

GENERAL MEDICAL COUNCIL

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**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may lead to proceedings by the former Disciplinary Committee or by the present Professional Conduct Committee which has superseded it.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**

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 5–14 of and Schedules 3 and 4 to the Medical Act 1978. The Act provides that if any registered practitioner:

- (1) is found by the Professional Conduct Committee to have been convicted in the United Kingdom or any of the Channel Islands or the Isle of Man of a criminal offence, or
- (2) 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 3 years, with such requirements as the Committee thinks fit to impose for the protection of

members of the public or in his interests.

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

## **Convictions**

The term “conviction”, used in this pamphlet, means a determination by a Criminal Court in the British Isles. 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.

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.*

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”**

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.”

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.”

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**

The Professional Conduct Committee is elected annually by the Council and consists of 20 members, of whom only ten sit on any case. Of the 20 members 12 are elected members of the Council and two 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.

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).

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 10 years’ standing.

### **Rules of Procedure**

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 1980 and are printed by H.M. Stationery Office as Statutory Instrument 1980 No. 858. 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**

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.

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.

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 statutory declarations (that is, statements declared in a prescribed form before a Commissioner for Oaths).

Every complaint and information received is scrutinised meticulously. Only a very small proportion is both found to relate to matters which could be regarded as raising a question of serious professional misconduct and is 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 all cases where an allegation of serious professional misconduct is proceeded with, 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 they consider the case.

### **Powers of the Preliminary Proceedings Committee: Warning Letters**

After considering cases of conviction or of alleged serious professional misconduct the Preliminary Proceedings Committee may decide either:

- (1) to refer such cases to the Professional Conduct Committee for inquiry; or
- (2) to send the doctor a warning letter; or
- (3) to take no further action.

The majority of cases considered by the Preliminary Proceedings Committee are disposed of by warning letter – 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.

If on considering a conviction, or allegation of serious professional misconduct, it appears to the Preliminary Proceedings Committee that the doctor is 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.

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**

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 the 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.

The primary concerns of the Professional Conduct Committee are to protect the public and to uphold the reputation of the medical profession. Subject, however, 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 find 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**

At the conclusion of any inquiry in which a doctor has been proved to have been convicted of a criminal offence, or is judged to have been guilty of serious professional misconduct, the Professional Conduct Committee must decide on one of the following alternative courses:

- (1) To admonish the doctor and conclude the case;
- (2) To place the doctor on probation by postponing judgment;
- (3) To direct that the doctor's registration be conditional on his compliance, for a period not exceeding 3 years, with such requirements as the Committee may think fit to impose for the protection of members of the public or in his interests;
- (4) To direct that the doctor's registration shall be suspended for a period not exceeding 12 months; or
- (5) To direct the erasure of the doctor's name from the Register.

### **Postponement of Judgment**

In any case where judgment is postponed, the doctor's name remains on the Register during the period of postponement. When postponing judgment 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 habits and 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, judgment 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**

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, or that he should not prescribe or possess controlled drugs.

When a doctor's registration is made subject to conditions the Committee may (after notifying the doctor) 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 suspension of his registration or erasure.

### **Suspension of Registration**

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 and then if it thinks fit 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 judgment, ask the doctor to give the names of referees from whom information may be sought as to his habits and conduct in the interval. This information will be taken into account when the Committee resumes consideration of the case.

## **Erasure**

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 10 months have elapsed since the original order took effect.

## **Appeal Procedure and Immediate Suspension**

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**

Applications for restoration may legally be made at any time after 10 months from the date of erasure. If such an application is unsuccessful, a further period of at least 10 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, 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 II

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

This part of the pamphlet mentions certain kinds of professional misconduct and of criminal offences which have in the past led to disciplinary proceedings or which in the opinion of the Council could give rise to a charge of serious professional misconduct. 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.

Any abuse by a doctor of any of the 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.

In the following paragraphs the areas of professional conduct and personal behaviour which need to be considered have been grouped under four main headings, namely:

- (i) Neglect or disregard by doctors of their professional responsibilities to patients for their care and treatment;
- (ii) Abuse of professional privileges or skills;
- (iii) Personal behaviour: conduct derogatory to the reputation of the medical profession;
- (iv) Advertising, canvassing and related professional offences.

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 recognis-

ing the proper principles to apply in various circumstances. In relation to these matters Part III of this pamphlet gives further advice.

