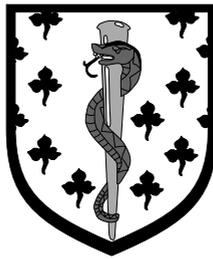


A Guide to Ethical Conduct and Behaviour



SIXTH EDITION 2004

A Guide to Ethical Conduct and Behaviour



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Introduction to the Sixth Edition of the Ethical Guide

This edition of the Ethical Guidelines continues key traditions of previous editions and introduces important new topics of real relevance to both doctors and members of the public in Ireland. As previously, the guide is fundamentally a set of ethical principles which doctors must apply to the clinical situations in which they work.

Such a strategy reinforces independence of clinical judgment and the key role of clinical reasoning in the work of doctors. It also places heavy responsibilities on those doctors to take into account a wide number of issues in providing care to patients.

Ethical principles are the very foundation of our role as doctors – the potential for damage to the bond of trust between doctor and a patient is very great and damage will occur if the ethical basis for practice is neglected. It is of great concern that since the last edition of these guidelines was published, much evidence has come to light both in Ireland and abroad of the harm done by doctors who do not put ethical practice at the heart of their work. The profession must respond to these tragedies by redoubling its commitment to the ethical purposes of medicine.

This edition benefits from the more straightforward presentation of certain guidelines which have repeatedly appeared in previous editions. It also contains important new guidelines – these include guidance to doctors about the competence of colleagues, guidance on acceptable financial support from the pharmaceutical and allied industries and an important addition to the guidance on IVE, allowing donation of embryos in defined circumstances.

The pace of scientific and technological change in medicine is increasing rapidly and will require new ethical guidelines in the near future. This edition introduces new regulatory mechanisms for information and communications technology in medicine but does not deal in any depth with emerging biotechnology issues. Such issues will require the medical profession and the society in which it works to come together to explore ethical values, scientific information and the expectations and limitations which they establish.

This edition has benefited from the contributions of many, both within and outside medicine. The Medical Council is grateful to all for their contributions.

Professor Gerard Bury
President

Ethical Conduct And Behaviour

“It shall be a function of the Council
to give guidance to the medical profession generally
on
all matters relating to ethical conduct and behaviour.”

Medical Practitioners Act, 1978, Section 69 (2).

SECTION A

Conduct and Behaviour

1.1 Tradition

The profession of medicine has a long and honourable tradition of service and care. Society allows doctors many privileges and it is the responsibility of doctors not to abuse these.

1.2 Ethical Conduct

In giving guidance to the medical profession about questions of ethical conduct, it is not the intention of the Council to issue a Code, but to provide a Guide by which the individual members of the profession may judge particular situations. The Council does not consider it appropriate to compile a detailed catalogue of exactly how doctors should behave in every circumstance.

1.3 Independence of Judgment

Medical care must not be used as a tool of the State, to be granted or withheld or altered in character under political pressure. Doctors require independence from such pressures in order to carry out their duties. Regardless of their type of practice the responsibility of all doctors is to help the sick and injured. They must practise without consideration of religion, nationality, gender, race, ethnicity, age, politics, socio-economic grouping or patient disability. They must not allow their professional actions to be influenced by any personal interest.

1.4 Trust and Privilege

The position of trust and privilege held by doctors in the community is founded not only on technical knowledge and skill, but also on high standards of personal and professional behaviour at all times. It is the statutory duty of the Council to investigate complaints about alleged lapses from such standards.

1.5 Professional Misconduct

Professional misconduct is:

- (a) Conduct which doctors of experience, competence and good repute consider disgraceful or dishonourable; and / or
- (b) Conduct connected with his or her profession in which the doctor concerned has seriously fallen short by omission or commission of the standards of conduct expected among doctors.

1.6 Court Convictions

Convictions in a court of criminal jurisdiction of any registered medical practitioner are notified to the Council which will investigate the circumstances involved. A doctor may not be able to avoid an inquiry by claiming that he/she was not on duty at the time of the alleged offence.

1.7 Withdrawal of Services

If doctors decide to participate in an organised collective or individual withdrawal of services, they are not released from their ethical responsibilities to patients. They must guarantee emergency services and also such care as may be required for those for whom they hold clinical responsibility.

SECTION B

Doctors and Patients

2.1 Responsibility to Patients

Doctors must do their best to preserve life and promote health. Once they undertake the care of patients they should ordinarily provide continuity of care for the duration of the illness. If they wish to withdraw their services, they must inform the patient and allow sufficient time for alternative medical care to be sought, during which clinical continuity must be maintained. They should also provide medical information, normally with the patient's knowledge and agreement, to another member of the profession when requested.

2.2 Patients with Disabilities

Patients with disabilities are entitled to the same treatment options and respect for autonomy as any other patient. Disability does not necessarily mean lack of capacity. Advances in technological, environmental and philosophical supports mean that people of any level of disability may live fulfilling lives. Any decision on intervention/non-intervention in the case of a person with a disability requires his or her consent. If a person with a disability lacks the capacity to give consent, a wide-ranging consultation involving parents/guardians and appropriate carers should occur. Where necessary, a second opinion should be considered before decisions on complex issues are made.

2.3 Emergencies

Doctors should provide care in emergencies unless they are satisfied that alternative arrangements have been made. They should also consider what assistance they can give in the event of a major incident, a road traffic accident, fire, drowning or other similar occurrences.

2.4 Communicable Diseases

Acceptance of the risk of treating patients with communicable diseases is a time-honoured tradition of the medical profession. Failure to do this may be unethical.

2.5 Moral Disapproval

Treatment must never be refused on grounds of moral disapproval of the patient's behaviour.

2.6 Conscientious Objection

If a doctor has a conscientious objection to a course of action this should be explained and the names of other doctors made available to the patient.

2.7 Differing Skills

If a doctor considers that he/she does not have the professional skills or necessary facilities to undertake management, the patient should be referred to an appropriate colleague.

