Ethical and Legal Obligations of the Medical Profession*

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It is only too easy for doctors to feel tied, fettered, and menaced by the obligations that the ethical code and the law impose on them. It is all the more important, therefore, to be clear that the ethical code is the expression of our essential relationship to our patients and to our colleagues, and that the legal impositions relate us in our specially privileged position as doctors to society as a whole. If we can look on both these groups of carefully formulated obligations as an expression of these relationships and as safeguards against the hazards that exist both to the public and to ourselves within the profession then we can more easily have a positive and constructive approach to them rather than a feeling of limitation, frustration, and indignation.

There are two further groups of regulations that control us in addition to our ethical code and the Medical Acts. The first is incorporated in the National Health Service Acts and concerns our work within the Service: these regulations are listed in the terms and conditions of our contracts as general practitioners with the executive councils in whose areas we practise. The contracts are with hospital management committees for junior hospital staff and those general practitioners who work on a sessional basis, and with regional hospital boards for senior registrars upwards. Local authority terms of employment for doctors are on a somewhat different footing. Second, like other citizens, we are subject to the Common Law for torts, misdemeanours, crimes, and the rest of it, with the added liability that claims may be made against us for professional negligence. It is doubtful whether any other profession is so hedged about in this way, and the small number of cases brought against us in relation to the large number of practising doctors and the millions of patients seen is the most remarkable aspect of it all. Fortunately the very great majority of us do survive to retirement without foundering on ethical or legal reefs.

Interest of Patient

In the title of this talk ethical obligations come first. This is surely right, for the whole basis of satisfactory medical work in practice is based on good ethical personal relations. For these to be seen in perspective the interests of the patient must be recognized as the first consideration. Hippocrates put this ideal into words five centuries before Christ. Other philosophers such as Maimonides modified but never improved on the first wording of the oath, which is still held to to-day and sworn to on graduation by doctors at Edinburgh University, among others. Since the end of the last war the World Medical Association (formed largely by the initiative of the British Medical Association) has framed an international code of ethics in words that are more suited to the modern world, but no more clear and cogent than the original example drawn up in the 5th century B.C.

Fundamentally there must be mutual respect and confidence between every doctor and his patient. The patient expects from his doctors professional skill, human understanding, and absolute confidentiality in all their dealings.

Onus of Confidentiality

This confidentiality is fundamental, even though under certain special circumstances it has to be broken. I personally have always refused to discuss the concerns of daughters over 21 with their mothers, wives with husbands, and vice versa, without the patient's knowledge and permission; this sometimes causes surprise. Incidentally this permission is very rarely withheld, though suspicion and antagonism between all the three parties concerned can breed and grow if this simple rule is ignored. The imparting of important information to a relative is somewhat different. At times the patient's mental or physical condition is such that a responsible person must be informed without the sufferer's permission. The onus of confidentiality then transfers to the relative or friend as well.

All notifications of disease break this confidence and should therefore be mentioned to the person suffering from the notifiable disease or condition. Reports to employers or those concerning insurance or legal claims break confidence unless the patient is informed and agrees. In the case of those recently deceased information about their past history should not be disclosed without the consent of the nearest relative. As far as possible, even when the patient has given his consent, information should be passed only to another doctor, such as an industrial medical officer. Courts of law can oblige doctors to divulge confidential information. If the doctor's claim to exemption on the grounds of special privilege is made but refused he has to decide whether to yield to this compulsion or face a sentence for contempt of court.

The increased hazards to the doctor that may arise from reference to mental illness of all kinds must always be remembered, especially since 1959. In fact, reticence by psychiatrists can make the family doctor's responsibility very arduous. A special example of this is found in the treatment of a case of established drug addiction. Special risks can follow the victim's determination and ingenuity in obtaining supplies of the drug in question from many sources. I believe that the only solution is to inform him that you will treat him only if he agrees to your reporting his case to the Home Office. I have never known this consent refused, and on occasion secret attendance on other doctors, in addition to my partners or myself, has been more quickly detected because of this precaution.