**(i) Neglect or disregard of personal responsibilities to patients for their care and treatment**

*(a) Responsibility for standards of medical care*

In considering complaints or information about the conduct of a doctor the Council is not ordinarily concerned with errors in diagnosis or treatment. But 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 to his patients, 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 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. Apart from a doctor's personal responsibility to his patients, doctors who undertake to manage, or 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.

*(b) Improper delegation of medical duties*

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.

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.

**(ii) Abuse of professional privileges or skills**

*(a) Abuse of privileges conferred by law: Misuse of professional skills*

*(1) Prescribing of drugs*

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.

*(2) Medical certificates*

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.

*(3) Termination of pregnancy*

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 Isles for the termination of pregnancy in circumstances which contravene the law in itself affords grounds for a charge before the Professional Conduct Committee.

*(b) Abuse of privileges conferred by custom*

*Professional confidence : Undue influence :*

*Personal relationships between doctors and patients*

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 the question of serious professional misconduct.

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

- (1) A doctor may improperly disclose information which he obtained in confidence from or about a patient;
- (2) A doctor may exert improper influence upon a patient to lend him money or to alter the patient's will in his favour;
- (3) 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.

**(iii) Personal behaviour : Conduct derogatory to the reputation of the profession**

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 the conviction of a doctor for 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, namely:

- (a) Personal abuse of alcohol or other drugs;
- (b) Dishonest behaviour;
- (c) Indecent or violent behaviour.

*(a) Personal misuse of alcohol or other drugs*

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 before the Professional Conduct Committee.

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.

*(b) Dishonesty: Improper financial transactions*

A doctor is liable to disciplinary proceedings if he is convicted of criminal deception (obtaining money or goods by false pretences), forgery, fraud, theft or any other offence involving dishonesty.

The Council takes a particularly serious view of dishonest acts committed in the course of a doctor's professional duties or against his patients or colleagues. Disciplinary proceedings may accordingly be taken if a doctor improperly demands or accepts fees from patients in circumstances contrary to National Health Service regulations, or if he knowingly and improperly obtains from a Family Practitioner Committee or Health Authority any payment to which he is not entitled, or if he issues prescriptions improperly to patients on his dispensing list.

The Council has also regarded with concern (1) prescribing for commercial motives of drugs or appliances in which a doctor has a financial interest; (2) arrangements for fee splitting under which one doctor would receive part of a fee paid by a patient to another doctor; and (3) 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.

*(c) Indecency and violence*

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 was committed in the course of a doctor's professional duties or against his patients or colleagues.

**(iv) Advertising, canvassing, and related professional offences**

*(a) Advertising: general considerations*

The purpose of the original establishment of the Medical Register was stated in the Medical Act 1858 to be to enable "persons requiring medical aid to distinguish qualified from unqualified practitioners". The Council does not wish to hinder the ethical dissemination of relevant factual information about individual practitioners. This can facilitate an informed choice by patients seeking treatment and assist general practitioners in advising their patients on the choice of specialist. Such information may also indicate to the reader of a medical book or article the professional standing of the author.

The Council recognises that the profession has a duty to disseminate information about advances in medical science and

therapeutics. The following paragraphs are not intended to inhibit this provided that it is done in an ethical manner.

The medical profession in this country has long accepted the convention that doctors should refrain from self-advertisement. In the Council's opinion self-advertisement is not only incompatible with the principles which should govern relations between members of a profession but could be a source of danger to the public. A doctor successful at achieving publicity may not be the most appropriate doctor for a patient to consult. In extreme cases advertising may raise illusory hopes of a cure.

The professional offence of advertising may arise from the publication in any form of matter commending or drawing attention to the professional attainments or services of a doctor, if that doctor has either personally arranged for such publication or has instigated, sanctioned or acquiesced in its publication by others. The question whether such publication amounts to serious professional misconduct will depend on the circumstances of each case such as:

- (i) whether the matter published conformed to currently accepted standards (for example, on professional doorplates);
- (ii) whether the matter sought to suggest that the doctor had personal and unique abilities as compared with other doctors;
- (iii) whether the matter was published in a manner likely to attract patients to, or to promote the professional advantage or financial benefit of, the doctor;
- (iv) the motive of the doctor concerned in arranging for or agreeing to publication; and
- (v) in the case of doctors working for or accepting patients from private organisations which advertise, or advertise and provide, clinical, diagnostic, or medical advisory services, whether the doctor has observed the guidance given in Part III of this pamphlet on pages 19 to 21 below.

