GENERAL MEDICAL COUNCIL

PROFESSIONAL CONDUCT AND DISCIPLINE: FITNESS TO PRACTISE

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PROFESSIONAL CONDUCT AND DISCIPLINE: FITNESS TO PRACTISE

The first part of this pamphlet describes the statutory basis and machinery of the Council's jurisdiction in cases of serious professional misconduct and criminal offences. The second part deals with various forms of misconduct which have led or may lead to proceedings by the Professional Conduct Committee. The third part contains more specific and positive advice in certain areas of professional conduct. The final part describes the Council's jurisdiction in relation to doctors whose fitness to practise is seriously impaired by their physical or mental condition.

PART 1

THE DISCIPLINARY PROCESSES OF THE COUNCIL

Statutory provisions

1. Disciplinary powers were first conferred on the Council by the Medical Act 1858, which established the Council and the Register. The Council's jurisdiction in relation to professional misconduct and criminal offences is now regulated by sections 36 and 38-45 of and Schedule 4 to the Medical Act 1983. The Act provides that if any registered practitioner

(a) is found by the Professional Conduct Committee to have been convicted in the British Islands of a criminal offence, or

(b) is judged by the Professional Conduct Committee to have been guilty of serious professional misconduct,

the Committee may if it thinks fit direct that the doctor's name shall be erased from the Register, or that the doctor's registration shall be suspended for a period not exceeding 12 months, or shall be conditional on the doctor's compliance, during a period not exceeding three years, with such requirements as the Committee thinks fit to impose for the protection of members of the public or in the doctor's own interests.

2. These powers apply to doctors holding full, provisional or limited registration.

Convictions

3. The term 'conviction', used in this pamphlet, is restricted to a determination by a criminal court in the British Islands. A conviction in itself gives the Professional Conduct Committee jurisdiction even if the criminal offence did not involve professional misconduct. The Committee is, however, particularly concerned with convictions for offences which affect a doctor's fitness to practise.

4. In considering convictions the Council is bound to accept the determinations of the courts as conclusive evidence that the doctors were guilty of the offences of which they were convicted. Doctors who face a criminal charge should remember this if they are advised to plead guilty, or not to appeal against a conviction, in order to avoid publicity or a severe sentence. It is not open to doctors who have been convicted of an offence to argue before the Professional Conduct Committee that they were in fact innocent. *It is therefore unwise for doctors to plead guilty in a court of law to a charge to which they believe that they have a defence.*

5. A finding or a decision of a Medical Service Committee or other authority under the National Health Service does not amount to a conviction for these purposes. A charge of serious professional misconduct may however, if the facts warrant, be made in respect of conduct which has previously been the subject of proceedings within the National Health Service or before an overseas court or medical council; or in respect of conduct of which a doctor has been found guilty by a British criminal court but placed on probation or discharged conditionally or absolutely.

The meaning of 'serious professional misconduct'

6. The expression 'serious professional misconduct' was substituted by the Medical Act 1969 for the phrase 'infamous conduct in a professional respect' which was used in the Medical Act 1858. The phrase 'infamous conduct in a professional respect' was defined in 1894 by Lord Justice Lopes as follows:

> *'If a medical man in the pursuit of his profession has done something with regard to it which will be reasonably regarded as disgraceful*

or dishonourable by his professional brethren of good repute and competency, then it is open to the General Medical Council, if that be shown, to say that he has been guilty of infamous conduct in a professional respect.'

7. In another judgment delivered in 1930 Lord Justice Scrutton stated that:

'Infamous conduct in a professional respect means no more than serious misconduct judged according to the rules, written or unwritten, governing the profession.'

8. In proposing the substitution of the expression 'serious professional misconduct' for the phrase 'infamous conduct in a professional respect' the Council intended that the phrases should have the same significance.

The Professional Conduct Committee and the Preliminary Proceedings Committee

9. The Professional Conduct Committee is elected annually by the Council and consists of 32 members, of whom only 11 sit on any case. Of the 32 members, 18 are elected members of the Council and six are lay members. The Committee normally sits in public and its procedure is closely akin to that of a court of law. Witnesses may be subpoenaed and evidence is given on oath. Doctors who appear before the Committee may be, and usually are, legally represented.

10. The Preliminary Proceedings Committee consists of 11 members, and is also elected annually. It sits in private and on the basis of written evidence and submissions determines which cases should be referred for inquiry by the Professional Conduct Committee. It may also refer cases to the Health Committee (see Part 4 of this pamphlet).

11. The Professional Conduct and Preliminary Proceedings Committees are advised on questions of law by a Legal Assessor, who is usually a Queen's Counsel and must be a barrister, advocate or solicitor of not less than ten years' standing.

Rules of procedure

12. The proceedings of the Professional Conduct and Preliminary Proceedings Committees are governed by rules of procedure made by the Council after

consultation with both representative medical organisations and bodies representing patients, and approved by the Privy Council. The current rules were made in 1988 and are printed by HM Stationery Office as Statutory Instrument 1988 No. 2255. Other rules govern the functions of the Legal Assessor and the procedure for appeals to the Judicial Committee of the Privy Council.

Proceedings: the preliminary stages

13. Cases giving rise to proceedings by the Preliminary Proceedings Committee or the Professional Conduct Committee are of two kinds - those arising from a conviction of a doctor in the courts and those where a doctor is alleged to have done something which amounts to serious professional misconduct. In either kind of case the Council acts only when relevant matters have been brought to its notice.

14. Convictions of doctors are normally reported to the Council by the police. Unless the conviction is of a minor motoring or other trivial offence it is normally referred to the Preliminary Proceedings Committee.

15. Information or complaints concerning behaviour which may be regarded as serious professional misconduct reach the Council from a number of sources. Frequently they concern matters which have already been investigated through some other procedure - for example a Medical Service Committee, or a Committee of Inquiry in the hospital service. Information or complaints received from individual doctors or members of the public, as distinct from public authorities, must be supported by evidence of the facts alleged in the form of one or more affidavits or statutory declarations made in a prescribed form before a Commissioner for Oaths or a Justice of the Peace.

16. Every complaint or item of information received is scrutinised meticulously. Only a very small proportion are found both to relate to matters which could be regarded as raising a question of serious professional misconduct and to be supported, or capable of being supported, by adequate evidence. Where it appears from the allegations made that a question of serious professional misconduct may arise, but the evidence initially received is insufficient or does not comply with the Rules, the Council's Solicitor may be asked to make inquiries to establish the facts. A decision whether to proceed with an allegation of serious professional misconduct is then taken by the President or by another medical member of the Council appointed for the purpose. A decision not to proceed, for example, because the matter does not raise a question of serious

professional misconduct, is taken only after consultation between the President (or the medical member of the Council) and a lay member appointed to assist in the screening of cases. In a case where it is decided to proceed the doctor is informed of the allegations and is invited to submit a written explanation, which may include evidence in answer to the allegations. Any such explanation is placed before the Preliminary Proceedings Committee when it considers the case.

Powers of the Preliminary Proceedings Committee: warning letters and letters of advice

17. After considering a case of conviction or of alleged serious professional misconduct the Preliminary Proceedings Committee may decide either:

(a) to refer the case to the Professional Conduct Committee for inquiry; or

(b) to send the doctor a letter; or

(c) to take no further action.

