

GENERAL MEDICAL COUNCIL

**PROFESSIONAL CONDUCT
AND DISCIPLINE:
FITNESS TO PRACTISE**



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GENERAL MEDICAL COUNCIL

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may lead to proceedings by the former Disciplinary Committee or by the present Professional Conduct Committee which has superseded it.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

PART I

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 his name shall be erased from the Register, or that his registration shall be suspended for a period not exceeding 12 months, or that his registration shall be conditional on his 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 his interests.

2. These powers apply to practitioners 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 determination of a court as conclusive evidence that the doctor was guilty of the offence of which he was 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 a doctor who has been convicted of an offence to argue before the Professional Conduct Committee that he was in fact innocent. *It is therefore unwise for a doctor to plead guilty in a court of law to a charge to which he believes that he has 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 IV 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 representative medical organisations, and approved by the Privy Council. The current rules were made in 1988 and are printed by H.M. 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 both found to relate to matters which could be regarded as raising a question of serious professional misconduct and also 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 action shall be taken on an allegation of serious professional misconduct is then taken by the President or by another member of the Council appointed for the purpose. If it appears to the President that the matter is trivial, or irrelevant to the question of serious professional misconduct, he will normally decide that it shall proceed no further. In a case where it is decided to proceed with allegations of serious professional misconduct, the doctor is informed of the allegations made against him and is invited to submit a written explanation. If the doctor responds to this invitation his explanation, which may include evidence in answer to the allegations, is then 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 cases where a doctor has been convicted for the first time of driving a motor car when under the influence of drink, 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 may be suffering from a physical or mental condition which seriously impairs his fitness to practise, 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 a doctor has been convicted as conclusive evidence that he was guilty of the offence of which he was 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 his 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 himself. 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 his 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 his 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 his 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 intimates that the doctor will be expected before his next appearance to furnish the names of professional colleagues and other persons of standing to whom the Council may apply for information, to be given in confidence, concerning his 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 that he should practise only in a particular appointment or under supervision. Another is that he should not prescribe or possess controlled drugs. Another is that he should take specified steps to remedy evident deficiencies in his knowledge, clinical skills, professional attitudes and/or abilities to manage or communicate.

26. When a doctor's registration has for a period been subject to conditions the Committee may, on resuming consideration of his 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 of his registration, the Committee may direct either suspension of his 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 his 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 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 the restoration of his name 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 that a doctor's name shall be erased or that his registration shall be suspended or that his registration 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 he gives notice of appeal, until the appeal is heard, his 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 a further application may be made. The names of many doctors which have been erased have subsequently been restored to the Register, after an interval. An applicant may, and normally does, appear in person before the Professional Conduct Committee. He 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 II

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 by a doctor of any privileges and opportunities afforded to him 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
- Disparagement of 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 III 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 his 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 his professional responsibility to patients or such a neglect of his 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 he has endangered the welfare of patients by persisting in unsupervised practice of a branch of medicine in which he does not have the appropriate knowledge and skill and has not 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 a doctor cannot himself at all times attend to all his patients' needs. It is therefore both necessary and desirable that arrangements should be made whereby the professional responsibilities of a doctor may be undertaken, during his absence from duty, by a suitably qualified professional colleague. A general practitioner who makes use of deputising services has a duty to satisfy himself that the deputies who may attend his patients 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 himself responsible for any neglect or disregard of his professional responsibilities towards patients of the doctor for whom he 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 his 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. Accordingly 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 accordingly 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 his professional capacity signs any certificate or similar document containing statements which are untrue, misleading or otherwise improper renders himself 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) A doctor may improperly disclose information which he obtained in confidence from or about a patient.
- (b) A doctor may improperly exert influence upon a patient to lend him money or to alter the patient's will in his favour.
- (c) A doctor 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 III 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 his 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 a motor car when under the influence of drink) 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 a warning letter. Further convictions may lead to an inquiry by the Professional Conduct Committee or the Health Committee.