*(b) Depreciation of other doctors : Canvassing*

The Council also regards as capable of amounting to serious professional misconduct:

- (i) the depreciation by a doctor of the professional skill, knowledge, qualifications or services of another doctor or doctors, and
- (ii) canvassing by a doctor for the purpose of obtaining patients whether the doctor does this directly or through an agent, or is associated with or employed by persons or organisations which canvass.

*(c) Improper arrangements to extend a doctor's practice*

Disciplinary proceedings may also result from other improper arrangements calculated to extend a doctor's practice. These include improper arrangements for the transfer of patients to a doctor's National Health Service list without the knowledge and consent of the patients or in a manner contrary to the National Health Service regulations (which have been agreed by the profession). Arrangements whereby a general practitioner issues National Health Service prescriptions for drugs ordered for a patient by another general practitioner who is treating that patient privately have also been regarded as serious professional misconduct.

## CONCLUSION

### THE NATURE OF SERIOUS PROFESSIONAL MISCONDUCT

As stated on page 9 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 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

Section 5 of the Medical Act 1978 provides that the powers of the Council shall include that of providing in such manner as the Council think 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 and on circumstances in which questions of advertising most commonly arise.

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.

#### **(i) Personal relationships between doctors and patients**

Section (b) on pages 11–12 of this pamphlet, dealing with the abuse by doctors of certain privileges conferred on them by custom, explained why doctors must exercise great care and discretion not to damage the crucial relationship between doctors and patients and identified 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.

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.

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.

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.

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.

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 section (iii) (c) on page 13 above, 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.

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.

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 on page 4 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.

## **(ii) Professional confidence**

The following guidance<sup>1</sup> has been given on the principles which should govern the confidentiality of information relating to patients:

“(i) It is a doctor's duty (except as below) strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third

<sup>1</sup>Quoted from the British Medical Association's booklet *Medical Ethics*, 1974, pages 13–14.

party information which he has learned directly or indirectly in his professional relationship with the patient. The death of the patient does not absolve the doctor from the obligation to maintain secrecy.

(ii) There are some exceptions to this principle: if the doctor is in doubt before making any such exception in disclosing information he should seek advice... The exceptions to the general principle are: (a) the patient or his legal adviser gives valid consent; (b) the information is required by law; (c) the information regarding a patient's health is given in confidence to a relative or other appropriate person, in circumstances where the doctor believes it *undesirable on medical grounds* to seek the patient's consent; (d) rarely, the public interest may persuade the doctor that his duty to the community may override his duty to maintain his patient's confidence; (e) information may be disclosed for the purposes of a medical research project... In such a case the project should have been approved by a recognised Ethical Committee appointed for such a purpose.

(iii) If, in the doctor's opinion, disclosure of confidential information to a third party is 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 so given. If the patient still refuses, then only very exceptionally will the doctor feel entitled to overrule that refusal. Again, if in doubt, he should seek advice.

(iv) A doctor should be prepared to justify his action in disclosing confidential information."

### **(iii) Principles governing the reference of patients to, and their acceptance by, doctors providing specialist services**

#### ***(a) Reference of patients to specialists***

The medical profession in this country has always considered that it is in the best interest 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.

*(b) Acceptance of patients by specialists*

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.

In expressing this view 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.

**(iv) Advertising: Circumstances in which questions of advertising most commonly arise**

Section (iv) (a) on pages 13–14 of the pamphlet sets out the reasons why advertising by doctors is undesirable and may in some cases be regarded as amounting to serious professional misconduct. The following paragraphs discuss various circumstances in which questions of advertising most commonly arise.

*(a) Notices or announcements by doctors*

Advertising may arise from notices or announcements displayed, circulated or made public by a doctor in connection with his own practice if such notices or announcements materially exceed the limits customarily observed by the profession in this country.

