GUIDELINES

ON

ETHICAL CONDUCT

FOR MEDICAL & DENTAL PRACTITIONERS

REGISTERED WITH

THE SRI LANKA MEDICAL COUNCIL

SRI LANKA MEDICAL COUNCIL
31, NORRIS CANAL ROAD
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SRI LANKA MEDICAL COUNCIL

"Medicine is a *sacred calling and he who makes it ridiculous isguilty of sacrilege"* - **Sodhoff**

This is a revised edition of the Guidelines on Ethical Conduct for Medical and Dental Practitioners published in 2003. There are a fewchanges in the format and there is a Page of Contents.

The publication on serious professional misconduct and guidelines in writing medical certificates are printed separately so that practitioners can have easy access to each of these booklets makingreading each one easier.

All these publications have been prepared by the Ethics Committeeof the SLMC.

The Hippocratic Oath is included here together with the oath taken prior to the full registration with the Sri Lanka Medical Council. The latter has been adapted from the Geneva Declaration of 1948 of the World Medical Association and has been amended in 1968 and againin 1983 in Vienna. It is the modem version of the Hippocratic Oath.

The Hippocratic Oath is an ethical code attributed to the ancient Greek Physician Hippocrates (460-370 B.C). It is adopted as a guide to conduct by the medical profession throughout the ages and is still used in the graduation ceremonies of many medical schools.

The text of the oath itself is divided into two major sections. The firstsets out the obligations of the physician to students of medicine andthe duties of the pupil tothe teacher. In the second section the physician pledges to prescribe only beneficial treatments according to his abilities and judgement, to refrain from causing harm and to live an exemplary personal and professional life.

It is an oath to uphold a high ethical standard in practice and an indenture m which the candidate agrees to share his livelihood withhis teacher and teach students like his own children.

The poem "If' was written by a professor of medicine of a bygone era. At his feet we learnt excellent bed-side clinical medicine during a time when sophisticated laboratory and radiological investigations were scarce and present day scans were non-existent. He inspired many generations of doctors to show concern and compassion to patientsirrespective of their social status.

The article on Doctor-Doctor and Doctor-Patient relationship is included here and needs careful consideration.

The chapter on good medical practice is adapted from the publication of the General Medical Council. ?

Readers must take note of the Disciplinary Procedures.

It is essential that doctors have a nurse or chaperone especially when examining patients of the opposite sex. Following this simple principle will avoid embarrassment to both the doctor and the patient.

Written consent is required prior to surgical procedures and when examining persons for alleged assault or rape.

Blowing your own trumpet would certainly be a way of advertising your wares. The medical profession discourages such advertising. The article on Advertising by Doctors and Institutions was prepared by the Ethics Committee of the Sri Lanka Medical Association and some additions were made by our own committee.

The guideline for writing prescriptions must be adhered to.

The medical profession is often blamed for its association with the pharmaceutical industry. Guidelines with regard to this and Ethics

and Medical Research are included. Ethical clearance by an Ethics Committee is mandatory prior to commencement of medical research. Such committees should be established in every Medical Faculty and Teaching Hospital. When articles on medical research are published in journals or read at scientific meetings, a clear declaration should be made that such ethical clearance has been obtained.

The Council had already prepared a report on Guidelines to be followed with regard to *in vitro* fertilization. This will require legislative enactments.

Euthanasia whether active, assisted or passive is illegal in Sri Lanka and this includes withdrawal of life support or notices stating "Do not resuscitate".

There are many other bioethical issues related to genetic engineering and stem cells which will need to be included in futurepublications.

All doctors should understand that the prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration.

In carrying out this noble service, one should conduct oneself with propriety, remaining modest, sober, kind and patient at all times. Physicians should merit the confidence of patients in their care, rendering to each a full measure of service and devotion, in keepingwith the dignity to which every human being is entitled.

The practitioner should practice methods of healing founded on a scientific basis. The honoured ideals of the medical profession imply that the responsibilities of the physician extend not only to individuals but also to society itself.

The SLMC expects all members of the medical profession to adhereto these guidelines.

Finally, I commend the following principles adopted by the American Medical Association. They are not laws, but standards of conductwhich define the essentials of honourable behaviour of the physician.