51. A doctor who treats patients or performs other professional duties while he is under the influence of drink or drugs, or who is unable to perform his professional duties because he is under the influence of drink or drugs, is liable to disciplinary proceedings or to inquiry by the Council into his 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 Practitioner Committee 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 110–114 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 and 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.

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 a doctor's professional duties or against his patients or colleagues.

The advertising of doctors' services

59. The Council encourages doctors to provide factual information about their qualifications and services. The provision of information of this kind is nonetheless a sensitive matter. 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 89–107 of this booklet. 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.

60. 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 not in the interest of patients or of the medical profession.

Disparagement of professional colleagues

61. It is improper for a doctor to disparage, whether directly or by implication, the professional skill, knowledge, qualifications or services of any other doctor, irrespective of whether this may result in his own professional advantage, and such disparagement may raise a question of serious professional misconduct.

62. It is however entirely proper for a doctor, having carefully considered the advice and treatment offered to a patient by a colleague, in good faith to express a different opinion and to advise and assist the patient to seek an alternative source of medical care. The doctor must however always be able to

justify such action as being in the patient's best medical interests.

63. Furthermore, a doctor has a duty, where the circumstances so warrant, to inform an appropriate body about a professional colleague whose behaviour may have raised a question of serious professional misconduct, or whose fitness to practise may be seriously impaired by reason of a physical or mental condition. Similarly, a doctor may also comment on the professional performance of a colleague in respect of whom he acts as a referee.

CONCLUSION

The nature of serious professional misconduct

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

PART III

ADVICE ON STANDARDS OF PROFESSIONAL CONDUCT AND ON MEDICAL ETHICS

65. 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.

66. 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

67. 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 areas – 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.

68. The Council has always taken a serious view of a doctor who uses his 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 of a doctor's professional position 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 his pursuit of the personal relationship with the patient (or, where the patient is a child, with the patient's parent). Or he may use his 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.

69. 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 whom he 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.

70. 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.

71. 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.

72. Cases have been reported to the Council where a doctor when attending a patient professionally has indecently assaulted her or exposed himself to her. 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.

73. For convenience these paragraphs describe a situation where the doctor is a man and the patient a woman. Similar principles would apply if the doctor were a woman and the patient a man or to a homosexual relationship.

74. 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

75. The following guidance is given on the principles which should govern the confidentiality of information relating to patients.

76. It is a doctor's duty, except in the cases mentioned below, strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information about a patient which he has learnt directly or indirectly in his professional capacity as a registered medical practitioner. The death of the patient does not absolve the doctor from this obligation.

77. The circumstances where exceptions to the rule may be permitted are as follows:

- (a) If the patient or his legal adviser gives written and valid consent, information to which the consent refers may be disclosed.

- (b) Confidential information may be shared with other registered medical practitioners who participate in or assume responsibility for clinical management of the patient. To the extent that the doctor deems it necessary for the performance of their particular duties, confidential information may also be shared with other persons (nurses and other health care professionals) who are assisting and collaborating with the doctor in his professional relationship with the patient. It is the doctor's responsibility to ensure that such individuals appreciate that the information is being imparted in strict professional confidence.
- (c) If in particular circumstances the doctor believes it undesirable on medical grounds to seek the patient's consent, information regarding the patient's health may sometimes be given in confidence to a close relative or person in a similar relationship to the patient. However, this guidance is qualified in paragraphs 79–81 below.
- (d) If in the doctor's opinion disclosure of information to a third party other than a relative would be in the best interests of the patient, it is the doctor's duty to make every reasonable effort to persuade the patient to allow the information to be given. If the patient still refuses then only in exceptional cases should the doctor feel entitled to disregard his refusal.
- (e) Information may be disclosed to the appropriate authority in order to satisfy a specific statutory requirement, such as notification of an infectious disease.
- (f) If the doctor is directed to disclose information by a judge or other presiding officer of a court before whom he is appearing to give evidence, information may at that stage be disclosed. Similarly, a doctor may disclose information when he has been summoned by authority of a court in Scotland, or under the powers of a Procurator-Fiscal in Scotland to investigate sudden, suspicious or unexplained deaths, and appears to give evidence before a Procurator-Fiscal. Information may also be disclosed to a coroner or his nominated representative to the extent necessary to enable the coroner to determine whether an inquest should be held. But where litigation is in prospect, unless the patient has consented to disclosure or a formal court order has been made for disclosure, information should not be disclosed merely in response to demands from other persons such as another party's solicitor or an official of the court.
- (g) Rarely, disclosure may be justified on the ground that it is in the public interest which, in certain circumstances such as, for example, investigation by the police of a grave or very serious crime, might override the doctor's duty to maintain his patient's confidence.
- (h) Information may also be disclosed if necessary for the purpose of a medical research project which has been approved by a recognised ethical committee.