*(b) Questions of advertising arising from relationships between doctors and organisations providing clinical, diagnostic, or medical advisory services*

There are in operation at the present time a number of family planning, cosmetic surgery, slimming and vasectomy clinics, health check and screening centres, pregnancy advisory bureaux, private hospitals and nursing homes, including those providing facilities for the termination of pregnancy. Some of these organisations are owned or directed by non-medical persons and regularly advertise their

services to the public in the ordinary course of their business. Others advertise their services only to the medical profession. All doctors connected with such organisations have a duty to seek to ensure that those organisations conform with the principles stated in the following paragraphs. This applies to any doctor who has a financial interest in such an organisation, or is concerned with its management, or is employed by it to perform clinical services. It also applies to a doctor who accepts for examination or treatment patients referred by any such organisation to him or to the organisation by which he is employed.

*(1) Doctors in relationship with organisations which advertise their services to the public*

(a) If a doctor or his or her spouse owns or holds shares in an organisation which advertises diagnostic or clinical services to the public:

- (i) the doctor should not also work for it in a clinical capacity;
- (ii) the doctor should not use or permit the use of his professional qualifications in communications addressed by the organisation to the public as an advertisement for the organisation or be personally involved in advertising its services, for example by public speaking, broadcasting, writing articles or signing circulars.

(b) (i) Doctors who do not own or hold shares in an organisation may manage or direct it, or examine, advise or treat patients on behalf of the organisation, but such doctors must be remunerated on a regular sessional basis and not on a basis related to the number of patients whom the organisation attracts or whom the doctor sees.

(ii) Doctors must also satisfy themselves, before entering into and while maintaining a connection with the organisation, that any advertisements issued by the organisation are factual, do not improperly advertise the personal qualities or services of individual doctors connected with the organisation, and do not make invidious comparisons with the services of other organisations.

(c) Doctors who undertake clinical work for such organisations have a duty to satisfy themselves (1) that patients referred to them have not been attracted by misleading advertisements issued by that organisation or by any counselling centres or other agencies or agents; and (2) that no commission or other payments have been made on behalf of the organisation or doctor for the referral of such patients.

(d) A doctor working for such specialist clinics also has a duty to ensure that every possible step consistent with the patient's wishes is

taken to inform in advance each patient's general practitioner of any treatment or services which he intends to provide, and to give the general practitioner concerned an opportunity to comment and provide details of previous investigations and treatment of which the doctor may be unaware. There is also the duty to keep the general practitioner informed of progress and outcome. If the patient expressly withholds consent for his general practitioner to be so informed, or if the patient has no general practitioner, it is the personal responsibility of the specialist both to ensure that the patient is fit to undergo any surgical or other procedure which he intends to perform and also to undertake or arrange any aftercare which may prove necessary.

*(2) Doctors in relationship with organisations which advertise to the medical profession but not to the public*

(a) A doctor who owns or holds shares in or manages or directs any nursing home, private hospital, clinic or screening service which advertises to the medical profession (but not to the public) has a duty to seek to ensure that the advertisements are sent under sealed cover, are factual, do not advertise the personal qualities or services of individual doctors, and do not make invidious comparisons with the services of other organisations. The same principles should apply to advertisements placed in medical journals.

(b) Doctors who use nursing homes and private hospitals may not accept any commission, payment, or other inducement for the use of such homes or hospitals for their patients, and doctors who manage or direct such homes or hospitals must ensure that none are offered.

*(c) Public references to doctors by other companies or organisations*

Questions of advertising may also arise in regard to reports or notices or notepaper issued by companies or organisations with which a doctor is associated or by which he is employed even if the business of the company or organisation is not connected with medical practice. There can be no objection to showing on the notepaper of a company the name of a doctor who is a director of it, since this is a statutory requirement. But questions of advertising can arise if reports, notices or notepaper issued by a company or organisation draw attention to or mention the professional attainments of the doctor in a way likely to promote his professional advantage. Doctors accordingly should take steps to avoid the publication of such references.

(d) *Questions of advertising arising from articles or books, broadcasting or television appearances by doctors*

Publicity in newspapers or books or on the radio and television, mentioning a practitioner's name, qualifications and appointments or publications, has frequently attracted uninformed criticism of the doctors concerned, but in most instances has appeared on examination to be harmless. The Council agrees that "professional men may be amply justified in publishing books and articles and in publishing them in their own names"<sup>1</sup> and that "The public has a legitimate interest in the advances made in the science and art of medicine", and that "medical practitioners who possess the necessary knowledge and talent may properly participate in the presentation and discussion of medical or semi-medical topics"<sup>2</sup> in newspapers or on radio and television. The Council also agrees that readers, listeners and viewers are entitled to be given information as to the professional standing of a doctor who writes a book or article or gives a talk, provided that this information is not given in a way which implies that he is the only or the best person practising in his particular field. There can be no objection to mentioning in the relevant context a doctor's name, his current appointment and whichever qualification held by him is most relevant to his particular interest. References to other publications by the doctor, whether forthcoming or past, should be factual, and not presented in a way which suggests that he is the only authority in a particular area and more experienced than other specialists in this field.

