of public media on a personal basis, save as in 7 below.

4. In relation to qualifications, only registrable medical qualifications are permitted.

5. In-house information to patients or prospective patients should be available but confined to surgery premises. Such information may be in the form of leaflets, posters, other displays. Special procedures may be specified.

6. The individual doctor may direct-mail patients of the practice, those who have attended the practice within the previous three years, with material which is limited to recall, prevention and screening.

7. Two discreet notices are permitted, in the press, in relation to the establishment of a practice, change of location or personnel change. Information in relation to surgery hours is permitted in relation to public holidays or duty rotas.

8. The practice of having doctors' names in the Yellow Pages and local telephone directories is approved. Information should be confined to a doctor's name, address, telephone number(s) and registrable medical qualifications.

Approved by the Medical Council at its meetings on 4th March, 1992, and 30th June 1998.

APPENDIX B

Registrable Primary Qualifications

(Reference Section D, paragraph 7.7)

Abbreviations	Titles	Licensing Bodies
LAH Dubl	Licentiate	Apothecaries Hall, Dublin
LLM RCPI LLM RCSI	Licentiates and Licentiates in Midwifery	Royal College of Physicians of Ireland and Royal College of Surgeons in Ireland
LM LS U Dubl	Licentiate in Medicine and Licentiate in Surgery	University of Dublin
LMED LCH U Dubl	Licentiate in Medicine and Licentiate in Surgery	University of Dublin
LRCP & SI	Licentiates	Royal College of Physicians of Ireland and the Royal College of Surgeons in Ireland
LRCP & SI MB BCh NUI	Licentiates and Bachelor of Medicine and Bachelor of Surgery	Royal College of Physicians of Ireland and the Royal College of Surgeons in Ireland, National University of Ireland
MB BCh NUI	Bachelor in Medicine and Bachelor in Surgery	National University of Ireland
MB BCh U Dubl	Bachelor in Medicine and Bachelor in Surgery	University of Dublin

Registrable Additional Qualifications

(Reference Section D, paragraph 7.7)

Abbreviations	Titles	Licensing Bodies
DPH Dubl	Diploma in Public Health	University of Dublin
DPH NUI	Diploma in Public Health	National University of Ireland
DPH RCPSI	Diploma in Public Health	Royal College of Physicians and Surgeons in Ireland
DSM Dubl	Diploma in State medicine	University of Dublin
FFARCSI	Fellow	Royal College of Surgeons in Ireland – Faculty of Anaesthetists
FFPHMI*	Fellow	Royal College of Physicians of Ireland – Faculty of Public Health Medicine
FFOM RCPI	Fellow	Royal College of Physicians of Ireland – Faculty of Occupational Medicine
FFR RCSI	Fellow	Royal College of Surgeons in Ireland – Faculty of Radiologists
FRCPI	Fellow	Royal College of Physicians of Ireland
FRCSI	Fellow	Royal College of Surgeons in Ireland
MAO Dubl	Master in Obstetrics	University of Dublin
MAO NUI	Master of Obstetrics	National University of Ireland
MCh Dubl	Master in Surgery	University of Dublin
MCh NUI	Master of Surgery	National University of Ireland
MD Dubl	Doctor in Medicine	University of Dublin
MD NUI	Doctor of Medicine	National University of Ireland
MFPHMI*	Member	Royal College of Physicians of Ireland – Faculty of Public Health Medicine
MFOMRCPI	Member	Royal College of Physicians of Ireland – Faculty of Occupational Medicine
MRCPI	Member	Royal College of Physicians of Ireland
MICGP	Member	Irish College of General Practitioners
MPH	Master of Public Health	National University of Ireland
MMedSc NUI	Master of Medical Science	National University of Ireland
FF Path	Fellow	Royal College of Physicians of Ireland – Faculty of Pathology

* Name of Faculty of Community Medicine changed to Faculty of Public Health Medicine on 1st May 1991. F/M FCMI continue to be registrable.

Recognised Specialties

(reference Section D, paragraph 6.1)

Accident and Emergency Medicine

Anaesthetics

General Practice

Medicine:
- Cardiology
- Clinical Genetics
- Clinical Pharmacology and Therapeutics
- Communicable Diseases
- Dermatology
- Endocrinology and Diabetes Mellitus
- Gastroenterology
- General (Internal) Medicine
- Geriatric Medicine
- Medical Oncology
- Nephrology
- Neurology
- Palliative Medicine
- Respiratory Medicine
- Rehabilitation Medicine
- Rheumatology
- Tropical Medicine
- Venereology

Obstetrics and Gynaecology

Occupational Medicine

Pathology:
- Chemical Pathology
- Clinical Immunology
- Haematology
- Microbiology
- Morbid Anatomy and Histopathology

Paediatric Medicine

Psychiatry:
- Child and Adolescent Psychiatry
- Psychiatry

Public Health Medicine

Radiology:
- Diagnostic Radiology
- Radiotherapy

Surgery:
- General Surgery
- Neurological Surgery
- Opthalmology
- Oral and Maxillo-Facial Surgery
- Orthopaedic Surgery
- Otolaryngology
- Paediatric Surgery
- Plastic Surgery
- Thoracic Surgery
- Urology

Recognised Specialist Training Bodies

In relation to each recognised specialty, the Medical Council currently recognises the following bodies in Ireland for the purpose of granting evidence of satisfactory completion of specialist training:

Accident and Emergency Medicine
The Irish Surgical Postgraduate Training Committee, Royal College of Surgeons in Ireland, 123 St. Stephen's Green, Dublin 2.