1. A physician shall be dedicated to providing competent medical services with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
3. A physician shall respect the law and also recognise a responsibility to seek changes in those requirements which arecontrary to the best interests of the patient.
4. A physician shall respect the rights of patients, colleagues and of other health professionals, and shall safeguard patient confidence within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate and the environment in which to provide medical services.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

"The physician is the finest flower of our civilization"

- R. L. Stevenson

Dr. H. H. R. Samarasinghe
President
Sri Lanka Medical Council

THE HIPPOCRATIC OATH

(5TH CENTURYB.C)

I swear by Apollo the healer, by Aescalapius, by Hygieia, Panacea and by all the gods and goddesses, making them my witness that I may keep this oath, and promise to carry out to the best of my abilityand judgement this indenture.

To reckon him who taught this art equally dear to me as my parents;to make him partner in my livelihood; when he is in need of money toshare mine with him. I will regard his sons as my brothers and teach them the science, if they desire to learn it, without fee or contract. I will impart precepts, lectures and all other learning to my own sons,and to those of my master, and to those pupils duly apprenticed andsworn, and to none other.

I will use my power to help the sick to the best of my ability and judgment; I will abstain from harming or wrongdoing any man by it.

I will give no deadly medicine to any one if asked, nor suggest any such counsel. Similarly, I will not give to a woman a pessary to cause an abortion.

I will be chaste and religious in my life and in my practice.

I will not use the knife, not even, verily in sufferers from stone, but Iwill give place to such as are craftsmen therein.

Into whatsoever house I enter, I will enter to help the sick, and I will abstain from all intentional wrong doing and harm, especially from abusing the bodies of man or woman, bond or free.

And whatsoever I shall see or hear in the course of my profession inmy intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.

Now if I carry out this oath, and break it not, may gain forever reputation among all men for my life and for my art: but if I transgress it and forswear myself may the opposite befall me.

MEDICAL PRACTITIONER'S OATH

I, Dr.

of(Address).

At the time of being admitted as a member of the medical profession,

I solemnly pledge myself to dedicate my life to the service of humanity;

The health of my patient will be my primary consideration and I will notuse my profession for exploitation andabuseof my patient;

I will practise my profession with conscience, dignity, integrity and honesty;

I will respect the secrets which are confided in me, even after thepatient has died;

I will give to my teachers the respect and gratitude, which is theirdue;

I will maintain by all the means in my power, the honour and nobletraditions of the medical profession;

I will not permit considerations of religion, nationality, race, partypolitics, caste or social standing to intervene between my dutyandmy patient;

I will maintain the utmost respect for human life from its beginning even under threat and I will notuse my medical knowledge contraryto the laws of humanity;

I make this promise solemnly, freely and upon my honour.

…… ……..

Signature Date

The oath was administered by the Registrar/Asst. Registrar/President/ Vice President orDesignated Member oftheSri Lanka Medical Council.

……..

Signature of Registrar / Assistant Registrar/ President/VicePresident/ Designated Member

;;;

IF

by Professor K. Rajasuriya

(With apologies to Rudyard Kipling)

If you can bear in mind that you are dealing
With human life and not with 'cases', pray,
If you can treat them without discriminating
Whether they are labeled 'pauper' or 'to pay';

If you can rush with equal alacrity
To see a case that needs attention stat,
If it's no matter, there's no 'buckshee' in it
Yet, if offered, you can refuse it flat;

If you can by a smile cheer up the ailing,
Or by a touch, relieve the suffering pain,
If you can by a word, console the dying
Who'll never taste this earth's tortures again;

If you can force your heart and nerve and sinew
To work overtime for those who need your skill;
If all that counts is just the joy of serving
And it matters not what happens to the bill;

If you can wait but not be tired of waiting
For the fame that one day perhaps you'll earn
Cheap notoriety the while disdaining,
Nor rush to print 'cos there's much more to learn;

If you can leave the trick of advertisement
To those who made it a crooked art:
Knowing it's but a quack's one accomplishment,
Of honest men it never forms a part;

If you can talk with touts and keep your virtue,
And treat Big Bugs, nor with the poor lose touch;
If neither wealth nor fame can yet corrupt you,
All beings count with you, but none too much;

If you can fill the unforgiving minute
With sixty seconds of work well done;
You'll then have reached a noble profession's summit,
And what is more, you'll die content, my son.