78. Whatever the circumstances, a doctor must always be prepared to justify his action if he has disclosed confidential information. If a doctor is in doubt whether any of the exceptions mentioned above would justify him in disclosing information in a particular situation he will be wise to seek advice from a medical defence society or professional association.

79. Where a child below the age of 16 consults a doctor for advice or treatment, and is not accompanied at the consultation by a parent or a person in loco parentis, the doctor must particularly have in mind the need to foster and maintain parental responsibility and family stability. Before offering advice or treatment the doctor should satisfy himself, after careful assessment, that the child has sufficient maturity and understanding to appreciate what is involved. For example, if the request is for treatment for a pregnancy or contraceptive advice, the doctor should satisfy himself that the child has sufficient appreciation of what is involved in relation to his or her emotional development, family relationships, problems associated with the impact of pregnancy and/or its termination and the potential risks to health of sexual intercourse and certain forms of contraception at an early age.

80. If the doctor is satisfied of the child's maturity and ability to understand, as set out above, he must nonetheless seek to persuade the child to involve a parent, or another person in loco parentis, in the consultation. If the child nevertheless refuses to allow a parent or such other person to be told, the doctor must decide, in the patient's best medical interests, whether or not to offer advice or treatment. He should however respect the rules of professional confidentiality set out above in the foregoing paragraphs of this section.

81. If the doctor is not so satisfied, he may decide to disclose the information learned from the consultation; but if he does so he should inform the patient accordingly, and his judgment concerning disclosure must always reflect both the patient's best medical interests and the trust the patient places in the doctor.

82. Special problems in relation to confidentiality can arise in circumstances where doctors have responsibilities both to patients and to third parties, for example in the practice of occupational medicine. An occupational physician should ensure that any employee whom he sees in that capacity understands the duty of the occupational physician in relation to the employer and the purpose of the consultation. In particular, where an occupational physician is asked by the employer to assess the fitness to work of an employee he should not undertake such assessment except with the informed consent of the employee.

83. The extent to which disclosure of medical information after the death of a patient is regarded as improper will depend on a number of factors, for example:

- (a) the nature of the information disclosed;
- (b) the extent to which such information has already appeared in published material;

- (c) the circumstances of the disclosure, including the period which has elapsed since the patient's death.

The Council feels unable to specify an interval of years to apply in all such cases, and a doctor who discloses such information without the consent of the patient or a surviving close relative of the patient may be required to justify his action.

84. The foregoing guidance on confidentiality applies not only to information which a doctor has received in a clinical relationship with a patient, but also to information which he has received, either directly from the patient or indirectly, in the course of administrative or non-clinical duties, for example when employed by a public or private health authority, commercial firm, insurance company or other comparable organisation, or as a medical author or medical journalist. Where one doctor shares confidential information with another doctor, the interests of the patient require that the doctor with whom the information is shared must observe the same rule of professional secrecy as the doctor who originally obtained the information from the patient.

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

Reference of patients to specialists

85. 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

86. 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 his 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.

87. 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 85 and 86 above is fully observed at all times.

88. 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

89. 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.

90. 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' 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 can expect.

91. This section of the booklet 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 general practitioner services and specialist services;
- information about general practitioner services;

- information about specialist services;
- information about independent organisations offering medical services;
- information to companies, firms or professional practitioners or associations;
- information about associations of doctors;
- other public references to doctors.