18. Many cases considered by the Preliminary Proceedings Committee are disposed of by a warning letter or a letter of advice - for example, certain cases where a doctor has been convicted for the first time of driving when under the influence of alcohol, or of shoplifting, or cases where a doctor's professional conduct appears to have fallen below the proper standard but not to have been so serious as to necessitate a public inquiry.

19. If on considering a conviction, or allegations of serious professional misconduct, it appears to the Preliminary Proceedings Committee that the doctor's fitness to practise may be seriously impaired by a physical or mental condition, the Committee may refer the case to the Health Committee instead of the Professional Conduct Committee.

20. If the Preliminary Proceedings Committee decides to refer a case either to the Professional Conduct Committee or to the Health Committee, it may make an order for the interim suspension of the doctor's registration or for interim conditional registration if it is satisfied that this is necessary for the protection of members of the public or is in the doctor's own interests. Such orders may be made for a period not exceeding two months and are intended to be effective only until the case has been considered by the Professional

Conduct Committee or by the Health Committee. No such order can be made unless the doctor has been offered an opportunity of appearing before the Preliminary Proceedings Committee and being heard on the question whether such an order should be made. For this purpose the doctor may be legally represented.

Inquiries before the Professional Conduct Committee

21. As already mentioned, the Professional Conduct Committee is bound to accept the fact that doctors have been convicted as conclusive evidence that they were guilty of the offence of which they were convicted. Provided therefore that a doctor admits a conviction, proceedings in cases of conviction are concerned only to establish the gravity of the offence and to take due account of any mitigating circumstances. In cases of conduct, however, the allegations, unless admitted by the doctor, must be strictly proved by evidence, and the doctor is free to dispute and rebut the evidence called. If facts alleged in a conduct charge are found by the Committee to have been proved, the Committee must subsequently determine whether, in relation to those facts, the doctor has been guilty of serious professional misconduct. Before taking a final decision the Committee invites the doctor, or the doctor's legal representative, to call attention to any mitigating circumstances and to produce testimonials or other evidence as to character. The Committee takes account of the previous history of the doctor.

22. The primary concerns of the Professional Conduct Committee are to protect the public and to uphold the reputation of the medical profession. Subject to these overriding considerations, the Committee will consider what is in the best interests of the doctor. If in the course of an inquiry it appears to the Committee that a doctor's fitness to practise may be seriously impaired by reason of a physical or mental condition, the Committee may refer that question to the Health Committee for determination. If the Health Committee finds that it is so impaired, the Professional Conduct Committee will then take no further action in the case.

Powers of the Professional Conduct Committee at the conclusion of an inquiry

23. At the conclusion of an inquiry in which a doctor has been proved to have been convicted of a criminal offence, or judged to have been guilty of

serious professional misconduct, the Professional Conduct Committee must decide on one of the following courses:

(a) to conclude the case;

(b) to postpone its determination;

(c) to direct that the doctor's registration be conditional on compliance, for a period not exceeding three years, with such requirements as the Committee may think fit to impose for the protection of members of the public or in the doctor's interests;

(d) to direct that the doctor's registration shall be suspended for a period not exceeding 12 months; or

(e) to direct the erasure of the doctor's name from the Register.

Postponement of determination

24. In any case where the Committee's determination is postponed, the doctor's name remains on the Register during the period of postponement. When postponing its determination to a later meeting the Committee normally indicates that the doctor will be expected, before the resumed hearing, to provide the names of professional colleagues and other persons of standing to whom the Council may apply for information, to be given in confidence, concerning the doctor's conduct since the previous hearing. The replies received from these referees, together with any other evidence as to the doctor's conduct, are then taken into account when the Committee resumes consideration of the case. If the information is satisfactory, the case will then normally be concluded. If however the evidence is not satisfactory, the determination may be postponed for a further period, or the Committee may direct suspension or erasure or may impose conditions on the doctor's registration.

Conditional registration

25. Examples of conditions which may be imposed are that the doctor should not engage in specified branches of medical practice, or should practise only in a particular appointment or under supervision, or should not prescribe or possess controlled drugs, or should take specified steps to remedy any evident deficiencies of knowledge, clinical skills, professional attitudes, or of management or communication skills.

26. When a doctor's registration has for a period been subject to conditions the Committee may, on resuming consideration of the case, revoke the direction for conditional registration, or revoke or vary any of the conditions, or it may extend the original period of conditional registration. If a doctor is judged by the Professional Conduct Committee to have failed to comply with any of the conditions, the Committee may direct either suspension of the doctor's registration or erasure.

Suspension of registration

27. If a doctor's registration is suspended, the doctor ceases to be entitled to practise as a registered medical practitioner during that period. When a doctor's registration has been suspended the Committee may, after notifying the doctor, resume consideration of the case before the end of the period of suspension. At that time, if the Committee thinks fit, it may extend the original period of suspension or order erasure or impose conditional registration. Before resuming consideration of the case in such circumstances the Committee may, as when postponing its determination, ask the doctor to give the names of referees from whom information may be sought as to his or her conduct in the interval. This information will be taken into account when the Committee resumes consideration of the case.

Erasure

28. Whereas suspension can be ordered only for a specified period, a direction to erase remains effective unless and until the doctor makes a successful application for restoration to the Register. Such an application cannot be made until at least ten months have elapsed since the original order took effect.

Appeal procedure and immediate suspension

29. When the Committee has directed erasure from the Register, or that a doctor's registration shall be suspended or shall be subject to conditions, the doctor has 28 days in which to give notice of appeal against the direction to the Judicial Committee of the Privy Council. During that period and, if there is an appeal, until the appeal is heard, the doctor's registration is not affected unless the Professional Conduct Committee has made a separate order that the doctor's registration shall be suspended forthwith. The Committee may make such an order if it is satisfied that to do so is necessary for the protection of

members of the public or would be in the best interests of the doctor. There is a right of appeal against an order for immediate suspension to the High Court (in Scotland, the Court of Session), but such an appeal, whether successful or not, does not affect the right of appeal to the Judicial Committee of the Privy Council referred to above.

Restoration to the Register after disciplinary erasure

30. Applications for restoration may legally be made at any time after ten months from the date of erasure. If such an application is unsuccessful, a further period of at least ten months must elapse before another application may be made. The names of many doctors which have been erased have subsequently been restored to the Register, after an interval. An applicant may, and normally does, appear in person before the Professional Conduct Committee, and may be legally represented. The Committee determines every application on its merits, having regard among other considerations to the nature and gravity of the original offence, the length of time since erasure, and the conduct of the applicant in the interval.

PART 2

CONVICTIONS AND FORMS OF PROFESSIONAL MISCONDUCT WHICH MAY LEAD TO DISCIPLINARY PROCEEDINGS

31. This part of the pamphlet mentions certain kinds of criminal offences and of professional misconduct which have in the past led to disciplinary proceedings or which in the opinion of the Council could give rise to such proceedings. It does not pretend to be a complete code of professional ethics, or to specify all criminal offences or forms of professional misconduct which may lead to disciplinary action. To do this would be impossible, because from time to time with changing circumstances the Council's attention is drawn to new forms of professional misconduct.