MEDICAL ETHICS AND ETIQUETTE

(Excerpts from an article by **Dr. E. M. Wijerama,** MD. (Lond.), MRCP (Lond.) published in the *Journal of the Ceylon Branch of the British Medical Association* of l8th June 1948)

"Medicine aims at preserving thelives of human beings as long as possible, at curing diseases and preventing suffering. As this devotion to the cause of human life conditions the traditions, methods and regulations of medical practice, it is ranked among the noblest of professions. Hence, service to humanity and not personal gain is the ideal of the profession and one who chooses to join the profession must assume the obligation to conduct himself in accordance with the ideal. To guide him are found the traditional rules of medical ethics and etiquette. The practice of medicine brings one in contact with three units of society. viz.- the public, the patients and fellow practitioners. To serve humanity, the practitioner must ever be conscious of the interest of these three units.

The first duty of the doctor is towards his/her patient. One of the greatest of obligations of a medical practitioner to his patients is secrecy with regard to the information received from the patient The practitioner should always bear in mind the words of Hippocrates 'That which I see or hear in my professional practice or in the life of a patient which ought not tobe spoken outside, I will notdivulge, but consider them to be holy secrets."

The one interest that overrides the all important doctor-patient relationship is the interest of the public. It is in the interest of the public that the doctor overcomes professional secrecy and notifies infectious diseases, informs the police of injuries, and issues death and birth certificates. Similarly, in a Court of Law, it is the welfare of the society that judges safeguard, by insisting ona medical witness disclosing professional secrets.

Everyone on entering the profession incurs an obligation to uphold dignity and honour, to exalt its standing and extend the bounds of its usefulness. The practitioner should guard against whatever may injure the respectability of the profession and should avoid all contumelious representations of the profession at large and all general charges that may be made against the selfishness and improbity of colleagues."

DOCTOR-DOCTOR AND DOCTOR-PATIENT RELATIONSHIP

Doctor-doctor relationship

An example of a physician's responsibility to another may beset out in the manner outlined below.

An attending physician A calls another specialist B for consultation to advise on a problem in relation to B'sfield. On being thus summoned B should render the advice sought by specialist A but let A decide how he should proceed further. It would not be proper for B to call for another specialist C without A's assent or concurrence unless A on his first request to Boffered to him a"free hand" to call a specialist C. Asthe specialist in charge of the case is A it is not proper for B or C to take charge unless specifically asked to do so by A.

Statement to patient or relatives afterconsultation

Ideally, all communications with the patient/ relatives/ representatives should take place in the presence or with the knowledge of attending physician A. It is the attending physician A's responsibility to disclose B's opinion or discuss the opinion with the patient or relatives. Unless otherwise agreed or there is good understanding among the professionals, B or C should not disclose their opinion to the patient or relatives without theassent of A. Ths is to prevent misunderstanding or misrepresentation of an opinion which may lead to unnecessary breach of trust or confidence placed in the attending physician.

When called for consultation by an attending physician all due respect should be shown to him as the physician in charge of the case. No statement, remark or comment should be made which would undermine the attending physician's standing vis-a-vis theother consultants whose opinions have been sough. It is prudent not to discuss or express opinions inthe presence of the patient or his relatives until the consultant's have

discussed among themselves what needs to be said or best left unsaid. Differences of opinion should not be divulged unless it is absolutely necessary to doso in the interests of the patient's trust and confidence in the specialist consulted. Irreconciliable differences of opinion mand ate, free and frank discussion with the patient or relatives who are then free to seek further advice under the changed circumstances, or on the face of new information or conflicting opinions.

Management after consultation

The attending physician Aretains the responsibility to make changes in the treatment if any unexpected changes occur before specialist B has seen the patient. It follows that the necessity for change in the treatment should be explained or discussed with specialist B, e.g., a convulsion occurring in a patient with head injury or meningitis. Specialist B too retains the privilege of treating the patient if called upon to do so in the absence of the attending physician. In all such instances the patients' interests should be held paramount and the course of action rational and defensible.

