Guidelines from the American Medical Association recommend that doctors should routinely ask all women direct questions about abuse.¹³ The need for this stems largely from the absence of specific indicators of violence that could be useful in a clinical setting.¹⁴ In addition, many women do not spontaneously disclose that they are being battered, and doctors may feel inhibited about asking. When a protocol for detecting injuries caused by battering was introduced in an emergency department in the United States the identification of battered women among women presenting with trauma rose from 6% to 30%.¹⁵ The Joint Commission on the Accreditation of Healthcare Organisations now requires all emergency and ambulatory care services in the United States to adopt written policies and procedures relating to adult victims of abuse.¹⁶ Healthcare guidelines exist in Britain, such as those published by the Royal College of General Practitioners¹⁷ and unpublished guidelines from the British Association of Accident and Emergency Medicine, but they require implementation.

The recent re-emergence of domestic violence into the public domain should provoke action in the health service. Purchasers have a key role in ensuring that providers implement guidelines for identifying and caring for victims of domestic violence. A Home Office circular on interagency working promotes further development of domestic violence forums, although it does not offer any new resources.¹⁸ But guidelines alone are not enough. A comprehensive document produced by the Department of Health and Social Services and Northern Ireland Office¹⁹ sets out four aims in tackling domestic violence: to heighten awareness of domestic violence, highlighting domestic assault as a crime; to improve services for victims; to challenge perpetrators' attitudes and behaviour; and to improve the information base. Doctors and other

health care professionals must contribute to each of these aims.

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Only doing my duty?

The GMC's new guidance on doctors' professional and ethical duties

See p972

This week, the General Medical Council publishes its guidance to doctors on their professional duties.¹ Previously, doctors seeking clarification about ethical dilemmas would have turned to the Council's "Blue Book";² a thin volume from which it was sometimes difficult to extract user-friendly information. This may have contributed to a perception of the General Medical Council as a grim institution filled with medical grandees handing out discipline like a Victorian grandparent.

The "Blue Book" placed little emphasis on relationships in health care and seemed to make ethical dilemmas somewhat peripheral to good practice. By contrast, in *Duties of a Doctor* good relationships with patients and observance of ethical obligations become essential elements of medical practice. This is an important development; by putting ethics and the doctor patient relationship at the heart of good practice, a doctor cannot act professionally if also simultaneously acting unethically. Professional relations between colleagues also receive special attention. Most doctors will already know that they are now duty bound to report colleagues who appear to be practising incompetently. For the first time too, there is express statement forbidding discrimination against each other on any grounds, including ethnicity and sex.

Instead of a list of possible "offences" and criteria for

"fitness to practise" the new guidance emphasises care and "duties." The new guidance states that doctors should make the "care of [your] patient your first concern." Professional competence is obviously an essential of good practice, as is the need to maintain that competence, but what might be called the "technoclinical" sphere of health care is recognised as being only one dimension of good practice. Experienced (and wiser) doctors, nurses and patients have always known this, but to have it formally emphasised in a document of this kind is most welcome.

In fact the document is rather less formal than its predecessor. It comes as four booklets: one a general statement about professional duties; the other three dealing with confidentiality, HIV/AIDS, and advertising. Its tone is direct, addressing the doctor as "you"; the layout is easier to read, making the messages clearer, although a summary page at the end of each booklet would have been as helpful as the index supplied.

The document provides ethical guidance based on core principles, and not a code of ethics. There are therefore gaps in the coverage of many common ethical dilemmas. For example, a difficulty faced by all doctors is the scope of their duties to third parties. The issue of confidentiality is covered to some extent but there are other aspects to be addressed. Different types of doctor-patient relationships give rise to

different ethical duties or at least a different emphasis. In the regulation of expert witness testimony, for example, there are many different types of doctor-patient relationship. Apart from the general principle of acting competently (often highly questionable in the civil courts), it is hard to see how the guidance has much application to a sphere of medical work which appears to be expanding with great rapidity.

Curiously, unlike the Blue Book the new guidance gives no information about the disciplinary process. If one of the aims of the document is to make doctors better acquainted with their professional duties, it would seem reasonable to outline what happens if doctors do not fulfil those duties. Most doctors are convinced that they will be struck off for any ethical lapse, when in fact only a small minority of complaints ever reaches the council's professional conduct committee. Perhaps the next edition could include a half page outline (or a flow chart)?

No document of this sort could be perfect. The Blue Book needed an overhaul; over the last five years complaints about

medical care have increased enormously.^{3,5} Even if some of this increase is only a temporary phenomenon in response to the Patient's Charter, such increases suggest that patients have something to complain about. Patients have a strong interest in the ethical aspects of good medical practice; doctors should not wait to become patients to take the same interest. This description of their ethical professional duties is a good start to a process which will need to continue.

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Hospital jobs on the Internet

Your next job is waiting for you at <http://www.bmj.com/bmj/>

Older readers of the journal turn first to the obituary pages to check whether they are still alive; younger readers turn to the classified supplements to find their next job. While the obituary pages have been discussed at the highest levels (two editorials,^{1,2} a "how to do it,"³ and 10 letters to the editor having been published on the topic already this year⁴), the classified supplements have been quietly minding their own business, which has been expanding apace. This year the hospital doctor and general practice supplements will carry about 60 000 recruitment advertisements and 2500 advertisements for educational courses.

From this week, in response to readers' requests, we are adding all hospital jobs to the information that is available from the *BMJ's* site on the Internet.⁵ A menu lists the various medical and surgical specialties and, within each specialty, jobs at each grade. Vacancies for registrars in, say, orthopaedic surgery are merely four mouse clicks away from the *BMJ's* home page. At this stage the advertisements that will appear will be the same as those in the weekly journal and will be updated each week by the day of publication of the paper copy of the journal.

We hope to augment this basic service by adding general practice posts (once we have solved the technical problems of breaking up the GP classification into usable sections) and posts in academic and public health medicine. We envisage providing the BMA's guidelines on grades, salaries, training, removal expenses, and overseas employment. Extracts from

our "how to do it" series (such as how to prepare a curriculum vitae and how to be interviewed⁶) could also be included. We hope that readers will suggest other ways in which the service should develop (as they have done with the editorial content of our home pages).

Speed will be one of the greatest benefits of advertising jobs on the Internet, allowing overseas readers to read job advertisements before the closing date for applications. We hope that very soon electronic delivery will allow us to publish the electronic supplement earlier in the week—a huge advance for readers and advertisers alike.

We are aware that many readers remain mystified by talk of home pages and the like. Detailed guidance is already available from the recent article in the ABC of Medical Computing devoted to the Internet,⁷ and next month we begin a short series devoted to the topic. A regular column will follow.

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