32. Any abuse of the privileges and opportunities afforded to a doctor or any grave dereliction of professional duty or serious breach of medical ethics may give rise to a charge of serious professional misconduct. In discharging their respective duties the Preliminary Proceedings Committee and Professional Conduct Committee must proceed as judicial bodies. Only after considering the evidence in each case can these Committees determine the gravity of a conviction or decide whether a doctor's behaviour amounts to serious professional misconduct. Doctors who seek detailed advice on professional conduct in particular circumstances should consult a medical defence society or professional association. The Council can rarely give such advice because of its judicial function.

33. In the following paragraphs areas of professional conduct and personal behaviour which need to be considered have been grouped under five main headings:

- Neglect or disregard by doctors of their professional responsibilities to patients for their care and treatment
- Abuse of professional privileges or skills
- Personal behaviour: conduct derogatory to the reputation of the medical profession
- The advertising of doctors' services
- Comment on professional colleagues.

34. These headings have been adopted for convenience, but such classifications can only be approximate. In most cases the nature of the offence or misconduct will be readily apparent. In some cases, such as those involving personal relationships between doctors and patients or questions of advertising, doctors may experience difficulty in recognising the proper principles to apply in various circumstances. In relation to these matters Part 3 of this pamphlet gives further advice.

Neglect or disregard of personal responsibilities to patients for their care and treatment

Responsibility for standards of medical care

35. In pursuance of its primary duty to protect the public the Council may institute disciplinary proceedings when a doctor appears *seriously* to have disregarded or neglected professional duties, for example, by failing to visit or to provide or arrange treatment for a patient when necessary. Many cases of this kind which have been investigated by a Medical Service Committee or other complaints procedure under the National Health Service machinery (see Part I above) are reported to the Council, but cases which have arisen in other ways may also be considered.

36. The public are entitled to expect that a registered medical practitioner will afford and maintain a good standard of medical care. This includes:

- (a) conscientious assessment of the history, symptoms and signs of a patient's condition;
- (b) sufficiently thorough professional attention, examination and, where necessary, diagnostic investigation;
- (c) competent and considerate professional management;
- (d) appropriate and prompt action upon evidence suggesting the existence of a condition requiring urgent medical intervention; and
- (e) readiness, where the circumstances so warrant, to consult appropriate professional colleagues.

37. A comparable standard of practice is to be expected from medical practitioners whose contribution to a patient's care is indirect, for example, those in laboratory and radiological specialties.

38. The Council is concerned with errors in diagnosis or treatment, and with the kind of matters which give rise to action in the civil courts for negligence, only when the doctor's conduct in the case has involved such a disregard of professional responsibility to patients or such a neglect of professional duties as to raise a question of serious professional misconduct. A question of serious professional misconduct may also arise from a complaint or information about the conduct of a doctor which suggests that the welfare of patients has been endangered by a doctor persisting in unsupervised practice of a branch of medicine without having the appropriate knowledge and skill or having acquired the experience which is necessary.

39. Apart from a doctor's personal responsibility to patients, doctors who undertake to manage, to direct, or to perform clinical work for organisations offering private medical services should satisfy themselves that those organisations provide adequate clinical and therapeutic facilities for the services offered.

Delegation of medical duties to professional colleagues

40. The Council recognises that in many branches of professional practice doctors cannot at all times attend to all their patients' needs. It is therefore both necessary and desirable that, when doctors are absent from duty, arrangements should be made whereby their professional responsibilities may be undertaken by suitably qualified professional colleagues. General practitioners who make use of deputising services have a duty to satisfy themselves that their deputies are registered medical practitioners who have the appropriate experience, knowledge and skill to discharge the duties for which they will be responsible. Similarly, doctors under contract of service, such as consultants in hospital practice, and doctors engaged in private practice on either a part-time or a whole-time basis, should seek to ensure that proper arrangements are put in hand to cover their own duties, or those of their junior colleagues, during any period of absence, by doctors with appropriate qualifications and experience. Consultants and other senior hospital staff should delegate to junior colleagues only those duties which are within their capabilities.

41. Any deputising arrangements should make provision for prompt and proper communication between the deputy and the doctor who has primary

responsibility for the patients' care. However, so far as the Council is concerned, the deputy is personally accountable for any neglect or disregard of professional responsibilities towards patients of the doctor for whom he or she is deputising.

Delegation of medical duties to nurses and others

42. The Council recognises and welcomes the growing contribution made to health care by nurses and other persons who have been trained to perform specialised functions, and it has no desire either to restrain the delegation to such persons of treatment or procedures falling within the proper scope of their skills or to hamper the training of medical and other health students. But a doctor who delegates treatment or other procedures must be satisfied that the person to whom they are delegated is competent to carry them out. It is also important that the doctor should retain ultimate responsibility for the management of these patients because only the doctor has received the necessary training to undertake this responsibility.

43. For these reasons a doctor who improperly delegates to a person who is not a registered medical practitioner functions requiring the knowledge and skill of a medical practitioner is liable to disciplinary proceedings. The Council has in the past proceeded against those doctors who employed assistants who were not medically qualified to conduct their practices. It has also proceeded against doctors who by signing certificates or prescriptions or in other ways have enabled persons who were not registered medical practitioners to treat patients as though they were so registered.

Abuse of professional privileges or skills

Abuse of privileges conferred by law: Misuse of professional skills

Prescribing of drugs

44. The prescription of controlled drugs is reserved to members of the medical profession and of certain other professions, and the prescribing of such drugs is subject to statutory restrictions. The Council has regarded as serious professional misconduct the prescription or supply of drugs of dependence otherwise than in the course of bona fide treatment. Disciplinary proceedings have also been taken against doctors convicted of offences against the laws

which control drugs where such offences appear to have been committed in order to gratify the doctor's own addiction or the addiction of other persons.

Medical certificates

45. A doctor's signature is required by statute on certificates for a variety of purposes on the presumption that the truth of any statement which a doctor may certify can be accepted without question. Doctors are therefore expected to exercise care in issuing certificates and similar documents, and should not certify statements which they have not taken appropriate steps to verify. Any doctor who in a professional capacity signs any certificate or similar document containing statements which are untrue, misleading or otherwise improper may be liable to disciplinary proceedings.

Termination of pregnancy

46. The termination of pregnancy is regulated by the law and doctors must observe the law in relation to such matters. A criminal conviction in the British Islands of termination of pregnancy in circumstances which contravene the law in itself affords grounds for a charge before the Professional Conduct Committee.

Abuse of privileges conferred by custom: Professional confidence; Undue influence; Personal relationships between doctors and patients

47. Patients grant doctors privileged access to their homes and confidences, and some patients are liable to become emotionally dependent upon their doctors. Good medical practice depends upon the maintenance of trust between doctors and patients and their families, and the understanding by both that proper professional relationships will be strictly observed. In this situation doctors must exercise great care and discretion in order not to damage this crucial relationship. Any action by a doctor which breaches this trust may raise a question of serious professional misconduct.

48. Three particular areas may be identified in which this trust may be breached:

(a) Doctors may improperly disclose information obtained in confidence from or about a patient.