Doctor-patient relationship

Over the last few decades, the vastly expanded private healthcare services in the country have brought in their wake a multitude of problems many of which have clearly ethical dimensions. This booklet is issued by theSri Lanka Medical Council titled "Guidelines on Ethical Conduct for Medical and Dental Practitioners"and deals with the more common issues and concerns arising intheday to day practiceboth in theprivate and publicsectors. But some of these bear repetition especially for the benefit of younger members of the profession practicing today as they do not see many role models worthy of emulation in either sector.

For the sake of easy reference some of the topics which are commonly brought to our notice by members of the public and profession are

Given below. As members of the healingand caring profession we cannot feign ignorance that we are unaware of the inconvenience, distress or hardship we are causing to those seeking our services by our thought lessness, insensitivity, indifference or lack of concern. The simple test of placing oneself in the position of the patient is likely to convince most that our attitude, conduct or behaviour is indefensible or unacceptable.

Punctuality

This is a virtue to be greatly admired, especially when working in the private sector, as the patient is directly under your care waiting to be seen or attended to by you and no other. Having a 'large' practice, a 'busy' practice or being held up in another institution or theatre are not good enough to be accepted as excuses. Often one gives the same time as arrival time at two different places of work. This is clearly impossible for one to do but is done to prevent patients from seeking the services of any available specialist and to compel them to wait till the first called specialist arrives at whatever time, day or night. One sensible way of overcoming this is by giving staggered times, commencing at a given time. Any inordinate delay either by traffic blocks or for any other reason should be conveyed to the hospital or clinic, so that those who cannot wait that long could seek another's services or leave to come back another day. It is unethical to accept fees from a patient you have not seen. If you have done so you should not charge him at the next visit.

Poor quality of services

Some specialists draw large crowds. However, they should not allow their quality of care to suffer by'rushing through' consultations.

A reasonable period of time must begiven for patients to present their complaints in order of priority or importance as seen by them. Time

must be given for them to get their doubts and uncertainties clarified as they may have come to see the specialist simply to get these sorted! Very few professionals restrict numbers at private clinics; often over hundred are seen at one session. Even if one spends a mere three minutes with a patient it takes more than five hours to 'clear the crowd'. The quality of service in a specialist clinic is thus brought down to the level of an outpatient department of a government hospital. With this level of work load one must not forget the fact that the specialist is also expectedto report for work in the state sector institution at 8. 00a.m thefollowing morning.

That the quality of work suffers at both places is too obvious to mention. One therefore expects specialists, however superhuman they seem to be, to realise this weakness of theirs and to take appropriate action to prevent the inevitable fall in their standard of care.

Some specialists try to get over the problem of having to see large numbers by resorting to simultaneous attention to several patients; three or four patients are taken into one examining chamber where history taking and examination are carried out clearly breaching privacy and confidentiality. Embarrassing questions of a personal nature can be heard by all patients in the room, after which some patients opt to remain silent. This type of practice which denies the patients their dignity and self respect needs to be condemned, and patients encouraged to refuse interrogation or examination under such stressful and distressing conditions. Whether the much publicised Private Health Services Regulatory Act is endowed with powers to prevent specialists from treating patients in this degrading manner remains to be seen!

Today it is a common sight to see State sector specialists working in the private sector during' normal working hours without any sense of guilt or shame. Some even start working in the private sector long after 8.00 a m and visit State institutions only after fulfilling their obligations to the

private sector. Needless to say that they create a very poor impression on undergraduate students and other categories of health workers who are helpless to complain about the neglect of official duties such as teaching and patient care. The Ministry of Health too should share the blame for this reprehensible behaviour of specialists as nothing is done to deter them from breaking rules with impunity.

Reasonable charges

Complaints are received that an 'unreasonably large' quantum of fees is charged by some, specially when there has been no indication that the figure would be 'that high'. This is more likely to happen after the use of intensive care facilities or after surgical or other interventional procedures. It is better for one to give some indication as to what it would ordinarily amount to 'in the normal course of events'. It may be possible for one to say that the charges are most unlikely to exceed the figure 'X' in the normal course of events. Sometimes complications may compel an extended stay or additional consultation with other specialists. A guarded statement that the stipulated amount 'X' is likely to be exceeded in view of the unforeseen complications is likely to be better received, specially if given well before the final bill is received!