2.8 Prisoners

Prisoners must be treated with courtesy and respect and afforded confidentiality but with due regard for security. However, doctors have a right to take appropriate precautions if they think there is a risk to themselves. The Council supports the 1975 Declaration of Tokyo issued by the World Medical Association concerning torture and other cruel, inhuman and degrading punishments (see Appendix B).

Doctors should not assist in judicial execution.

2.9 Disagreements with Patients

If a patient and a doctor consider that there is an insoluble disagreement between them, an arrangement to help the patient to transfer to another doctor may be the best way of dealing with the matter, subject to continuity of care (see paragraph 2.1).

Behaviour towards Patients

3.1 Identification

Doctors should identify themselves to their patients.

3.2 Dignity of the Patient

Patients must always be treated with dignity and respect. Rude and insensitive behaviour towards patients or their relatives is unacceptable.

3.3 Information for Patients

A request for information from a patient always requires a positive response. In general, doctors should ensure that a patient and family members, subject to patient consent, are as fully informed as possible about matters relating to an illness.

Patients do not always fully understand the information and advice given to them by doctors. They should be encouraged to ask questions. These should be answered carefully in non-technical terms with or without information leaflets. The aim is to promote understanding and compliance with recommended therapy. The doctor should keep a note of such explanation and if it is felt that the patient still does not understand, it may be advisable to ask the patient's permission to speak to a relative.

3.4 Maternity Care

Doctors who agree to undertake antenatal and obstetric care should keep the patient informed about the arrangements for delivery.

3.5 Procedures/Treatment

Patients undergoing procedures or treatment of any sort have the right to be informed as to which doctor or doctors are to be involved.

3.6 Fees

Doctors' fees should be appropriate to the service provided. Patients should be informed in advance of the consultation and treatment what the costs are likely to be.

3.7 A Second Opinion

Patients are entitled to a second or further medical opinion about their illness. Doctors must either initiate or facilitate a request for this and provide the information necessary for an appropriate referral.

3.8 Physical Examination

Physical examinations should be conducted in the context of a thorough assessment of the patient, including relevant history-taking. Doctors should normally ask permission from a patient before making a physical examination. In the case of minors, the child's parent/guardian should be present or should give permission for the examination.

3.9 Intimate Examination

Any intimate examination should be accompanied by an explanation. The patient, irrespective of age or gender, should be offered a chaperone.

3.10 Communication with Patients

Many complaints to the Council refer to lack of communication, or discourtesy, on the part of the doctor. Where differences have arisen between the doctor and the patient or the patient's relatives there is much to be gained and rarely anything to be lost by the expression of regret by the doctor. Doctors may have been inhibited by feeling that any such expression would amount to an admission of liability; this is not necessarily so.

3.11 Personal Relationships

A doctor's professional position must never be used to pursue a relationship of an emotional, sexual or exploitative nature with a patient, the patient's spouse, or a near relative of a patient.

The practice of medicine involves a complex affinity between doctors and their patients with the latter sometimes becoming emotionally dependent. Doctors should be aware of this and are urged to take special care and prudence in circumstances that could leave them open to an allegation of abuse of their position.

SECTION C

Professional Responsibilities

4.1 Denigration of a Colleague

Doctors should give professional support to each other. Denigration of a colleague is never in the interest of patients and is to be avoided. When disputes arise, they should be settled as speedily as possible and without undue publicity. Differences about clinical management are best aired without rancour in the appropriate settings.

4.2 A Colleague's Practice

Doctors must not deliberately damage the practice of colleagues.

4.3 A Colleague's Conduct and Competence

Where risk to a patient exists in relation to a colleague's conduct or competence, doctors should express their concern initially to the colleague concerned and advise remedial action. Where local systems of support or remediation are available they should be availed of as the next step. Should the colleague's response be unsatisfactory, then the doctor should refer the matter to the Medical Council.

4.4 Consultation and Co-Operation

Doctors should not hesitate to consult, in the patient's interest, with other doctors and to co-operate, where necessary, with other health-care professionals. However, they have a duty to satisfy themselves that those to whom they refer patients are competent.

4.5 Complementary Medicine

Complementary medicine should only be used where there is evidence that it will benefit the patient. Doctors who practise or refer patients for complementary medicine must be aware of the efficacy and potential side effects of those treatments and advise patients accordingly.

4.6 Junior Colleagues and Trainees

The Medical Council considers that doctors have a personal and professional responsibility towards junior colleagues, medical students and other

healthcare workers. They should assist and advise doctors in training on the development of correct professional values, and the courtesies, attitudes and behaviour required when dealing with others.

Junior doctors should never be asked to perform tasks for which they are not fully competent except under the direct supervision of senior colleagues who can take over should difficulty be encountered. Senior staff must always be willing to undertake troublesome or unpleasant tasks rather than instructing juniors to do so. Delegation of duties to doctors in training of whatever level does not obviate the responsibility of the trainer for the actions taken.

Doctors are reminded that they have a responsibility to treat all health care workers, including healthcare students, with dignity and respect.

4.7 References

When references are requested about colleagues, honesty and fairness are essential.

4.8 Clinical Commitments

Doctors who accept contractual appointments or commitments with public bodies, the boards of voluntary hospitals or other medical and teaching institutions have a duty to fulfil these. If they find that they cannot do so they should ask to be relieved of them.

The Medical Council will take a grave view should such commitments be delegated on a regular basis, especially to someone of junior status.

4.9 Accepting Posts

A doctor, having formally accepted any post, including a locum post, must not then withdraw without due cause unless the employer will have time to make other arrangements to ensure that patient care is not compromised.

4.10 Medical Records

It is in the interest of both doctors and patients that accurate records are always kept. These should be retained for an adequate period (this may be for periods in excess of 21 years) and eventual disposal may be subject to advice from legal and insurance bodies.

Patients are entitled to receive a copy of their own medical records, provided it does not put their health (or the health of others) at risk.

Doctors are reminded of their responsibility in advising administrative authorities of the importance of medical records being stored in such a manner that ensures confidentiality, security and ready accessibility for clinical staff when required for patient management.