(b) Doctors may improperly exert influence upon a patient to lend them money or to alter wills in their favour.

(c) Doctors may enter into an emotional or sexual relationship with a patient (or with a member of a patient's family) which disrupts that patient's family life or otherwise damages, or causes distress to, the patient or his or her family.

Further advice is given in Part 3 of this pamphlet in relation to the first and last of these matters.

Personal behaviour: Conduct derogatory to the reputation of the profession

49. The public reputation of the medical profession requires that every member should observe proper standards of personal behaviour, not only in professional activities but at all times. This is the reason why a doctor's conviction of a criminal offence may lead to disciplinary proceedings even if the offence is not directly connected with the doctor's profession. In particular, three areas of personal behaviour can be identified which may occasion disciplinary proceedings:

- Personal misuse or abuse of alcohol or other drugs
- Dishonest behaviour
- Indecent or violent behaviour.

Personal misuse or abuse of alcohol or other drugs

50. In the opinion of the Council, convictions for drunkenness or other offences arising from misuse of alcohol (such as driving when under the influence of alcohol) indicate habits which are discreditable to the profession and may be a source of danger to the doctor's patients. After a first conviction for drunkenness a doctor may expect to receive at the least a warning letter, and may, particularly if there are further convictions, become the subject of an inquiry by the Professional Conduct Committee or investigation of fitness to practise (see Part 4 of this pamphlet).

51. Doctors who treat patients or perform other professional duties while under the influence of drink or drugs, or who are unable to perform their professional duties because they are under the influence of drink or drugs, are liable to disciplinary proceedings or to inquiry by the Council into their fitness to practise.

Dishonesty: improper financial transactions

52. Doctors are liable to disciplinary proceedings if they are convicted of criminal deception (obtaining money or goods by false pretences), forgery, fraud, theft or any other offence involving dishonesty.

53. The Council takes a particularly serious view of dishonest acts committed in the course of a doctor's professional practice (whether under the National Health Service or otherwise), or against patients or colleagues. Such acts, if reported to the Council, may result in disciplinary proceedings. Among the circumstances which may have this result are the improper demand or acceptance of fees from patients contrary to the statutory provisions which regulate the conduct of the National Health Service and, in particular:

(a) the charging of fees to in-patients or out-patients treated at National Health Service hospitals, when the proper steps have not been taken to ensure that such patients enjoy the status of resident or non-resident private patients, as required by statute;

(b) knowingly and improperly seeking to obtain from a Family Health Services Authority or other health authority any payment to which the doctor is not entitled, including the improper issue of National Health Service prescriptions either to patients on the doctor's dispensing list or to patients whom the doctor, or another member of the practice, is treating under private contract.

54. Disciplinary proceedings may also result from other improper arrangements calculated to extend, or otherwise benefit, a doctor's practice, whether in relation to the provision of specialist services or in general practice. These include, for example, pressure by a specialist to persuade a patient to accept private treatment by reliance upon representations about the comparative availability of treatment under the National Health Service and privately. Improper arrangements made for the transfer of patients to a general practitioner's National Health Service list without the knowledge and consent of the patient, or in a manner contrary to the National Health Service regulations, have also in the past led to disciplinary proceedings.

55. The Council also takes a serious view of the prescribing or dispensing of drugs or appliances for improper motives. The motivation of doctors may be regarded as improper if they have prescribed a drug or appliance in which they have a direct financial interest or if they have prescribed a product

manufactured or marketed by an organisation from which they have accepted an improper inducement. Further guidance on this matter is contained in paragraphs 117-121 of this pamphlet.

56. The Council has also regarded with concern arrangements for fee-splitting under which one doctor would receive part of a fee paid by a patient to another doctor. The association of a medical practitioner with any commercial enterprise engaged in the manufacture or sale of any substance which is claimed to be of value in the prevention or treatment of disease but is of undisclosed nature or composition, may also be regarded as improper.

57. Doctors, like lay members or officers of any health authority, have a duty to declare an interest before participating in discussion which could lead to the purchase by a public authority of goods or services in which they, or a member of their immediate family, have a direct or indirect pecuniary interest. Non-disclosure of such information may, under certain circumstances, amount to serious professional misconduct.

Indecency and violence

58. Indecent behaviour to or a violent assault on a patient would be regarded as serious professional misconduct. Any conviction for assault or indecency would render a doctor liable to disciplinary proceedings, and would be regarded with particular gravity if the offence were committed in the course of professional duties or against the doctor's patients or colleagues.

The advertising of doctors' services

59. The Council encourages doctors to provide factual information about their professional qualifications and services. The term 'advertising' is used by the Council to mean the provision of information about doctors and their services, in any form, to the public or other members of the profession. There is a general requirement that any advertising in this country must be 'legal, decent, honest and truthful', and that it should conform with the other requirements of the British Code of Advertising Practice. But the advertising of doctors' services must be subject to additional restriction in order to ensure that the public is not misled or put at risk in any way.

60. It is the duty of all doctors to satisfy themselves that the content and presentation of any material published about their services, and the manner in

which it is distributed, conform with the guidance given both in this section and in paragraphs 96-114. This applies whether a doctor personally arranges for such publication or permits or acquiesces in its publication by others. Failure to abide by the Council's guidance may call a doctor's professional conduct into question.

61. In no circumstances should the distribution of advertising material be undertaken so frequently or in such a manner as to put recipients, including prospective patients, under pressure. Such a course of action is in the interest neither of patients nor of the medical profession.

Comment about professional colleagues

62. Doctors are frequently called upon to express a view about a colleague's professional practice. This may, for example, happen in the course of a medical audit or peer review procedure, or when a doctor is asked to give a reference about a colleague. It may also occur in a less direct and explicit way when a patient seeks a second opinion, specialist advice or an alternative form of treatment. Honest comment is entirely acceptable in such circumstances, provided that it is carefully considered and can be justified, that it is offered in good faith and that it is intended to promote the best interests of patients.

63. Further, it is any doctor's duty, where the circumstances so warrant, to inform an appropriate person or authority about a colleague whose professional conduct or fitness to practise may be called into question or whose professional performance appears to be in some way deficient. Arrangements exist to deal with such problems, and they must be used in order to ensure that high standards of medical practice are maintained.

64. However, gratuitous and unsustainable comment which, whether directly or by implication, sets out to undermine trust in a professional colleague's knowledge or skills, is unethical.

The nature of serious professional misconduct

65. As stated in paragraph 32 of this pamphlet the question whether any particular course of conduct amounts to serious professional misconduct is a matter which falls to be determined by the Professional Conduct Committee after considering the evidence in each individual case. This applies equally to the categories of misconduct described in Part 2 and to the situations

contemplated in Part 3. Further, it must be emphasised that the categories of misconduct described in Part 2 cannot be regarded as exhaustive. Any abuse by doctors of any of the privileges and the opportunities afforded to them, or any grave dereliction of professional duty or serious breach of medical ethics, may give rise to a charge of serious professional misconduct.