It is obviously not possible to lay down guidelines to cover all eventualities. Members of the healing profession, and those who are said to belong to the most noble of professions, are expected to work conscientiously and in an exemplary manner. The above issues and concerns have been consistently raised by members of the public as well as the more discerning members of the profession. They feel that the SLMC is failing in its duty to protect and safeguard the public, an allegation which we cannot accept given the limitations placed by statute on our authority and responsibilities by the existing medical ordinance.

Let us hope that members of our profession would be more responsive

and receptive to criticism leveled against them and conduct themselves in a manner that befits the dignity and prestigeof the profession.

Private work during"normal working hours"

When doctors are contracted *I* employed to work in an institution which has specified working hours, it wouldbe considered unethical to engage in anyother activity during those working hours forwhich a fee is paid.

The obviously would excludelectures delivered to medical students or others, or academic activities which are considered as part of the routine duty of a doctor.

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CODE OF ETHICS RECOMMENDED BY THE SLMC

Practitioners should take note of the Oath taken by doctors prior to applying for full registration, the provisions adapted from the Common Wealth Medical Association (1993) and the Guidelines to Practitioners and Media regarding indirect fonns ofadvertising issued by theSri Lanka Medical Council.

Practitioners should conduct them selves with dignity at all times. They should be properly attired and neat in appearance when visiting and attending on patients.

Whatever the provocation may be, they should act with restraint and abstain from rude or abusive behaviour topatients, colleagues and other staff. Indecent behaviour or violence towards a patient would be regarded asserious professional misconduct.

Practitioners are advised to show sympathy and compassion to patients at all times.

Professional misconduct could be caused by deprecation by one doctor of the skill, knowledge, qualification orservices of another doctor. Itis the responsibility of a practitioner to bring instances of professional misconduct, medical incompetence, incapacity, dishonesty or negligence of a fellow medical practitioner to the notice of the Medical Council in the best interests of the medical profession and the general public.

Name boards and rubber seals should not be ostentatious in size and form. Name boards should contain only the doctor's name, professional qualifications and surgery hours. Only medical qualifications registered with the Sri Lanka Medical Council should be used. Direction boards should be of reasonable size and not expansively or extensively displayed.
In the opinion of the Council, convictions for drunkenness and other offences arising from the misuse of alcohol and/or drug abuse, indicate

habits which bring discredit to the profession and may be a source of danger to the patients.

Doctors who treat patients or perform other professional duties while under the influence of alcohol and/or drugs, or who are unable to perform their professional duties because they are under the influence of such substances are liable to disciplinary proceedings by the Council as to their fitness to practice.

Fees charged by practitioners should be reasonable. When fees are charged for surgical operations and other interventions, patients should be given an indication of the likely charges before performing such a procedure. "Fee splitting" (fees accepted on behalf of colleagues orother staff) is unacceptable and unethical.

Major surgical operations carried out as planned routine procedures (not emergencies) should not be undertaken lateat night since this may affect the overall efficiency of those associated with the operations. A physician should endeavour to add to the comfort of the sick by making his visits at reasonable times of the day unless otherwise indicated.

A physician should neither exaggerate nor minimize the gravity of a patient's condition. He should assure himself that the patient, his relatives, guardian or his responsible friends have such knowledge of the patient's condition, as will serve the best interests of the patient and the family.

While it is acknowledged that doctors must retain the right to dispense drugs to their patients, it is considered unethical for a doctor to own a pharmacy for dispensing prescriptions by doctors other than himself or for sale of medical or surgical appliances. They should also not direct patients toa particular pharmacy or laboratory for personal gain. Doctors should refrain from procuring appliances such as heart valves, joint implants or lens implants for their patients. If questioned by a patient,

it is in the best interests of the doctor to mention why he prescribes a particular brand of medicine or appliance.