4.11 Continuing Medical Education and Competence Assurance

Doctors must maintain their competence. This is best achieved by taking part in Continuing Medical Education, Continuing Professional Development, peer review and audit. The Council regards the maintenance of up to date knowledge and competence as a professional responsibility for every doctor.

4.12 Healthcare Resources

Funds for healthcare are limited. A decision to spend money in one area may involve not having it available in another. The Council considers that doctors have a place in helping to ensure the efficient and effective use of resources and in giving advice on their allocation.

Lack of facilities does not excuse failure to help patients. Doctors have an obligation to point out deficiencies to the appropriate authorities and should not yield to pressures for cost savings if it means acting against the interests of patients.

4.13 Drug Trials

Drug trials must conform to the Declaration of Helsinki. Trials must be managed well, data must be collected accurately and doctors appropriately remunerated. Doctors are reminded that data collection represents participation in drug trials and attention must be paid to the interpretation and dissemination of the data.

4.14 Research

Doctors engaged in research have a duty to be truthful to patients about all aspects of the study. Doctors must be truthful about their results and must never make unjustified claims for authorship.

They should not allow their relationship with commercial firms to influence their attitude towards the design or the results of trials. (See also paragraph 20).

4.15 Professional Indemnity

Doctors must ensure that they have adequate professional indemnity for the work they perform.

Health Problems

5.1 Alcohol and Drugs

The perceived misuse of alcohol or other drugs by a doctor may be grounds for the holding of an inquiry. The complaint that a doctor has been under the influence of alcohol or drugs is a grave charge, and may lead to a finding of professional misconduct.

Doctors have a further responsibility to protect the interest of the public when they become aware that the use of alcohol or other drugs is affecting the competence of a colleague. In such circumstances they should express their anxiety directly to the colleague concerned and advise that expert professional help be obtained or that the colleague be referred to the Medical Council's Health Committee. If such approaches fail or where the interests of patients are or may be at risk, the facts must be given promptly to the Fitness to Practise Committee. Any dereliction of a doctor's responsibility in this regard will be viewed seriously.

5.2 Physical or Psychological Disorder

A similar procedure to paragraph 5.1 is recommended when other forms of physical or psychological disorder or the ageing process appear to seriously affect a doctor's professional competence.

5.3 Doctors with Communicable Diseases

It is unethical for doctors who believe that they might be infected with a serious communicable disease not to seek appropriate medical advice. Colleagues who are consulted have a dual role. They must counsel and support the doctor concerned, but they must ensure that the doctor does not pose a risk to patients and others. If such a risk exists, the Health Committee or Fitness to Practise Committee must be informed as soon as possible.

5.4 General Healthcare

Doctors should be aware that they too can suffer ill-health. Doctors should seek advice and help from another doctor rather than treating themselves.

Doctors are advised that they should have a general practitioner of their own.

5.5 Doctor's Families

Except for minor illnesses, it is not considered advisable for doctors to treat or to issue prescriptions or certificates for themselves or for members of their families.

SECTION D

Doctors in Practice

Practice Announcements

6.1 Setting Up Practice

Registered medical practitioners who are setting up practice may make announcements in the following manner:

Announcements concerning the commencement of practise may be placed in the national and / or local press, giving the registered name of the doctor, the address of the practice, the practice hours and the telephone number(s). The doctor should include his/her area of speciality if it is one that is recognised by the Medical Council and the doctor is entered for that speciality in the Register of Medical Specialists. The announcement should not be inserted as a display notice. The notice should not measure more than 100mm in any direction.

6.2 The Internet

The Medical Council recognises that the internet and practice websites can provide valuable services to patients. Doctors must take responsibility for the content of their sites. The content of the site must be non-promotional, evidence based, verifiable and compatible with Section 14. Particular care must be exercised with links to other sites.

6.3 Registered Names

Doctors must practise in the names in which they are registered. The Council registers doctors in the names in which their primary medical qualification is conferred and when a change of surname occurs, formal evidence must be furnished to enable an alteration to be made in the Register (e.g. State marriage or Deed Poll certificate). Commonly used abbreviations of forenames may be submitted for entry.

Practice Premises

7.1 Premises

The premises of medical practitioners should be adequate and suitable for their purpose.

7.2 Place of Practice Signs

A professional plate and sign may be displayed at the place of practice. If the practice is carried on in a business premises, the doctor's name may be included in a list of the occupants of the complex. Practice signs may include the doctor's registered name, registerable qualifications and registered specialities together with the following information:

- (a) Days and hours of attendance.
- (b) Telephone numbers of the practice.
- (c) Particulars of an emergency service.

7.3 Information for the Public

Information from recognised postgraduate training bodies about the address of a doctor's practice premises may be exhibited or distributed in places such as libraries, post-offices, health centres, citizens advice bureaux and other suitable locations. However, such information should be restricted to the particulars mentioned in paragraphs 6.1 and 7.4, and should not contain comments about the doctor's personal qualities or expertise.

7.4 Patient Information

The Council welcomes the use of appropriate information (including professional fees) for patients. This is most suitable for display or distribution in the place of practice by the doctor or practice staff.

7.5 Letter Heading

Doctors' letter headings should be confined to registerable qualifications. Membership of various 'Associations' and 'Societies' which are not post-graduate qualifications should not be included (see Appendix A).

Medical Reports

8.1 Provision of Reports

Doctors have a responsibility to supply medical reports for solicitors or insurance companies on behalf of patients they have seen or treated professionally or for whom they have been responsible. However such reports should not be given without the patient's permission (see paragraph 16.7).

Doctors who perceive a conflict of interest in preparing a report should inform the patient or the patient's legal adviser.

8.2 Accuracy

Reports must be factual and true. They are not to be influenced by the fee or by pressure from anyone to omit some details or to embellish others and strict accuracy must be observed. They should concentrate on relevant medical problems.

8.3 Delay

Undue delay in furnishing reports may amount to professional misconduct if such a delay results in the patient being disadvantaged. The report should be supplied within two months of the examination or receipt of a written request, whichever occurred last.