PART 3

ADVICE ON STANDARDS OF PROFESSIONAL CONDUCT AND ON MEDICAL ETHICS

66. Section 35 of the Medical Act 1983 provides that the powers of the Council shall include that of providing, in such manner as the Council thinks fit, advice for members of the medical profession on standards of professional conduct or on medical ethics. The Council has approved the following paragraphs giving general advice on personal relationships between doctors and patients, on professional confidence, on the reference of patients to and acceptance of patients by specialists, on circumstances in which difficulties in relation to self-promotion most commonly arise and on relationships between the medical profession and the pharmaceutical and allied industries.

67. The Council will also respond to inquiries from individual doctors about questions of professional conduct, although many of these doctors are advised to consult their medical defence society or professional association. The Council will also provide advice to individual doctors concerning their own professional conduct if, after receiving a complaint against them and seeking the doctor's observations on the complaint, it appears that such advice is necessary.

Personal relationships between doctors and patients

68. Paragraphs 47-48 of this pamphlet, dealing with the abuse by doctors of certain privileges conferred on them by custom, explain why doctors must exercise great care and discretion not to damage the crucial relationship between doctors and patients, and identify three areas in which experience shows that this trust is liable to be breached. The following paragraphs relate to one of these area - personal relationships between a doctor and a patient (or a member of the patient's family) which disrupt the patient's family life or otherwise damage the maintenance of trust between doctors and patients.

69. The Council has always taken a serious view of the abuse of a doctor's professional position in order to pursue a personal relationship of an emotional or sexual nature with a patient or the close relative of a patient. Such abuse may be aggravated in a number of ways. For example, a doctor may use the pretext of a professional visit to a patient's home to disguise the pursuit of the personal relationship with the patient (or, where the patient is a child, with the patient's parent). Or a doctor may use knowledge, obtained in professional

confidence, of the patient's marital difficulties to take advantage of that situation. But these are merely examples of particular abuses.

70. The question is sometimes raised whether the Council will be concerned with such relationships between a doctor and a person for whose care the doctor is contractually responsible but has never actually treated, or between a doctor and a person whom the doctor has attended professionally in the distant past. In view of the great variety of circumstances which can arise in cases of this nature, the Council's judicial position has prevented it from offering specific advice on such matters. It can however be said that the Council is primarily concerned with behaviour which damages the crucial relationship between doctors and patients, and that this relationship normally implies actual consultation.

71. The trust which should exist between doctors and patients can be severely damaged when, as a result of an emotional relationship between a doctor and a patient, the family life of that patient is disrupted. This may occur without sexual misconduct between the doctor and the patient.

72. The foregoing paragraphs refer to personal relationships between doctors and patients or the close relatives of patients. The Council is not concerned with personal relationships between doctors and other persons.

73. Cases have been reported to the Council where doctors attending a patient professionally have indecently assaulted or exposed themselves to a patient. As will be clear from paragraph 58 of this pamphlet, such behaviour may render the doctor liable to criminal proceedings; it may also in the absence of a criminal conviction be treated as serious professional misconduct.

74. These principles apply to both heterosexual and homosexual relationships.

75. Innocent doctors are sometimes caused anxiety by unsolicited declarations of affection by patients or threats that a complaint will be made on the grounds of a relationship which existed only in the patient's imagination. As indicated in paragraph 16 of this pamphlet, all complaints received by the Council are screened most carefully, and action is taken only when the evidence received is sufficient to require investigation.

Professional confidence

Principles

76. Patients are entitled to expect that the information about themselves or others which a doctor learns during the course of a medical consultation, investigation or treatment, will remain confidential. Doctors therefore have a duty not to disclose to any third party information about an individual that they have learned in their professional capacity, directly from a patient or indirectly, except in the cases discussed in paragraphs 81-91 below.

77. Where a patient, or a person properly authorised to act on a patient's behalf, consents to disclosure, information to which the consent refers may be disclosed in accordance with that consent. An explicit request by a patient that information should not be disclosed to particular people, or indeed to any third party, must be respected save in the most exceptional cases, for example where the health, safety or welfare of someone other than the patient would otherwise be at serious risk.

78. Doctors carry prime responsibility for the protection of information given to them by patients or obtained in confidence about patients. They must therefore take steps to ensure, as far as lies in their control, that the records, manual or computerised, which they keep or to which they have access, are protected by effective security systems with adequate procedures to prevent improper disclosure.

79. Most doctors in hospital and general practice are working in health care teams, some of whose members may need access to information, given or obtained in confidence about individuals, in order to perform their duties. It is for doctors who lead such teams to judge when it is appropriate for information to be disclosed for that purpose. They must leave those whom they authorise to receive such information in no doubt that it is given to them in professional confidence. The doctor also has a responsibility to ensure that arrangements exist to inform patients of the circumstances in which information about them is likely to be shared and to give patients the opportunity to state any objection to this.

80. A doctor who decides to disclose confidential information about an individual must be prepared to explain and justify that decision, whatever the circumstances of the disclosure.

Disclosures without the consent of the patient

81. Doctors who are faced with the difficult decision whether to disclose information without a patient's consent must weigh carefully the arguments for and against disclosure. If in doubt, they would be wise to discuss the matter with an experienced colleague or to seek advice from a medical defence society or professional association. The following paragraphs discuss circumstances of this kind.

Disclosure in relation to the clinical management of a patient

82. In exceptional circumstances a doctor may consider it undesirable, for medical reasons, to seek a patient's consent to the disclosure of confidential information. In such cases information may be disclosed to a relative or some other person but only when the doctor is satisfied that it is necessary in the patient's best medical interests to do so.

83. Deciding whether or not to disclose information is particularly difficult in cases where a patient cannot be judged capable of giving or withholding consent to disclosure. One such situation may arise where a doctor believes that a patient may be the victim of physical or sexual abuse. In such circumstances the patient's medical interests are paramount and may require the doctor to disclose information to an appropriate person or authority.

84. Difficulties may also arise when a doctor believes that a patient, by reason of immaturity, does not have sufficient understanding to appreciate what the treatment or advice being sought may involve. Similar problems may arise where a patient lacks understanding because of illness or mental incapacity. In all such cases the doctor should attempt to persuade the patient to allow an appropriate person to be involved in the consultation. If the patient cannot understand or be persuaded, but the doctor is convinced that the disclosure of information would be essential to the patient's best medical interests, the doctor may disclose to an appropriate person or authority the fact of the consultation and the information learned in it. A doctor who decides to disclose information must be prepared to justify that decision and must inform the patient before any disclosure is made.

Disclosure required by statute

85. Information may be disclosed in order to satisfy a specific statutory requirement, such as notification of an infectious disease or of attendance upon a person known or suspected to be addicted to controlled drugs.

Disclosure in the public interest

86. Rarely, cases may arise in which disclosure in the public interest may be justified, for example, a situation in which the failure to disclose appropriate information would expose the patient, or someone else, to a risk of death or serious harm.

Disclosure in connection with judicial proceedings

87. Where litigation is in prospect, unless the patient has consented to disclosure or a court order has been made, information should not be disclosed by a doctor merely in response to demands from other people such as a third party's solicitor or an official of the court. A doctor may disclose such information as may be ordered by a judge or presiding officer of the court, as may a doctor summoned to assist a Coroner, Procurator Fiscal or similar officer either at an inquest or when the need for an inquest is being considered. In such circumstances the doctor should first establish the precise extent of the information which needs to be disclosed, and should not hesitate to make known any objections to the proposed disclosure, particularly when the order would involve the disclosure of confidential information about third parties.