The episodes in this area which raise a substantial question of advertising usually arise either from *matter included* in talks given, or in articles or books written, by doctors, or from matter included in material introducing, accompanying or advertising a talk, article or book where the matter "directs attention to the personal and unique performances and abilities of the writer"<sup>1</sup> or speaker. Moreover "There is a clear distinction to be made between discussions solely of general principles of medicine, where no objection would be made to the naming of the doctor involved, and those discussions which result in any particular reference by that named doctor to the way in which he approached clinical problems.... Anonymity is particularly important in circumstances where the doctor refers to his personal management of individual clinical matters."<sup>2</sup>

<sup>1</sup> Quoted from a judgment of the Judicial Committee of the Privy Council on an appeal by L. E. Gardiner in 1960.

<sup>2</sup> Quoted from the British Medical Association's booklet *Medical Ethics*, 1974, page 39.

Particular problems arise in relation to the few doctors in clinical practice who *regularly write*, in magazines or journals addressed to the lay public, articles or columns which offer advice on common medical conditions or problems, or who are involved in a *regular series* of television or radio programmes dealing with such matters. Such doctors would be well advised to remain anonymous, and it should be stated explicitly that they cannot offer individual advice or see patients as a result of the articles.

(e) *Signposts or noticeboards relating to health centres or medical centres: Choice of titles for such centres or for group practices*

Paragraph (iv) (a) on page 19 above says that "Advertising may arise from notices or announcements displayed, circulated or made public by a doctor in connection with his own practice, if such notices or announcements materially exceed the limits customarily observed by the profession in this country." The customary limits are well established in relation to door plates used by individual practitioners although the acceptable limits vary in different areas and parts of the country according to local circumstances. Questions however have from time to time been raised as to what is acceptable in relation to medical centres provided by group practices or to health centres provided by Area Health Authorities (or, in Scotland, Health Boards): and indeed such authorities have on occasion sought to erect signs without consulting the doctors who will use the centre.

The Council accepts that it is important that the public should be informed of the location of such premises and that no objection should be made to signs which are necessary for this purpose. In choosing the wording and size of such notices considerations applying generally to professional doorplates should be borne in mind: in this connection the Council endorses the view that doorplates "should be unostentatious in size and form."<sup>1</sup> In deciding what is acceptable it is also necessary to take into account the nature of the area. What may be necessary to indicate the position of premises in large towns could be unsuitable and unnecessary for doctors practising in small villages. It is desirable that no notices or signposts should be larger or repeated more frequently than is necessary to indicate to patients the location of the premises in question. Notices or signposts should not be used to draw public attention to the services of one practice at the expense of others.

In selecting a name for a health centre or a medical centre or indeed a collective title for a group or partnership it is desirable to avoid a name which could be interpreted as implying that the services provided in that centre or by that partnership have received some official recognition not

<sup>1</sup> Quoted from the British Medical Association's booklet *Medical Ethics*, 1974, page 22.

extended to other local doctors. For this reason terms such as “Medical Centre” or “Health Centre” should not be used in a manner which might imply that doctors using the centre or practising in the partnership enjoy some special status in a particular place or area.

#### PART IV

### FITNESS TO PRACTISE: PROCEDURES ASSOCIATED WITH THE HEALTH COMMITTEE

Provisions of the Medical Act 1978, which came into force on 1st August, 1980, 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. The Act required 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 have eventually to be referred. The rules, which were made after consultation with professional bodies and are approved by the Privy Council, are the Health Committee (Procedure) Rules, published as Statutory Instrument 1980 No. 859.

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 others 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.

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 usually 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.

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.

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, 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.

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 the doctor whose case is being considered. The Health Committee may if it thinks fit either adjourn consideration of a case or, if it finds that a doctor's fitness to practise is seriously impaired, 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.

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

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