8.4 Fees for Reports

It is acceptable practice to request a fee prior to forwarding a report. To accept a fee and not provide a report is unethical.

8.5 Revenue Commissioners/Financial Personnel

When discussing their own finances with the Revenue Commissioners and other financial personnel, doctors should not reveal information about patients.

Certification

9.1 Accuracy

Strict accuracy is essential when issuing certificates, reports and other formal documents bearing the signature of a doctor. Pressure from any source to deviate from this standard must be resisted. Certificates, reports or other formal documents should only be issued after the doctor has assessed the patient.

9.2 Format and Details

Certificates must be dated and give the full name and address of the patient. Certificates, prescriptions, reports and other formal documents should be legible, should bear the doctor's name and address and should be personally signed by the doctor.

Prescribing and Irresponsible Prescribing

10.1 Prescribing

A doctor should prescribe appropriate therapies for the patient's condition and best interest.

The manner in which doctors are remunerated, or any financial interest they may have in the pharmaceutical or allied industries, must not influence the doctor when recommending therapy for their patients.

Non-promotional educational grants represent the only acceptable mechanism for financial support by the pharmaceutical and medical manufacturing industries to individual doctors.

10.2 Writing the Prescription

A prescription must be legible, dated and signed by a registered medical practitioner.

Should the need arise to prescribe over the telephone, the doctor should make a record of the call and forward the appropriate prescription to the pharmacist in a reasonable time.

Electronic prescribing is acceptable (subject to paragraph 10.6) if it meets legal and best practice clinical standards.

10.3 Indicative Drugs Budgeting

In exercising indicative drugs budgeting doctors should be principally concerned with the patient's best interests.

10.4 Drug Dependency

Doctors who wish to treat drug dependent patients must adhere to the requirements of the Misuse of Drugs Acts, the Methadone Treatment

Protocol (ICGP) and the Guidelines on Benzodiazepine Prescribing (DoHC, 2002) and other relevant reports and guidelines.

Doctors should only treat drug misusing patients if they have proper training, facilities and the support of the statutory and voluntary services.

Doctors must be cognisant of the dangers of drug dependency when prescribing benzodiazapines, opiates and other drugs with addictive potential.

10.5 Ionising Radiation

Doctors who undertake radiation procedures for patients and who are not radiologists or nuclear medicine physicians are required to complete a course of training in radiation safety and techniques recognised by the Medical Council. Council will then issue a certificate permitting the doctor to carry out such procedures provided that they are undertaken in hospital practice, in the presence of a radiologist or a nuclear medicine physician or a radiographer responsible to a radiologist or a nuclear medicine physician. Radiological consultation and investigative procedures should only be performed at the request of a registered medical or other specialist practitioner agreed with the Director of Radiological services. Reports of radiological procedures should be reviewed and signed by a doctor prior to filing. At all times the safety of the patient is paramount.

10.6 Telemedicine

Telemedicine allows doctors to practise medicine from a distance even across national boundaries using telecommunication systems such as telephone, internet and video link.

Doctors providing telemedicine services to patients in Ireland must be registered with the Medical Council. In certain circumstances, doctors in Ireland will consult with colleagues abroad; this is acceptable provided the overseas doctor is licensed in the jurisdiction in which he or she practices and is currently in good standing.

When providing telemedicine services, doctors must pay attention to issues such as record keeping and confidentiality as well as the training, competence, authorisation, legislation and indemnity required to practise telemedicine in any jurisdiction.

Deputising and Locum Arrangements

11.1 Doctors Absence and Standard of Care

Doctors must ensure that patients receive adequate care when alternative arrangements have to be made during their absence. Patients are entitled to locum cover of an acceptable standard. It is particularly important that cover for absence is provided by a suitably qualified medical practitioner. The unsupervised use of junior staff to cover the duties of the principal doctor or consultant is unacceptable.

11.2 The Principal Doctor

Doctors who use the services of a deputising agency or who employ a locum must satisfy themselves that:

- (a) The doctor standing in is registered with the Medical Council, has appropriate professional indemnity, is in good standing and is of good repute.
- (b) A high standard of continuing medical care is provided for their patients.
- (c) Patients are well informed in advance that in certain circumstances they will be seen by a doctor acting as a deputy for their own doctor.
- (d) Sufficient information and support is available for the locum to do his/her work adequately.

11.3 Responsibility for Care

Doctors using deputising facilities are reminded of their continuing responsibility for the care of their patients.

11.4 Rota Arrangements

Rotas should provide safe and continuing care for patients, should clearly identify the doctor on duty and should be easily understood and widely disseminated. Doctors participating in rotas are accountable for these arrangements.

11.5 Locum Doctors

Locum doctors must ensure that clinical details are transmitted directly to the principal doctor as soon as is feasible.

11.6 Transfer of Patients

It is especially important that locum doctors do not seek to attract patients wishing to transfer from the principal doctor.

Consultant Referral

12.1 Consultant Referral

It is in the best interests of the patient that the overall management of their health should be under the supervision and guidance of a general practitioner. However, a patient has a right to seek another opinion and a request should be accepted and facilitated, even if the general practitioner is not convinced that such a referral is necessary.

12.2 Accepting a Referral

A consultant should not normally accept a patient without referral from a general practitioner. In the exceptional circumstances that a consultant sees a patient without referral, the patient's general practitioner should be informed of the consultant's findings and treatment.

12.3 The Referral Process

Referring doctors should supply appropriate information for the consultation. Irrespective of the mode of referral, consultants have a duty to inform the patient's general practitioner as well as the referring doctor of the findings and recommendations.

12.4 Inappropriate Referral

If a consultant considers that a patient has been inappropriately referred or should have visited some other specialist, he or she should liaise with the patient's general practitioner.

12.5 Cross Referral/Inter Referral

Cross referral between consultants during an in-patient stay may be in the patient's best interest and the general practitioner should be kept informed.

Cross referral during out-patient care is inappropriate; patients should be referred to their general practitioner for further management.

Inter-referral between GPs is for a specific service and should always be followed by a report to the referring doctor.