A very difficult issue arises when the doctor has information strongly suggesting that an individual is unfit for the work he does because of a risk to the public—for example, a bus driver subject to occasional epileptic fits. Here persuasion may fail to achieve the patient's consent. The only solution may be that the doctor informs the man or woman that he feels under an obligation to pass on the essential information to the appropriate

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body or person—preferably to another medical practitioner on the staff of the employing body. This is an ugly dilemma.

Ethics and Colleagues

Ethical relations with colleagues are ultimately related to the public interest. A struggle to secure patients, whether overt or concealed, from neighbouring colleagues is the most obvious one. This ethical code covers all the perplexing situations that arise when a patient goes direct to a doctor other than his own. Every man or woman is free to do this, of course, but the onus is on the doctor consulted to make sure that no other practitioner is already involved in the case and treating the patient, and to make contact with the first doctor after telling the patient he must do so. This protects the patient from the serious confusion and harm that can follow multiple treatment—a development that can be observed in other countries where this convention has faded out. Communication between doctors whatever their line of work, whether they are engaged in the follow-up of patients, as consultants, or as industrial medical officers, must all turn on this vital ethical relationship. To save time, paper, and ink a certain easy agreement has been reached over minor overlap at work—such as eye-testing on schoolchildren and so on—but the principle remains. It should be remembered especially when deputizing for a colleague; any resultant change of medical loyalty by the patient must be discussed between the doctors concerned and agreed to. Emergencies invoke a special need for consideration between doctors. The doctor called into the home in an emergency, or a houseman in a casualty department or admission ward, can so easily murmur almost unconsciously that things have been left too late or unsuitable treatment prescribed. Though this may well be true, it is an assumption that can be quite uncalled for without fuller knowledge of the circumstances. It always adds to the relatives' and patients' distress, and can be disturbingly unfair to good medical relationships. Here as in all complex situations adequate communication between doctors, written as well as spoken, proper explanations to the patient and his family, and properly kept records can do almost everything to prevent such unhappiness, or to remedy it, or at the least to preserve the professional confidence between the doctors when the situation does break down. Tolerance and good will are better than pages of rules, and tolerance between colleagues is the more necessary because most of us all too often work under severe stress and pressure.

Settling near Previous Practice

The behaviour of a doctor when planning to settle near the practice centre of his previous principal or partner should be based on the same considerations. The complaints that reach the Central Ethical Committee of the B.M.A. are very often about this kind of situation. A well-drawn-up and reasonable agreement that is known and adhered to is the best way of avoiding such unhappy issues. There are cases of hardship on either side, undoubtedly, but to base the general relationship between colleagues on hard cases would be the worse for us all. What is legal can well be unethical and still a cause for unhappy conflict.

There are many other aspects of proper ethical relationships between doctors of all generations, of every status, and in all lines of work—including those involved in the process of setting-up in practice by family doctors, notification by consultants of availability for private consultation, the relationship in domiciliary consultations, and many more. They are well set out in the Association's *Members Handbook* in a clear and readily readable form.

The discreet behaviour and dignity of a practising doctor is related to sound professional relationships and to the respect

of the public for doctors as a whole. Publicity is occasionally unavoidable, but the repeated appearance of a doctor's name in the national or local press, too many records of his attendance at functions of one kind or another, added perhaps to the size of his door-plate or various enterprises that bring him excessively to public notice, can all be avoided if the practitioner so wishes, and are somewhat suspect when he takes no steps to do so.