Anaesthetics
The Faculty of Anaesthetists, Royal College of Surgeons in Ireland, 123 St. Stephen's Green, Dublin 2.

General Practice
The Irish College of General Practitioners, Corrigan House, Fenian Street, Dublin 2.

Medicine
The Irish Committee on Higher Medical Training, Royal College of Physicians of Ireland, 6 Kildare Street, Dublin 2.

Obstetrics and Gynaecology
The Institute of Obstetricians and Gynaecologists, Royal College of Physicians of Ireland, 6 Kildare Street, Dublin 2.

Occupational Medicine
The Faculty of Occupational Medicine, Royal College of Physicians of Ireland, 6 Kildare Street, Dublin 2.

Paediatric Medicine
The faculty of Paediatrics, Royal College of Physicians of Ireland, 6 Kildare Street, Dublin 2.

Pathology Specialists
The Faculty of Pathology, Royal College of Physicians of Ireland, 6 Kildare Street, Dublin 2.

Psychiatric Specialties
The Irish Psychiatric Training Committee, Corrigan House, Fenian Street, Dublin 2.

Public Health Medicine
The Faculty of Public Health Medicine, Royal College of Physicians of Ireland, 6 Kildare Street, Dublin 2.

Radiology
The Faculty of Radiologists, Royal College of Surgeons in Ireland, 123 St. Stephen's Green, Dublin 2.

Surgical Specialties
The Irish Surgical Postgraduate Training Committe, Royal College of Surgeons in Ireland, 123 St. Stephen's Green, Dublin 2.

APPENDIX C
(Reference Section B, paragraph 2.7)

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 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.

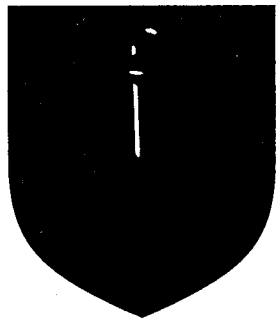
5. Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such 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.

Comhairle na
nDochtuiri Leighis

Medical
Council

A Guide to Ethical Conduct and Behaviour



Amendment No. 1 to
FIFTH EDITION 1998

Comhairle na
nDochtuiri Leighis

Medical
Council

17 October 2001

Dear Doctor

On 12 September 2001 the Medical Council agreed the enclosed amendments to Section 26.5 of the 1998 'A Guide to Ethical Conduct and Behaviour' (5th edition). This section deals with reproductive medicine and, in particular, with the Medical Council's guidance on termination of pregnancy.

The revised 'A Guide to Ethical Conduct and Behaviour' is accompanied by an extract from the All Party Oireachtas Committee on the Constitution: 5th Progress Report, which deals with abortion. The extract represents a written statement provided to the Oireachtas Committee by the Institute of Obstetricians and Gynaecologists and is referred to in the amended ethical guideline. The Report also contains the text of a more detailed oral statement given to the Oireachtas Committee by the Institute of Obstetricians and Gynaecologists.

The revised Section 26.5 comes into effect from the time of its adoption by the Medical Council and now replaces the earlier Section 26.5 of 'A Guide to Ethical Conduct and Behaviour'.

With best wishes.

Yours sincerely

Professor Gerard Bury
President

SECTION F

REPRODUCTIVE MEDICINE

26.5 THE CHILD IN UTERO

The Council recognises that termination of pregnancy can occur when there is real and substantial risk to the life of the mother and subscribes to the views expressed in Part 2 of the written submission of the Institute of Obstetricians and Gynaecologists to the All-Party Oireachtas Committee on the Constitution as contained in its Fifth Progress Report, Appendix IV, page A407 (see Appendix – page 4).

Approved by the Medical Council, Ireland, at its meeting
on 12 September 2001 and published in Dublin, December 2001

APPENDIX

(Reference page A407 The All-Party Oireachtas Committee on the Constitution – Fifth Progress Report – Abortion)

THE INSTITUTE OF OBSTETRICIANS AND GYNAECOLOGISTS RCPI
29 FEBRUARY 2000
PROFESSOR JOHN BONNAR MD, FRCPI, FRCOG
CHAIRMAN

1. The Institute of Obstetricians and Gynaecologists is the professional body representing the speciality of Obstetrics and Gynaecology in Ireland. The Executive Council of the Institute has examined the Green Paper on Abortion and the members have been consulted. We welcome the Green Paper, which provides a comprehensive, up to date and objective analysis of the issues arising in the care of the pregnant woman. Our expertise is in the medical area and our comments are confined to these aspects.

2. In current obstetrical practice rare complications can arise where therapeutic intervention is required at a stage in pregnancy when there will be little or no prospect for the survival of the baby, due to extreme immaturity. In these exceptional situations failure to intervene may result in the death of both mother and baby. We consider that there is a fundamental difference between abortion carried out with the intention of taking the life of the baby, for example for social reasons, and the unavoidable death of the baby resulting from essential treatment to protect the life of the mother.

3. We recognise our responsibility to provide aftercare for women who decide to leave the State for termination of pregnancy. We recommend that full support and follow up services be made available for all women whose pregnancies have been terminated, whatever the circumstances.