12.6 Hospital Consultations

When general practitioners refer patients to hospital they expect them to be seen during the course of their management by a doctor of consultant or equal status. It is not acceptable for patients to be cared for entirely by junior medical staff.

12.7 Fee Splitting

This practice is against the interests of patients.

Centres of Health Care

13.1 Financial Interest

A doctor who has a financial interest in a private clinic, hospital, pharmacy or any institution to which he/she is referring patients for investigation or therapy, has a duty to declare such an interest to patients. Such doctors must take exceptional care to prevent their financial interests influencing their management of patients.

13.2 Standards

Doctors associated with clinics must make certain that the services offered conform to the accepted standards of the medical profession. They are reminded that they have a duty to ensure that ethical guidelines are not breached and that they can be held responsible for unethical advertising by private clinics and hospitals.

The Media and Advertising

14.1 Educating the Public

Doctors have an important part to play in educating the public in medical matters and in disseminating medical knowledge. However, doctors must not imply that they have unique solutions to health problems.

Doctors are reminded that if they work in a clinic or any healthcare setting that makes unfounded claims about special expertise not found elsewhere they may be held responsible for such claims.

14.2 Information for the Public

Information given to the public should be expressed in clear and factual terms. It must never cause unnecessary public concern or personal distress nor should it raise unrealistic expectations.

Doctors dealing with the media on social, ethical, political, or research aspects of medicine must take responsibility for the views they express and establish the basis for them.

14.3 The Balance of Benefit

In adjudicating on complaints concerning doctors in the media, the Medical Council will consider whether the benefit to the doctor has been greater than that to the public and whether there has been an element of self-advertisement or a claim of possession of special skills, either of which could be interpreted as canvassing for patients. In all circumstances benefit to the patient must outweigh any incidental advantages to the practitioner concerned. Self-advertisement, or publicity to enhance or promote a professional reputation for the purpose of attracting patients is unacceptable, paragraphs 6, 7, 13 and 14 refer to all forms of communication.

Change of Practice, Retirement, Incapacity or Death

15.1 Change of Practice

If a patient wishes to attend another practitioner, all relevant medical information should be sent to the new doctor with the patient's consent.

15.2 Retirement

Doctors who propose to retire from medical practice or to reduce their workload should inform patients of their intention to do so. To facilitate the transfer of the patient's care all relevant medical data should be sent to the new doctor with the patient's consent.

The same guidelines apply in the dissolution of a practice or where a doctor feels, for whatever reason, that he/she cannot continue to care any longer for a particular patient.

15.3 Unplanned Events

Doctors should have procedures in place to facilitate continuity of care for their patients, in the event of incapacity or death.

SECTION E

Confidentiality and Consent

16.1 Confidentiality

Confidentiality is a time-honoured principle of medical ethics. It extends after death and is fundamental to the doctor/patient relationship. While the concern of relatives and close friends is understandable, the doctor must not disclose information to any person without the consent of the patient, subject to paragraph 16.3.

16.2 Third Party Information

Sometimes it may be necessary to obtain information about a patient from a third party e.g. a relative. This information is also governed by the same rules of confidentiality as in paragraphs 16.1 and 16.3.

16.3 Exceptions to Confidentiality

There are four circumstances where exceptions may be justified in the absence of permission from the patient:

- (1) When ordered by a Judge in a Court of Law, or by a Tribunal established by an Act of the Oireachtas.
- (2) When necessary to protect the interests of the patient.
- (3) When necessary to protect the welfare of society.
- (4) When necessary to safeguard the welfare of another individual or patient.

16.4 Medical Records

All medical records in whatever format and wherever kept, must be safeguarded. Doctors should take all reasonable measures to ensure that other health professionals and ancillary staff maintain confidentiality.

Doctors working in Ireland have a responsibility to ensure compliance of their record systems with current Irish Data Protection and Freedom of Information legislation.

16.5 Registers of Illness

With the increasing importance of audit in medicine and the necessity for evidence based medicine it is important for doctors to remember that where registers of specific illnesses are being kept, the principles of confidentiality must be adhered to and that results from research projects should protect patient anonymity.

Irish Data Protection legislation must also be considered when making use of clinical data for research or audit purposes.

16.6 Reports to Third Parties

Doctors may encounter difficulties with medical examinations which require subsequent reporting to a third party. Before commencing such examinations, the doctor should explain the nature, context and reporting implications of the examination and should have consent from the patient before proceeding.

Doctors' reports should adhere to paragraph 8.2. Normally the patient's general practitioner should be informed, provided that consent is obtained. The significance, rather than the precise details, of the medical findings should be conveyed to any third party under confidential cover.

16.7 Insurance Reports

A doctor who is asked by an insurance company to complete a medical report on a patient must ensure that this is not issued without the informed consent of the patient. Patients should be informed that such reports may be read by non-medical personnel. These reports should be sent to the medical officer acting on behalf of the company.

16.8 The Deceased Patient

If an insurance company requests a report on a patient who has died, the report may only be issued by the doctor of the deceased with permission from the next of kin or the executors to the estate. The medical records of a deceased person remain confidential and death does not absolve a doctor from the obligation of confidentiality.

16.9 Communicable Diseases

Certain communicable diseases are notifiable by statute. Such notifications should preferably be made with the informed consent of the patient. In cases

where informed consent is not provided, reporting should be to the relevant authority but should observe the patient's confidentiality in all other respects.

Where others may be at serious risk if not aware that a patient has a communicable infection, a doctor should do his/her best to obtain permission from the patient to tell them, so that appropriate safeguards can be put in place. If the patient refuses to consent to disclosure, those who might be at risk of infection should be informed of the risk to themselves.

16.10 Recording

Identifiable audio-visual or photographic recordings of a patient, or a relative of a patient, should only be undertaken with informed and appropriate consent (see paragraph 19.2).

Informed Consent

17.1 Informed Consent

It is accepted that consent is implied in many circumstances by the very fact that the patient has come to the doctor for medical care. There are however situations where verbal and if appropriate written consent is necessary for investigation and treatment. Informed consent can only be obtained by a doctor who has sufficient training and experience to be able to explain the intervention, the risks and benefits and the alternatives.