General Medical Council

Any persistent and excessive publicity of an individual doctor, or anything suspiciously like advertising or canvassing, brings us to the legal responsibilities of the General Medical Council. This was formed in 1858 by the Medical Acts, themselves the climax of 25 years of very hard work by the British Medical Association. Until that date education in medicine was variable indeed and with little control of standards. Treatment by unqualified persons was far more general, and in the eyes of the law quacks were on equal terms with trained doctors. There was often unprofessional behaviour by doctors that did not come within the Common Law. Hence the functions of the Council as carried out to-day. Its only sanction in disciplinary matters is the erasure of a doctor's name from the *Medical Register*. A doctor whose name has been struck off the *Register* can still treat patients, as any other unregistered person may. With certain exceptions, freedom to give and receive treatment is absolute in this country. However, since erasure removes a doctor's right to sign certain statutory certificates, including death certificates, it automatically removes his right to be involved with the death of a patient without the risk of indictment for manslaughter or murder. Should death supervene as a result of treatment, the therapist, whether wholly untrained or a one-time registered medical practitioner, runs the risk of being involved in a criminal suit.

The name of a fully or provisionally registered practitioner automatically comes before the disciplinary committee when he has been convicted in any court of the United Kingdom or Northern Ireland of a felony, misdemeanour, crime, or offence. Erasure in these cases is not automatic, and in lesser misdemeanours is enforced only after repeated convictions.

Infamous Conduct

The disciplinary committee also judges (after due inquiry) cases of doctors found guilty of infamous conduct in a professional respect. Action can only be initiated in this group of cases if a complaint is laid before the penal cases committee by an individual person. Adultery and improper conduct with a patient of the doctor concerned, advertising, canvassing, untrue and misleading information on statutory certificates, and what is loosely called covering of unqualified practitioners are all included in this group. In addition, carelessness about the control and safe-keeping of dangerous drugs, commercialization of secret remedies, addiction to alcohol or drugs, serious neglect of professional duties, or improperly obtaining or seeking payments from any source are all subject to the General Medical Council's control through the penal and disciplinary committee's procedure. Warning, or probation, or erasure are now usually followed by restoration after an interval of years.

These matters of control have all developed because of the chaotic and unsatisfactory conditions of the practice and malpractice of medicine that existed in the first half of the nineteenth century. It is sometimes said that the practice of the Council is out of step with present-day conditions. Nevertheless, the amount of disciplinary work that is carried out even now (often tempered by probation in order to give the erring doctor a chance to make good) reveals that the

wicked could perhaps flourish as the green bay tree if the Council's power of erasure did not exist.

The most controversial aspect of its work is probably the problem of personal publicity that has been precipitated by television programmes and the public's insatiable appetite for semi-medical programmes and articles in the popular press. If seen, it is argued, why not named? And if some details of work and position can be added to a doctor's name where does the forbidden publicity begin?

Who Deals with Complaints?

Statutory powers of inquiry are also conferred by the National Health Service Acts. So far as general practitioners are concerned a patient or the patient's relatives or friends can complain to the executive council in whose area his doctor practises. Complaints about failure to diagnose correctly, or about his clinical competence, do not belong to this group at all, but come under the routine processes of Common Law. It has to be remembered that because the country as a whole pays for the service each individual has the right to complain.

Complaints made within the Health Service are those referring to inadequate provision or inadequate attempts to secure treatment, failure to visit when requested to do so, refusal to give emergency treatment when a patient's own doctor is not available, irregularities in certification, and the doctor's failure to maintain personal responsibility for patients on his list by his own or his deputy's availability. Failure to visit on request is a special problem. A medical service committee exists in each executive council area, made up of six members, three professional and three lay, with a chairman and deputy chairman. The informal proceedings without legal representation of either side make these bodies into courts of informal inquiry—even of reconciliation in many cases. A large number of complaints are without justification and are dismissed without a hearing. They may be based on misunderstanding, on unhappiness in anxiety and bereavement, on mental instability, or occasionally on sheer unpleasantness. The sanctions that may be enforced are warnings to the doctor of varying degrees of severity, the withholding of part of his remuneration, and, in rare and very serious cases, referral of the complaint to the national tribunal that exists for the purpose. In the Hospital Service section of the N.H.S. complaints by patients are usually heard by an *ad hoc* committee within the hospital management committee or regional hospital board on the basis that responsibility for dealing with any difficulty lies with the hospital concerned.