The distinction between general practitioner services and specialist services

92. The Council distinguishes between the advertising of general practitioner services and the advertising of specialist services. Information about the services provided by general practitioners should be made widely available to the public. Specialists may provide information to professional colleagues but not to the public, except to the limited extent described in paragraph 97 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 expert advice before being referred for further investigation or treatment. Equally, the specialist to whom a patient is referred needs information of the patient's medical history and of any treatment which may already be under way.

Information about general practitioner services

Lists of general practitioners

93. 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 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

94. General practitioners should provide the public with practice leaflets giving factual information about their 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. Such material may be distributed on an unsolicited basis within the area which a general practitioner serves, subject to the guidance in paragraph 60 of this booklet and provided that no individual or group of patients is singled out to receive the information. 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 with the aim of recruiting patients; such conduct may render a doctor liable to disciplinary proceedings by the Council.

95. There is a general requirement that any advertising must contain only material which is 'legal, decent, honest and truthful', and that it should conform with the other requirements of the British Code of Advertising Practice. In addition to those requirements, doctors 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, qualifications, experience or skills.

96. 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

97. 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, 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 however be made available directly to the public in any other way.

98. 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 independent organisations offering medical services

99. Various independent organisations offer and advertise medical services to the public; they include private hospitals, screening centres, nursing homes, advisory bureaux or agencies, and counselling centres. The principles set out in paragraph 95 above, concerning the advertising of general practitioners' services, apply also to such advertising. In addition, the advertisements should not make invidious comparisons with the National Health Service or other organisations or doctors, nor claim superiority for the professional services offered or for any doctors connected with the organisation.

100. 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 take steps to ensure that the organisation's advertising 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.

101. Doctors should also avoid personal involvement in promoting the services of such an 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.

102. Further guidance on financial relationships between doctors and such organisations is given in paragraphs 108 and 109.

Information to companies, firms or professional practitioners or associations

103. Doctors who wish to offer medical services, such as medico-legal or occupational health services or medical examinations, to a company or firm or a professional practitioner or association may send factual information about their qualifications and services to an appropriate officer of the organisation. 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 paragraph 86 above concerning communication with each individual's general practitioner.

Information about associations of doctors

104. 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. Any association of doctors which wishes to begin releasing 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

105. 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 speciality to be included. Doctors should not however instigate, 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

106. 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

107. 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 regularly 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

108. 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 the doctor himself 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 a doctor has a financial interest in an organisation to which he proposes to refer a patient for admission or treatment, whether by reason of a capital investment or a remunerative position, he should always disclose that he has such an interest before making the referral.

109. 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

110. 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.

111. 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, a prescribing doctor should not only choose but also be seen to be choosing the drug or appliance which, in his independent professional judgment and having due regard to economy, will best serve the medical interests of his 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

112. 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 a doctor to accept per capita or other payments under arrangements for recording clinical assessments of a licensed medicinal product, whereby he is asked to report reactions which he has observed in patients for whom he has 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 a doctor to accept payment in money or kind which could influence his professional assessment of the therapeutic value of a new drug.

Gifts and loans

113. It may be improper for an individual doctor to accept from a pharmaceutical firm monetary gifts or loans or expensive items of equipment for his 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

114. 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 which enables him to 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 IV

FITNESS TO PRACTISE: PROCEDURES ASSOCIATED WITH THE HEALTH COMMITTEE

115. Provisions of the Medical Act 1978, now consolidated in the Medical Act 1983, gave the Council jurisdiction in cases where the fitness to practise of a doctor is seriously impaired by reason of his physical or mental condition. Those provisions require the Council to make rules to govern the consideration of such cases and to establish a Health Committee to which a proportion, but not all, of the cases may eventually be referred. The rules, which were first made in 1980 after consultation with professional bodies and are approved by the Privy Council, are the Health Committee (Procedure) Rules. The current rules were made in 1987 and are published as Statutory Instrument 1987 No. 2174.