A physician shall notgive, solicit or receive, nor offer to give, solicit orreceive, any gift, gratuity, commission orbonus, in consideration of or return for the referring, recommending or procuring for any patient medical, surgical orother treatment. These provisions shall apply with equal force to the referring, recommending or procuring bya physician or any person, specimen or material for diagnostic or other study or wotk Nothing mentioned here however shall prohibit payment of salaries bya qualified physician to other duly qualified persons rendering medical care under his supervision.

Doctors registered with the Sri Lanka Medical Council should not employ persons whoare not registered with the Council, to treat patients, for example, pre-internsor medical students.

GOOD MEDICAL PRACTICE

The guidance that follows describes what is expected of all doctors registered with the SLMC. It is your responsibility to be familiar with Good Medical Practice and to follow the guidance it contains. It is guidance, not a statutory code, therefore you must use your judgement to apply principles to the various situations you will face as a doctor, whether or not you routinely see patients. You must be prepared to explain and justify your decisions and actions.

In Good Medical Practice the terms "you must" and "you should" are used in following ways:

- "You must" isused foran overriding dutyor principle.
- "You should" isused when we are providing an explanation of how you will meet the overriding duty.
- "You should" is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your control that affect whether or how you can comply with the guidance.

Serious or persistent failure to follow these guidelines will put your registration at risk.

Good doctors

1. Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, honest and trust worthy, and act with integrity.

Providing good clinical care

2. Good clinical care must include:

   a) Adequately assessing the patient's condition, taking account of the history (including the symptoms, and psychological and social factors), the patient's views and examining the patient,

   b) providing or arranging advice, investigations or treatment where necessary and

   c) referring a patient to another practitioner, when this is in the patient's best interests.

3. In providing care you must:

   a) recognise and work within the limits of your competence,

   b) prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs,

   c) provide effective treatment based on the best available evidence,

   d) take steps to alleviate pain or distress whether or not a cure may be possible,

   e) respect the patient's right to seek a second opinion,

   f) keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigations or treatment,

   g) make records at the same time as events you are recording or as soon as possible after wards,

   h) be readily accessible when you are on duty,

   i) consult and take advice from colleagues, when appropriate, and

   j) make good use of the resources available to you.

Supporting self care

4. You should encourage patients and the public to take an interest in their health, and to take action to improve and maintain it.

Avoid treating those close to you

5. Wherever possible, you should avoid providing medical care to anyone with whom you have a close personal relationship, including members of your family.

Raising concerns about patient safety

6. If you have good reason to think that patient safety is or may be seriously compromised by inadequate premises, equipment, drugs ofdoubtful quality or efficacy or are outdated, or other resources, policies or systems, you should put the matter right if that is possible. In all other cases you should draw the matter to the attention of your employing or contracting body. If they donot take adequate action, you should take independent advice on how to take the matter further. You must record your concerns and the steps you have taken to try to resolve them.

Decisions about access to medical care

7. The investigations or treatment you provide or arrange must be based on the assessment you and the patient make of their needs and priorities, and on your clinical judgement about the likely effectiveness of the treatment options. You must not refuse or delay treatment because you believe that patient's actions have contributed to his condition. You must treat your patients with respect whatever their life choices and beliefs are.

8. If carrying out a particular procedure or giving advice about it conflicts with your religious or moral beliefs, and this conflict might affect the treatment or advice you provide, you must explain this to the patient and tell him they have the right to see another doctor.

You must be satisfied that the patient has sufficient information to enable him to exercise that right If it is not practical for a patient to arrange to see another doctor, you must ensure that arrangements are made for another suitably qualified colleague to take over your role.

9. You must give priority to the investigation and treatment of patients on the basis of clinical need, when such decisions are within your power. If inadequate resources, policies or systems prevent you from doing this and patient safety is or may be seriously compromised, you must follow the guidance in paragraph 6.

10. All patients are entitled to care and treatment to meet their clinical needs. You must not refuse to treat a patient because his medical condition may put you at risk. If a patient poses a risk to your health or safety, you should take all available steps to minimise the risk before providing treatment or making suitable alternative arrangements for treatment

Treatment in **emergencies**

11. In an emergency, where it arises, you must offer assistance taking account of your own safety, competence and the availability of other options of care.

Keeping up to date

12. You must keep your knowledge and skills up to date throughout your working life. You should be familiar with relevant guidelines and developments that effect your work You should regularly take part in educational activities that maintain and further develop your competence and performance.