88. Information may also be disclosed at the direction of the Chairman of a Committee of the Council which is investigating a doctor's fitness to practise, when the Committee has determined that the interests of justice and/or the public require such disclosure, and provided that every reasonable effort has first been made to seek the consent of the patient or patients concerned.

Disclosure for the purposes of medical teaching, medical research and medical audit

89. Medical teaching, medical research and medical audit necessarily involve the disclosure of information about individuals, often in the form of medical records, for purposes other than their own health care. Where such information is used in a form which does not enable individuals to be identified, no question of breach of confidentiality will usually arise. Where the disclosure would

enable one or more individuals to be identified, the patients concerned, or those who may properly give permission on their behalf, must wherever possible be made aware of that possibility and be advised that it is open to them, at any stage, to withhold their consent to disclosure.

Disclosure to employers and insurance companies

90. Special problems relating to confidentiality can arise where doctors have responsibilities not only to patients but also to third parties as, for example, where a doctor assesses a patient for an employer or an insurance company. In such circumstances, the doctor should ensure that at the outset patients understand the purpose of any consultation or examination, are aware of the doctor's obligation to the employer or insurance company and consent to be seen by the doctor on those terms. Doctors should undertake assessments for insurance, or of an employee's fitness to work, only where the patient has given written consent.

Disclosure after a patient's death

91. The fact of a patient's death does not of itself release a doctor from the obligation to maintain confidentiality. In cases where consent has not previously been given, the extent to which confidential information may properly be disclosed by a doctor after someone's death cannot be specified in absolute terms and will depend on the circumstances. These include the nature of the information disclosed, the extent to which it has already appeared in published material and the period which has elapsed since the person's death.

Principles governing the reference of patients to, and their acceptance by, doctors providing specialist services

Reference of patients to specialists

92. The medical profession in this country has always considered that it is in the best interests of patients for one doctor to be fully informed about and responsible for the comprehensive management of a patient's medical care, but increasing specialisation within medicine has led members of the public to an awareness of high standards of expertise and often to seek direct access to these. In this situation general practitioners have a double duty - to educate their

patients to an understanding of the central position of their primary role, and also to consider carefully any request by a patient for a specialist opinion even if the general practitioner is not convinced that such consultation is essential. In order to continue to fulfil their central role, general practitioners must have information about the range of specialist expertise which other doctors are qualified and available to provide, especially in their locality.

Acceptance of patients by specialists

93. Although an individual patient is free to seek to consult any doctor, the Council wishes to affirm its view that, in the interests of the generality of patients, a specialist should not usually accept a patient without reference from the patient's general practitioner. If a specialist does decide to accept a patient without such reference, the specialist has a duty immediately to inform the general practitioner of any findings and recommendations before embarking on treatment, except in emergency, unless the patient expressly withholds consent or has no general practitioner. In such cases the specialist must be responsible for the patient's subsequent care until another doctor has agreed to take over that responsibility.

94. Doctors connected with organisations offering clinical, diagnostic or medical advisory services must therefore satisfy themselves that the organisation discourages patients from approaching it without first consulting their own general practitioners, and that the guidance set out in paragraphs 92 and 93 above is fully observed at all times.

95. In expressing these views the Council recognises and accepts that in some areas of practice specialist and hospital clinics customarily accept patients referred by sources other than their general practitioners. In these circumstances the specialist still has the duty to keep the general practitioner informed.

The advertising of doctors' services

The need for good communication

96. Good communication between doctors and patients, and between one doctor and another, is fundamental to the provision of good patient care, and those who need information about the services of doctors should have ready access to it. Patients need such information in order to make an informed choice

of general practitioner and to make the best use of the services the general practitioner offers. Doctors, for their part, need information about the services of their professional colleagues. General practitioners in particular need information about specialist services so that they may advise patients and refer them, where appropriate, for further investigation or treatment.

97. People seeking medical attention for themselves or their families can nevertheless be particularly vulnerable to persuasive influence, and patients are entitled to protection from misleading advertisements. The promotion of doctors' medical services as if the provision of medical care were no more than a commercial activity is likely both to undermine public trust in the medical profession and, over time, to diminish the standards of medical care which patients have a right to expect.

98. This section offers guidance to doctors in various types of medical practice about the content and distribution of notices and other material providing information about their services. It discusses the following matters:

- the distinction between the advertising of general practitioner services and specialist services;
- information about general practitioner services;
- information about specialist services;
- information about organisations offering medical services;
- information to companies, firms and similar organisations;
- information about associations of doctors;
- other public references to doctors.

The distinction between the advertising of general practitioner services and specialist services

99. The Council distinguishes between the advertising of general practitioner services - which in this context includes advertising by doctors offering the sight test - and the advertising of specialist services. Information about the services provided by general practitioners should be made widely available to the public in the areas where those doctors practise. Specialists may provide information to professional colleagues but not to the public, except to the limited extent

described in paragraph 104 below. This distinction reflects the 'referral system' upon which general and specialist practice in the United Kingdom are based and which exists to protect patients. Most individuals, when choosing a general practitioner, are in good health and able to make a rational choice on the basis of factual information. People requiring the attention of a specialist may, by contrast, be ill or in a vulnerable state and need the advice of a general practitioner before being referred for further investigation or treatment. Equally, the specialist to whom a patient is referred needs information of the patient's relevant medical history and of any treatment which may already be under way.

Information about general practitioner services

Lists of general practitioners

100. Patients are best able to make an informed choice of family doctor if they have ready access to comprehensive, up-to-date, well-presented and easily understood information about all the general practitioners practising in their area. Lists including factual information, presented in an objective and unbiased manner, about the doctors and their professional qualifications, the facilities available and the practice arrangements should be distributed widely to the public. Full use should be made of the places in each area where members of the public can expect to find local information. It is best if such material is published by a body with statutory responsibilities for primary care services, or by some other body which has no reason to favour individual doctors or practices. As far as is practicable, material published in this way should provide the same items of information about each doctor and practice.

Notices about individual general practitioners or practices

101. General practitioners should provide the public with practice leaflets giving factual information about their professional qualifications, services and practice arrangements and including, if they wish, a statement about their approach to medical practice. Up-to-date information of this kind should be available at doctors' surgeries. It should also be placed in libraries and other places where the public would normally expect to find information in their locality. General practitioners may, if they so decide, distribute such information on an unsolicited basis within the areas which they serve, provided that the

distribution is not targeted in such a way as to put the recipients under pressure. General practitioners may also publish factual information of their services in the press, directories or other media. Doctors' services should not however be advertised by means of unsolicited visits or telephone calls, by doctors or by people acting on their behalf, with the aim of recruiting patients; such activities may render a doctor liable to disciplinary proceedings by the Council.

102. In addition to complying with the general requirements governing advertising in this country, which are referred to in paragraph 59 above, general practitioners publishing information about their services should not abuse the trust of patients or attempt to exploit their lack of medical knowledge. Especially, they must not offer guarantees to cure particular complaints. Advertising material should contain only factual information and must not include any statement which could reasonably be regarded as misleading or as disparaging the services provided by other doctors, whether directly or by implication. No claim of superiority should be made either for the services offered or for a particular doctor's personal qualities, professional qualifications, experience or skills.