116. Before these rules came into force a significant proportion of the cases reaching the Council's previous disciplinary machinery arose from the mental condition of the doctor. For example, a doctor who had become addicted to alcohol might as a result fail to visit his patients or be convicted of driving a motor car with excess alcohol in his blood. A doctor who had become addicted to drugs might commit offences against the Misuse of Drugs Act or other laws in order to gratify his addiction. A doctor suffering from senile dementia might fail to visit and treat his patients. Such cases could in the past be dealt with only by holding a disciplinary hearing if the doctor had been convicted in the courts or behaved in a way amounting to serious professional misconduct. Moreover the Council was unable to deal with other cases where a doctor's fitness to practise was seriously impaired by reason of a physical or mental condition in such a way as to imperil his patients, embarrass his professional colleagues and indeed jeopardise his own health, career and professional position but the doctor had not been convicted of a criminal offence or behaved in a way amounting to serious professional misconduct.

117. In devising procedures for the consideration of a doctor's fitness to practise, the Council was concerned to make it easier for a sick doctor's professional colleagues to exercise persuasion on the doctor to seek treatment for his condition and so wherever possible to avoid the need to refer a case to the Health Committee. Where the Council receives information suggesting that the fitness to practise of a doctor may be seriously impaired, the information is first considered by the President or other member of the Council appointed for the purpose. This member is known as the Preliminary Screener. If he is satisfied from the evidence that a question does arise whether the doctor's fitness to practise is seriously impaired, the doctor is then informed of this and invited to agree within 14 days to submit to examination by at least two medical examiners. These medical examiners are chosen by the Preliminary Screener from panels of examiners nominated by professional

bodies. Examiners are nominated in all parts of the United Kingdom so that examinations may be arranged locally if this is considered appropriate. It is also open to the doctor at this stage both to nominate other medical practitioners to examine him and report to the Preliminary Screener on his fitness to practise and to submit observations or other evidence in regard to this.

118. Where a doctor agrees to submit to examination the medical examiners are asked to report on his fitness to engage in practice either generally or on a limited basis and on the management of his case which they recommend. When the Preliminary Screener has received their reports these are communicated to the doctor. He is then asked to state within 28 days whether he is prepared voluntarily to undertake to accept the recommendations of the medical examiners as to the management of his case, including any limitations on his practice which they recommend. If he does so, the Preliminary Screener will then normally request a medical supervisor, who may already be treating him, to monitor the doctor's progress. Provided that the Preliminary Screener is satisfied that the doctor is implementing his undertaking no further action is taken.

119. It is only when the doctor refuses to be medically examined, or to accept the recommendations of the medical examiners, or if having accepted them he subsequently fails to follow them, or his condition deteriorates significantly, that the Preliminary Screener, after consulting at least two other members of the Council appointed for the purpose, may refer the case to the Health Committee. Cases may occasionally be referred to the Health Committee by the Preliminary Proceedings Committee or Professional Conduct Committee where a doctor has been convicted or is alleged to have committed serious professional misconduct, but it appears to either Committee that the fitness to practise of the doctor may be seriously impaired by reason of a physical or mental condition.

120. The Health Committee is elected annually by the Council and comprises a Chairman, Deputy Chairman, nine other medical members of the Council and one lay member. It meets in private and in most cases the principal evidence before it consists of the reports of the medical examiners. Its proceedings are regulated by rules and are of a judicial nature. The Health Committee is assisted both by a legal assessor and by medical assessors. The medical assessors are chosen by the Preliminary Screener from panels nominated by professional bodies. One medical assessor is chosen having regard to the nature of the physical or mental condition which is alleged to impair the doctor's fitness to practise; the other is chosen from the same branch of medicine as that of the doctor whose case is being considered. The Health Committee may if it thinks fit either adjourn consideration of a case or proceed to determine whether the doctor's fitness to practise is seriously impaired. If it finds that the doctor's fitness to practise is seriously impaired, it may impose conditions on his registration for a period not exceeding three

years or suspend his registration for a period not exceeding 12 months. Cases where conditions have been imposed or a doctor's registration has been suspended are reviewed by the Health Committee from time to time.

121. There is a right of appeal to the Judicial Committee of the Privy Council from a decision of the Health Committee, but only on a question of law.