In obtaining this consent the doctor must satisfy himself/herself that the patient understands what is involved by explaining in appropriate terminology. A record of this discussion should be made in the patient's notes.

A competent adult patient has the right to refuse treatment. While the decision must be respected, the assessment of competence and the discussion on consent should be carried out in conjunction with a senior colleague.

Special Situations and Consent

18.1 The Violent Patient

A doctor asked to examine or treat a violent patient is under no obligation to put him/herself or other healthcare staff in danger but should attempt to

persuade the patient concerned to permit an assessment as to whether any therapy is required.

18.2 Psychiatric Illness

Most patients with psychiatric illness are competent to provide consent. Where a patient with a psychiatric illness is not competent to give consent, the provisions of the Mental Health Act 2001 may nominate a specific process to give consent.

18.3 Children

If the doctor feels that a child will understand a proposed medical procedure, information or advice, this should be explained fully to the child. Where the consent of parents or guardians is normally required in respect of a child for whom they are responsible, due regard must be had to the wishes of the child. The doctor must never assume that it is safe to ignore the parental/guardian interest.

18.4 Emergency Treatment

In an emergency where consent cannot be obtained e.g. an unconscious patient or a child not accompanied by a parent or guardian, a doctor may provide treatment that is necessary to safeguard the patient's life or health.

Teaching and Consent

19.1 Students

Medical students must be identified by name and must not be represented as doctors. Students must obtain permission from patients before examining them. It is advisable to limit the number of students examining any one patient. Doctors should not allow schoolchildren or other inappropriate persons to become involved in or observe the clinical care of patients.

Medical students should be familiar with and should adhere to the principles of this ethical guide.

19.2 Visual Records

The taking of photographs, digital and video recording for teaching purposes requires the patient's informed consent. These records should normally remain as part of the patient's medical file. Images may have been recorded during emergency treatment without informed consent but this should be

sought as soon as possible and must be obtained before any teaching or other use of the images.

As far as possible these images should be taken in such a manner that a third party cannot identify the patient concerned (see paragraph 16.10). If the patient is identifiable, he or she should be informed about the security, storage, and eventual destruction of the record.

Research and Consent

20.1 Research

Informed, written consent must be obtained if patients are to be involved in clinical trials or any form of research. The aims and methods of the proposed research, together with any potential hazards or discomfort, should be explained to the patient (see paragraph 4.14).

20.2 Anonymity

Research results must always preserve patient anonymity unless permission has been given by the patient to use his or her name.

20.3 Refusal

Refusal to participate in research must not influence the care of a patient in any way.

20.4 Special Circumstances

In those who are not competent, consent to take part in research may be unobtainable. Consent may be obtained from a guardian but special care must be exercised in ensuring that the likely benefits to participants significantly outweigh the risks.

20.5 Research Ethics Committees

All institutions which undertake research should have Research Ethics Committees. Doctors are advised to submit proposed projects to such Committees for approval prior to commencing research.

20.6 Declaration of Helsinki

The Council supports the resolutions and draws attention to the Declaration of Helsinki adopted by the 18th World Medical Assembly and revised by the 48th World Medical Assembly.

Organ Transplantation and Consent

21.1 The Transplant Process

A doctor involved in organ transplantation has duties towards both donors and recipients. Living donors should be counselled as to the hazards and problems involved in the proposed procedures, preferably by an independent physician.

Brain death should be diagnosed, using currently accepted criteria, by at least two appropriately qualified clinicians, who are also independent of the transplant team.

21.2 Payment

Payment of any sort, apart from incidental expenses, should not be a factor in the ultimate decision made about organ donation.

Inability to Communicate and Consent

22.1 Serious Illness

For the seriously ill patient who is unable to communicate or understand, it is desirable that the doctor discusses management with the next of kin or the legal guardians prior to the doctor reaching a decision particularly about the use or non-use of treatments which will not contribute to recovery from the primary illness. In the event of a dispute between the doctor and relatives, a second opinion should be sought from a suitably qualified and independent medical practitioner.

Access to nutrition and hydration remain one of the basic needs of human beings, and all reasonable and practical efforts should be made to maintain both.

The Dying Patient

- 23.1** Where death is imminent, it is the responsibility of the doctor to take care that the sick person dies with dignity, in comfort, and with as little suffering as possible. In these circumstances a doctor is not obliged to initiate or maintain a treatment which is futile or disproportionately burdensome. Deliberately causing the death of a patient is professional misconduct.

SECTION F

Genetic Testing and Reproductive Medicine

24.1 In a rapidly evolving and complex area, doctors are reminded of their obligation to preserve life and to promote health. The creation of new forms of life for experimental purposes or the deliberate and intentional destruction of in-vitro human life already formed is professional misconduct

24.2 Gene Therapy

It is ethical to use gene therapy to modify the genome of human somatic cells provided that the risk is not disproportionate to the benefit. Gene therapy of gametes (sperm or ova) though not yet considered safe for use in humans, may become so with advancing technology. If it then has as its aim the improvement of health it may be ethical.

24.3 Genetic Testing

Genetic testing may be of benefit in diagnosing an illness or predicting its development in the future. Individuals who undergo such testing should be counselled regarding the consequences of their actions and testing should not be done without their informed consent.

24.4 Frozen Sperm and Ova:

Artificial Insemination by Donor (A.I.D.)

There is no objection to the preservation of sperm or ova to be used subsequently on behalf of those from whom they were originally taken. Doctors who consider assisting with donation to a third party must have regard to the biological difficulties involved, and pay meticulous attention to the source of the donated material. Doctors who fail to advise both donor and recipient about the potential implications of such measures and the possible consequences for the would-be parents and their baby could face disciplinary proceedings.

24.5 In-Vitro Fertilisation (I.V.F)

Techniques such as I.V.F. should only be used after thorough investigation has failed to reveal a treatable cause for the infertility. Prior to fertilisation

of an ovum, extensive discussion and counselling is essential. Any fertilised ovum must be used for normal implantation and must not be deliberately destroyed.