103. Doctors are responsible for ensuring that any nameplates, noticeboards or other signs about their practices are sufficient to inform the public of the existence or location of the premises while not being used to draw public attention to the services of one doctor or practice at the expense of others. In cases of doubt a professional association, a medical defence society or the Local Medical Committee should be consulted.

Information about specialist services

104. Specialists may keep their professional and managerial colleagues informed of the services they offer and of their practice arrangements. Material circulated in this way should not however disparage, directly or by implication, the services provided by other doctors, nor should it claim superiority for the specialist's personal qualities, qualifications, experience or skills. The name, professional qualifications, address and telephone number of a specialist may be included in national and local directories and similar publications, and doctors who are suitably qualified may, if they wish, include their names in more than one list within a single publication. Information about individual specialists should not otherwise be made available directly to the public, although the membership lists of associations of doctors may be released as indicated in paragraph 111.

105. Just as the public are assisted by comprehensive lists of local general practitioners, so doctors are best able to offer their patients informed advice if they themselves have up-to-date, factual information about all the specialist medical services which are available. Doctors may reasonably expect to be provided with such information by the local hospitals, clinics and other medical organisations, both in the National Health Service and in the private sector, where specialists practise.

Information about organisations offering medical services

106. Medical services are offered to the public not only by individual doctors but by a wide variety of organisations such as hospitals, screening centres, nursing homes, advisory bureaux or agencies, and counselling centres. Some of these, especially those within the private sector, advertise their services to the public and the principles set out in paragraph 102 above, concerning the advertising of general practitioner services, apply also to such advertising. In addition, the advertisements should not make invidious comparisons with other organisations, either within or outside the National Health Service, or with the services of particular doctors, nor should they claim superiority for the professional services offered or for any doctors connected with the organisation.

107. Doctors who have any kind of financial or professional relationship with such an organisation, or who use its facilities, are deemed by the Council to bear some responsibility for the organisation's advertising. This also applies to doctors who accept for examination or treatment patients referred by any such organisation. All such doctors must therefore make it their business to acquaint themselves with the nature and content of the organisation's advertising, and must exercise due diligence in an effort to ensure that it conforms with this guidance. Should any question be raised about a doctor's conduct in this respect, it will not be sufficient for any explanation to be based on the doctor's lack of awareness of the nature or content of the organisation's advertising, or lack of ability to exert any influence over it.

108. Such doctors should also avoid personal involvement in promoting the services of this kind of organisation, for example, by public speaking, broadcasting, writing articles or signing circulars, and should not permit the organisation's promotional material to claim superiority for their professional qualifications and experience. Nor should they allow a personal address or telephone number to be used as an inquiry point on behalf of an organisation.

109. Further guidance on financial relationships between doctors and such organisations is given in paragraphs 115 and 116 below.

Information to companies, firms and similar organisations.

110. Doctors who wish to offer medical services, such as medico-legal or occupational health services or medical examinations, to a company or firm, a school or club, or a professional practitioner or association may send factual information about their qualifications and services to a suitable person, and may where appropriate place a factual advertisement in a relevant trade journal, provided that the same principles are observed as in the guidance given in paragraph 102 about the advertising of general practitioner services. Doctors must not however use the provision of such services as a means to put pressure upon individuals to become their patients and should observe the guidance in paragraphs 92-95 above concerning communication with each individual's general practitioner.

Information about associations of doctors

111. Members of the public who are seeking medical advice or treatment occasionally approach an association of doctors for a list of its members. Such a list may be released in response to a direct request, but it is essential that no list should imply that those listed are the only doctors who are qualified to practise in a particular branch of medicine or that the inclusion of a doctor's name carries some form of recommendation. The lists which are released should include only those doctors who are eligible for registration by the Council as having completed higher specialist or vocational training. Any association of doctors which wishes to release lists of its members in response to requests by the public should therefore first consult the Council for guidance as to the form which the list should take.

Other public references to doctors

The use of professional directories

112. Factual information about a doctor who is appropriately qualified may be published in a professional directory of persons offering particular services, provided that it is open to all doctors practising in the relevant specialty to be

included. Doctors should not however cause, sanction or acquiesce in the publication of their names or practice details in any professional directory or book which purports to make recommendations as to the quality of particular doctors or their services.

Publicity material about companies or other organisations

113. The name and qualifications of a doctor who is a director of a company may be shown on the company's notepaper. Doctors should however take steps to avoid the inclusion, in material published by any company or organisation with which they are associated, of references which draw attention to their attainments in ways likely to promote their professional advantage, whether or not the business of their company is connected with medical practice.

Articles, books and broadcasting by doctors

114. Books or articles written by doctors may include their names, qualifications, appointments and details of other publications. Similar information may be given where doctors participate in the broadcast presentation and discussion of medical and related topics. Difficulties in this area arise chiefly when material included in articles, books or broadcasts by doctors, or the manner in which it is referred to, is likely to imply that the doctor is especially recommended for patients to consult. Doctors should see to it that no such implication is given. Where a doctor in clinical practice writes articles or columns which offer advice to the public on medical conditions or problems, or offers telephone or other recorded advice on such subjects, or broadcasts about them, it should be explicitly stated that the doctor cannot offer individual advice or see individual patients as a result.

Financial relationships between doctors and independent organisations providing clinical, diagnostic or medical advisory services

115. A doctor who recommends that a patient should attend at, or be admitted to, any private hospital, nursing home or similar institution, whether for treatment by that doctor or by another person, must do so only in such a way as will best serve, and will be seen best to serve, the medical interests of the patient. Doctors should therefore avoid accepting any financial or other inducement from such

an institution which might compromise, or be regarded by others as likely to compromise, the independent exercise of their professional judgment. Where doctors have a financial interest in an organisation to which they propose to refer a patient for admission or treatment, whether by reason of a capital investment or a remunerative position, they should always disclose that they have such an interest before making the referral.

116. The seeking or acceptance by a doctor from such an institution of any inducement for the referral of patients to the institution, such as free or subsidised consulting premises or secretarial assistance, may be regarded as improper. Similarly, the offering of such inducements to colleagues by doctors who manage or direct such institutions may be regarded as improper.

Relationships between the medical profession and the pharmaceutical and allied industries

117. The medical profession and the pharmaceutical industry have common interests in the research and development of new drugs of therapeutic value and in their production and distribution for clinical use. Medical practice owes much to the important advances achieved by the pharmaceutical industry over recent decades. In addition, much medical research and postgraduate medical education are facilitated by the financial support of pharmaceutical firms.

118. Advertising and other forms of sales promotion by individual firms within the pharmaceutical and allied industries are necessary for their commercial viability and can provide information which is useful to the profession. Nevertheless, prescribing doctors should not only choose but also be seen to be choosing the drug or appliance which, in their independent professional judgment, and having due regard to economy, will best serve the medical interests of the patient. Doctors should therefore avoid accepting any pecuniary or material inducement which might compromise, or be regarded by others as likely to compromise, the independent exercise of their professional judgment in prescribing matters. The seeking or acceptance by doctors of unreasonable sums of money or gifts from commercial firms which manufacture or market drugs or diagnostic or therapeutic agents or appliances may be regarded as improper. Examples of inducements which the Council may regard as improper are set out below.