It is obvious that occasionally a complaint can be made both to a medical service committee and also to the civil courts or to the General Medical Council—or conceivably to all three. In every case the right of appeal exists for both parties and in the medical service cases this amounts to a rehearing of the complaint and the defence by the doctor.

Lastly, there are the risks to a doctor in those cases that are brought against him in the civil courts. We are all exposed to this hazard from the first day of our first job as a junior house-officer. The risk is often thought to be greater to-day because legal aid is now available to those who could not otherwise meet the cost of lawyers' fees and all the expense concerned. It is worth remembering, however, that an applicant for legal aid has to show that the suit that he wishes to bring has some reasonable justification.

Doctors' Safeguards

Now how can a doctor feel any sense of security in this professional life so surrounded by the menace of complaints

and legal proceedings? Mercifully help is available in various ways, and to a very great extent from his own attitude and his own habits. It is not always easy to be clear that a patient's body is his own property (a basic concept in our law) as well as his own responsibility. Hence his touchiness about so many matters that doctors must be concerned with on his behalf. Courtesy of approach, a few extra words of explanation to him and to desperately anxious relatives, careful obtaining of consent for procedures that would rank as assaults outside the medical field, and a word of sympathetic understanding in the process—these things all help. We are all due to die, but few of us expect this even when ill!

Next, records: clear even if brief, and written down at, or very close to, the time. Clear records are the doctor's surest defence in any difficulty that arises from misunderstanding. Then, careful and sufficient communications of every kind; these should, whenever possible, be written as well as verbal, and be sent to the right person in the right place. It is in emergency situations that communications are most essential and most easily break down—for example, deputizing without giving complete information to the principal after an emergency visit. The transfer of a patient from home to hospital, from one hospital to another, and to home on discharge, and investigations and surgical interferences all demand adequate and, above all, immediate communications between doctors. Let it be remembered that communications between doctors and patients are often not only inadequate but require translation into colloquial terms. Unexpected risks and liabilities can arise however much care we take in these ways, but at least we can then show that we did all in our power to prevent foreseeable—and, as far as possible, unforeseeable—catastrophes.

Doctors' Defenders

Then there exist for the help of every member of the profession the medical defence societies—one in Scotland and two in the South, the Medical Defence Union and the Medical Protection Society. For a very small sum yearly we can receive advice and unlimited protection in courts of law, with legal representation when a situation could be hazardous as at an inquest. Provided that we do not start mucking about with our own defence and employing our own solicitors before turning for help to the professional associations, the help available is most generous at every point in our difficulties. I have served for nearly 20 years on the council of one of these three societies and my admiration for them is boundless. The definite decision to settle an indefensible case out of court, but when possible to fight a case where a principle is at stake whatever the risks of failure, supports the doctor client at all stages in his defence. The care taken in obtaining all relevant evidence and the best possible expert opinions never ceases to impress me. Above all to feel that it is possible to talk with a member of the medical secretariat when the first doubt arises, so as to avoid a false step, is the greatest comfort in any medical work relating to sick people.

In all ethical matters it is the British Medical Association through its Divisions and Branches, with their local ethical committees, and the Central Ethical Committee at Headquarters, which exists to guide and advise, and, when the painful necessity arises, to hear cases of serious difficulty between doctors. The Association's *Handbook* gives information about all these activities, and there is also a small folding card summarizing information about notifications, Mental Health Act procedure, and relations with coroners that is drawn up by the Medical Protection Society.

Finally, it is worth remembering that we inevitably run daily risks of misunderstanding between our colleagues, our patients, and ourselves, any of which could be very serious, but by good luck added to good management we do seem to survive.