If couples have validly decided they do not wish to make use of their own fertilised ova, the potential for voluntary donation to other recipients may be considered.

24.6 The Child in Utero

The Council recognises that termination of pregnancy can occur when there is real and substantial risk to the life of the mother and subscribes to the views expressed in Part 2 of the written submission of the Institute of Obstetricians and Gynaecologists to the All-Party Oireachtas Committee on the Constitution as contained in its Fifth Progress Report, Appendix IV, page A407. (See Appendix C).

24.7 Adoption

Adoption must occur only through the auspices of registered adoption agencies. Pregnant women who are considering adoption must be offered contact with a registered adoption agency (details of these may be obtained from the Adoption Board).

Conclusion

This Guide is based on previous Guides to Ethical Conduct and Behaviour because the principles which engendered them in the first place have not changed, despite the fact that the practices to which they apply have altered as medicine has developed. It is not possible to outline how doctors should behave in every circumstance but an attempt has been made to enable the ready assessment of how ethical principles might impinge on a particular area of practice.

The Council is most grateful to those bodies and individuals who took the time and trouble to respond to its request for contributions and suggestions during preparation of the Guide.

From time to time the Council will issue additional guidance as required and it is expected that in the future, with changes in medical practice, there will be a need for the compilation of further Guides.

The Council considers it important that the medical profession aspires to the highest possible standards of behaviour and practice amongst its members. There are numerous examples in history where doctors have allowed themselves to behave or have been forced to behave, in a manner which has led to the mistreatment of the very people they are meant to serve. The purpose of this Guide is to give guidance and help to maintain the honourable tradition of service which has always been expected from doctors in this country.

APPENDIX A

Registerable Primary Qualifications

(Reference Section D, paragraph 7.5)

Abbreviations	Titles	Licensing Bodies
LAH Dubl	Licentiate	Apothecaries Hall, Dublin
LLM RCPI LLM RCSI	Licentiates and Licentiates in Midwifery	Royal College of Physicians of Ireland and Royal College of Surgeons in Ireland
LM LS U Dubl	Licentiate in Medicine and Licentiate in Surgery	University of Dublin
LMED LCH U Dubl	Licentiate in Medicine and Licentiate in Surgery	University of Dublin
LRCP & SI	Licentiates	Royal College of Physicians of Ireland and Royal College of Surgeons in Ireland
LRCP & SI MB BCh NUI	Licentiates and Bachelor of Medicine and Bachelor of Surgery	Royal College of Physicians of Ireland and Royal College of Surgeons in Ireland, National University of Ireland
MB BCh NUI	Bachelor in Medicine and Bachelor in Surgery	National University of Ireland
MB BCh U Dubl	Bachelor in Medicine and Bachelor in Surgery	University of Dublin

Registerable Additional Qualifications

AFRCSI	Associate Fellow	Royal College of Surgeons in Ireland
DIBICM	Diploma, Intercollegiate Board in Intensive Care Medicine	Intercollegiate Board in Intensive Care Medicine
DPH Dubl	Diploma in Public Health	University of Dublin
DPH NUI	Diploma in Public Health	National University of Ireland
DPH RCPSI	Diploma in Public Health	Royal College of Physicians and Surgeons in Ireland
DSM Dubl	Diploma in State Medicine	University of Dublin
FFA RCSI	Fellow	Royal College of Surgeons in Ireland – Faculty of Anaesthetists
FCA RCSI ¹	Fellow	Royal College of Surgeons in Ireland – College of Anaesthetists
FFPHMI ²	Fellow	Royal College of Physicians of Ireland – Faculty of Public Health Medicine
FFOM RCPI	Fellow	Royal College of Physicians of Ireland – Faculty of Occupational Medicine
FFR RCSI	Fellow	Royal College of Surgeons in Ireland – Faculty of Radiologists
FRCPI	Fellow	Royal College of Physicians of Ireland
FRCSI	Fellow	Royal College of Surgeons in Ireland
FRCSI(C-Th)	Intercollegiate Fellowship in Cardiothoracic Surgery	Royal College of Surgeons in Ireland
FRCSI(Gen.Surg)	Intercollegiate Fellowship in General Surgery	Royal College of Surgeons in Ireland
FRCSI(OMFS)	Intercollegiate Fellowship in Oral and Maxillofacial Surgery	Royal College of Surgeons in Ireland
FRCSI(Tr and Orth)	Intercollegiate Fellowship in Trauma and Orthopaedic Surgery	Royal College of Surgeons in Ireland
FRCSI(ORL-HNS)	Intercollegiate Fellowship in Otolaryngology	Royal College of Surgeons in Ireland
FRCSI(Paed. Surg)	Intercollegiate Fellowship in Paediatric Surgery	Royal College of Surgeons in Ireland
FRCSI(Plast)	Intercollegiate Fellowship in Plastic Surgery	Royal College of Surgeons in Ireland
FRCSI(Neuro. Surg)	Intercollegiate Fellowship in Neurosurgery	Royal College of Surgeons in Ireland
FRCSI(Urol)	Intercollegiate Fellowship in Urology	Royal College of Surgeons in Ireland
MAO Dubl	Master in Obstetric Science	University of Dublin
MAO NUI	Master of Obstetrics	National University of Ireland
MCh Dubl	Master of Surgery	University of Dublin
MCh NUI	Master of Surgery	National University of Ireland
MD Dubl	Doctor of Medicine	University of Dublin
MD NUI	Doctor of Medicine	National University of Ireland
MFPHMI	Member	Royal College of Physicians of Ireland – Faculty of Public Health Medicine
MFOM RCPI	Member	Royal College of Physicians of Ireland – Faculty of Occupational Medicine
MRCPI	Member	Royal College of Physicians of Ireland
MICGP	Member	Irish College of General Practitioners
MPH	Master in Public Health	University College Dublin
MMed Sci NUI	Master in Medical Science	National University of Ireland
F F Path	Fellow	Royal College of Physicians of Ireland – Faculty of Pathology

1 The College of Anaesthetists, Royal College of Surgeons in Ireland replaced the Faculty of Anaesthetists, Royal College of Surgeons in Ireland on 19th October, 1988. The FFA RCSI which was awarded prior to October 1988 continues to be registerable.