Clinical trials of drugs

119. It may be improper for a doctor to accept per capita or other payments from a pharmaceutical firm in relation to a research project such as the clinical trial of a new drug, unless the payments have been specified in a protocol for the project which has been approved by the relevant national or local ethical committee. It may be improper for doctors to accept per capita or other payments under arrangements for recording clinical assessments of a licensed medicinal product, whereby they are asked to report reactions which they have observed in patients for whom they have prescribed the drug, unless the payments have been specified in a protocol for the project which has been approved by the relevant national or local ethical committee. It is improper for doctors to accept payment in money or kind which could influence their professional assessment of the therapeutic value of a new drug.

Gifts and loans

120. It may be improper for individual doctors to accept from a pharmaceutical firm monetary gifts or loans or expensive items of equipment for their personal use. No exception can, however, be taken to grants of money or equipment by firms to institutions such as hospitals, health care centres and university departments, when they are donated specifically for purposes of research.

Acceptance of hospitality

121. It may be improper for individual doctors or groups of doctors to accept lavish hospitality or travel facilities under the terms of sponsorship of medical postgraduate meetings or conferences. However, no exception is likely to be taken to acceptance by an individual doctor of a grant for the cost of travel to an international conference or to acceptance, by a group of doctors who attend a sponsored postgraduate meeting or conference, of hospitality at an appropriate level, which the recipients might normally adopt when paying for themselves.

PART 4

FITNESS TO PRACTISE:

PROCEDURES FOR DOCTORS IMPAIRED BY PHYSICAL OR MENTAL ILLNESS

Introduction

122. In 1980 the Council introduced procedures, known as the health procedures, for rehabilitating sick doctors, that is, doctors whose fitness to practise is seriously impaired by a physical or mental condition. The procedures are based in law, and the main provisions are set out in Part V of, and Schedule 4 to, the Medical Act 1983, and in the Health Committee (Procedure) Rules 1987, which are published by HMSO as Statutory Instrument 1987 No. 2174.

The principles of the health procedures

123. The health procedures are designed:

(a) to protect patients from doctors whose ill-health impairs their ability to practise medicine;

(b) to provide continuing monitoring and care of sick doctors, in their own and patients' interests, with the aim of returning them to unrestricted practice where possible;

(c) to treat the cases of sick doctors with the same confidentiality that is owed to any patient.

124. The health procedures involve four main stages:

(i) preliminary consideration of evidence;

(ii) medical examination of the sick doctor;

(iii) medical supervision and rehabilitation of the sick doctor;

(iv) the Health Committee.

Stage 1: Preliminary consideration of evidence

125. Evidence suggesting that a doctor's fitness to practise is seriously impaired by an illness usually comes to the Council from concerned colleagues.

It may also come from hospitals or health authorities, the police, pharmacists, patients and others. Sometimes doctors originally referred to the Council's conduct procedures are transferred to the health procedures when it appears that an illness may be the underlying cause of the referral.

126. Under the rules, the evidence must be considered by the President, or by another medical member of the Council appointed as the Preliminary Screener for health. Before taking formal action, the Screener must be satisfied that a question arises whether the doctor's fitness to practise is seriously impaired by a physical or mental condition. The Screener may also consider whether the problem has been, or could be, remedied by local action: in some cases, a doctor may be persuaded by colleagues to accept treatment, and if necessary cease to practise for a time, in which event the Council is unlikely to intervene, while there is no risk to patients.

Stage 2: Medical examination of the doctor

127. If the Screener is satisfied that the Council's involvement is necessary, the doctor is invited to be medically examined by at least two medical examiners chosen by the Screener from panels nominated by professional bodies, including Royal Colleges, Faculties and the British Medical Association. Examinations usually take place near to the doctor's home, unless the doctor asks otherwise. The examinations have to date almost invariably included psychiatric examination, since addiction or mental illness has caused virtually every referral to the health procedures. The doctor also has a right to choose additional medical examiners.

128. The medical examiners are asked to report on whether the doctor is fit to practise without restriction or, if not, what nature of medical management and supervision and limitations upon practice are recommended. The examiners' reports are sent to the doctor. If the examiners find that the doctor's fitness to practise is seriously impaired, the doctor is asked to undertake to accept medical care and supervision (often from the specialist who is already providing the doctor with treatment). The examiners may also recommend that the doctor should be asked to accept voluntary restrictions on practice (e.g. no single-handed general practice); or even to refrain from practice altogether for the time being.

Stage 3: Medical supervision of the sick doctor

129. If the doctor accepts the examiners' recommendations, the medical supervisor provides or arranges any necessary treatment, and reports periodically to the Screener on the doctor's progress. On the basis of these reports, the Screener may review any limitations on the doctor's practice and, if good progress is maintained, gradually remove them until the doctor is able to return to unrestricted practice without supervision.

Stage 4: The Health Committee

130. Most doctors under the health procedures never need to appear before the Health Committee. Cases are referred to the Health Committee only when:

(i) a doctor fails to co-operate with medical examination, or refuses to be placed under medical supervision;

(ii) a doctor under medical supervision ceases to follow the medical examiners' recommendations for medical management and/or limitations on professional practice, or suffers a serious deterioration in ill-health; or

(iii) it becomes apparent during the course of the Council's disciplinary proceedings that the health of the doctor concerned needs investigation by the Health Committee.

131. The Health Committee is elected annually by the Council from among its members. The membership comprises a Chairman, Deputy Chairman, nine other medical members, and one lay member. The Committee is advised by specialist medical assessors, chosen by the Preliminary Screener from panels nominated by professional bodies, and is assisted by a legal assessor who advises on points of law.

132. The Committee meets in private at the GMC's offices in London. Its proceedings are governed by legal rules, but the hearings are not adversarial, although the doctor is able to be legally represented, and may require the attendance of witnesses for cross-examination. The principal evidence usually comprises written medical reports, and all the papers are sent beforehand both to the doctor and to the Committee members. Members may ask the doctor (and any witnesses) questions arising from the written papers.

133. If the Committee finds the doctor's fitness to practise to be seriously impaired, it may impose conditions upon the doctor's registration for up to three years, or suspend registration for up to twelve months. The Committee does not have the power of erasure. Each case must be resumed by the Committee before the period of conditional or suspended registration expires. The conditions which the Committee may impose always include a requirement to accept medical supervision, and may also include restrictions on a doctor's professional practice, in order to protect patients and/or the doctor's own health.

134. Doctors may appeal against decisions of the Health Committee to the Judicial Committee of the Privy Council, but only on a question of law.

Conclusion

135. Although the Council's duty to protect patients is paramount, it is also the aim of the health procedures to secure the complete rehabilitation of the doctor. However, this may not be possible if action is delayed for too long. As with any patient suffering from a serious illness, it is not a kindness to a colleague, or to the colleague's patients, to help to conceal or to ignore a developing illness. It is every doctor's duty to inform an appropriate person or authority when doubt arises about a colleague's fitness to practise safely and effectively.