2 The name of the Faculty of Community Medicine was changed to Faculty of Public Health Medicine on 1st May, 1991. F,M FCMI continue to be registerable.

Recognised Specialities

Anaesthesia

Emergency Medicine

General Practice

Medicine:

- Cardiology
- Clinical Genetics
- Clinical Neurophysiology
- Clinical Pharmacology & Therapeutics
- Dermatology
- Endocrinology and Diabetes Mellitus
- Gastroenterology
- General (Internal) Medicine
- Genito-Urinary Medicine
- Geriatric Medicine
- Infectious Diseases
- Medical Oncology
- Nephrology
- Neurology
- Palliative Medicine
- Respiratory Medicine
- Rehabilitation Medicine
- Rheumatology
- Tropical Medicine

Obstetrics & Gynaecology

Occupational Medicine

Ophthalmology

Pathology:

- Chemical Pathology
- Haematology (Clinical & Laboratory)
- Histopathology
- Immunology (Clinical & Laboratory)
- Microbiology

Paediatrics

Psychiatry:

- Child and Adolescent Psychiatry
- Psychiatry
- Psychiatry of Learning Disability
- Psychiatry of Old Age

Public Health Medicine

Radiology:

- Radiology
- Radiation Oncology

Surgery:

- Cardiothoracic Surgery
- General Surgery
- Neurosurgery
- Ophthalmic Surgery
- Oral and Maxillo Facial Surgery
- Otolaryngology
- Paediatric Surgery
- Plastic, Reconstructive and Aesthetic Surgery
- Trauma and Orthopaedic Surgery
- Urology

Recognised Specialist Training Bodies

In relation to each recognised specialty, the Medical Council currently recognises the following bodies in Ireland for the purpose of granting evidence of satisfactory completion of specialist training:

Emergency Medicine

The Irish Surgical Postgraduate Training Committee,
Royal College of Surgeons in Ireland,
123 St. Stephen's Green, Dublin 2.

Paediatric Medicine

The Faculty of Paediatrics,
Royal College of Physicians of Ireland,
International House,
20-22 Lower Hatch Street, Dublin 2.

Anaesthetics

The College of Anaesthetists,
Royal College of Surgeons in Ireland,
22 Merrion Square, Dublin 2.

Pathology Specialists

The Faculty of Pathology,
Royal College of Physicians of Ireland,
International House,
20-22 Lower Hatch Street, Dublin 2.

General Practice

The Irish College of General Practitioners,
4-5 Lincoln Place, Dublin 2.

Psychiatric Specialties

The Irish Psychiatric Training Committee,
Corrigan House, Fenian Street, Dublin 2.

Medicine

The Irish Committee
on Higher Medical Training,
Royal College of Physicians of Ireland,
International House,
20-22 Lower Hatch Street, Dublin 2.

Public Health Medicine

The Faculty of Public Health Medicine,
Royal College of Physicians of Ireland,
International House,
20-22 Lower Hatch Street, Dublin 2.

Obstetrics and Gynaecology

The Institute of Obstetricians
and Gynaecologists,
Royal College of Physicians of Ireland,
International House,
20-22 Lower Hatch Street, Dublin 2.

Radiology

The Faculty of Radiologists,
Royal College of Surgeons in Ireland,
123 St. Stephen's Green, Dublin 2.

Occupational Medicine

The Faculty of Occupational Medicine
Royal College of Physicians of Ireland,
International House,
20-22 Lower Hatch Street, Dublin 2.

Surgical Specialties

The Irish Surgical Postgraduate
Training Committee,
Royal College of Surgeons in Ireland,
123 St. Stephen's Green, Dublin 2.

APPENDIX B

Declaration of Tokyo

Guidelines for Medical Doctors concerning Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in relation to Detention and Imprisonment.

As adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975.

Preamble

It is the privilege of the medical doctor to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patient. The utmost respect for human life is to be maintained even under threat, and no use made of medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

Declaration

1. The doctor shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offence of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.
2. The doctor shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.

3. The doctor shall not be present during any procedure during which torture or other forms of cruel, inhuman or degrading treatment is used or threatened.
4. A doctor must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The doctor's fundamental role is to alleviate the distress of his or her fellow men, and no motive whether personal, collective or political shall prevail against this higher purpose.
5. Where a prisoner refuses nourishment and is considered by the doctor as capable of forming an unimpaired and rational judgement concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgement should be confirmed by at least one other independent doctor. The consequences of the refusal of nourishment shall be explained by the doctor to the prisoner.

APPENDIX C

(Reference page A407 The All-Party Oireachtas Committee
on the Constitution – Fifth Progress Report – Abortion)

The Institute of Obstetricians and Gynaecologists RCPI

29 February 2000

Professor John Bonnar MD, FRCPI, FRCOG

Chairman

1. The Institute of Obstetricians and Gynaecologists is the professional body representing the speciality of Obstetrics and Gynaecology in Ireland. The Executive Council of the Institute has examined the Green Paper on Abortion and the members have been consulted. We welcome the Green Paper, which provides a comprehensive, up to date and objective analysis of the issues arising in the care of the pregnant woman. Our expertise is in the medical area and our comments area confined to these aspects.
2. In current obstetrical practice rare complications can arise where therapeutic intervention is required at a stage in pregnancy when there will be little or no prospect for the survival of the baby, due to extreme immaturity. In these exceptional situations failure to intervene may result in the death of both mother and baby. We consider that there is a fundamental difference between abortion carried out with the intention of taking the life of the baby, for example for social reasons, and the unavoidable death of the baby resulting from essential treatment to protect the life of the mother.
3. We recognise our responsibility to provide aftercare for women who decide to leave the State for termination of pregnancy. We recommend that full support and follow up services be made available for all women whose pregnancies have been terminated, whatever the circumstances.