13. You must keep up to date with and adhere to the laws and codes of practice relevant to your work.

Maintaining and improving your performance

14. You must work with colleagues and patients to maintain and improve the quality of your work and promote patient safety. In particular, you must:

    a) reflect regularly on your standards of medical practice in accordance with SLMC guidelines on licensing and revalidation,

    b) take part in regular and systematic audit if requested to do so,

    c) take part in systems of quality assurance and quality improvement,

    d) respond constructively to the outcome of audit, appraisals and performance reviews, undertaking further training where necessary if requested to do so,

    e) contribute to confidential inquiries and adverse event recognition and reporting to help reduce risk to patients,

    f) report suspected adverse drug reactions in accordance with the relevant reporting scheme, and

    g) co-operate with legitimate requests for information from organizations monitoring public health.

Teaching and training, appraising and assessing

15. Teaching, training and assessing doctor sand students are important for the care of patients now and in the future. You should be willing tocontribute to these activities.

16. If you are involved in teaching you must develop the skills, attitudes and practices of a competent teacher.

17. You must make sure that all staff, for whom you are responsible, including locums and students, are properly supervised.

18. You must be honest and objective when appraising or assessing the performance of colleagues, including locums and students. Patients will be put at risk if you describe as competent someone who has not reached or maintained a satisfactory standard of practice.

19. You must provide only honest, justifiable and accurate comments when giving reference for, or writing reports about, colleagues. When providing references, you must do so promptly and include all information that is relevant to your colleague's competence, performance or conduct.

The doctor-patient partnerships

20. Relationships based on openness, trust and good communication will enable you to work in partnership with your patient to address their individual needs.

21. To fulfill your role in the doctor-patient partnership you must:

a) be polite, considerate and honest

b) treat patients with dignity.

c) treat each patient as an individual.

d) respect patients' privacy and right to confidentiality.

e) support patients in caring for themselves to improve and maintain their health.

f) encourage patients who have knowledge about their condition to use this when they are making decisions about their care.

Good communication

22. To communicate effectively you must

a) listen to patients, ask for and respect their views about their health, and respond to their concerns and preferences,

b) share with patients, in a way they can understand the information they want or need to know about their conditions, its likelyprogression, and the treatment options available to them, including associated risks and uncertainties,

c) respond to patients' questions and keep them informed about the progress of their care,

d) make sure that patients are informed about how information is shared within teams and among those who will be providing their care.

23. You must make sure, wherever practical, that arrangements are made to meet patients' language and communication needs.

Children and young people

24. The guidance that follows in paragraph 25-27is relevant whether or not you routinely see children and young people as patients. You should be aware of the needs and welfare of children and young people when you see patients who are parents or carers, as well as any patient who may represent a danger to children or young people.

25. You must safeguard and protect the health and well being of children and young people.

26. You should offer assistance to children and young people if you have reason to think that their rights have been abused or denied.

27. When communicating with children or young persons you must:

a) treat them with respect and listen to their views,

b) answer their questions to the best of your ability, and

c) provide information in a way they can understand.

28. The guidance in paragraphs 25-27 is about children and young people, but the principles also apply to other vulnerable groups.

Relatives, carers and partners

29. You must be considerate to relatives, carers, partners and others close to the patient, and be sensitive and responsive in providing information and support, including after a patient has died.

Being open and honest with patients if things go wrong

30. If a patient under your care has suffered harm or distress, you must act immediately to put matters right, if that is possible. You should offer an apology and explain fully and promptly to the patient what has happened, and the likely short-term and long-term effects.

31. Patients who complain about the care or treatment they have received have a right to expect a prompt open, constructive and honest response including an explanation and if appropriate, an apology. You must not allow a patient's complaints to affect adversely the care or treatment you provide or arrange.

Maintaining trust in the profession

32. You must not use your professional position to establish or pursue a sexual or improper emotional relationship with a patient or someone close to him/her.

33. You must not express to your patients your personal beliefs, including political, religious or moral beliefs in a way that exploits their vulnerability or that are likely to cause them distress.

34. You must be familiar with your SLMC registration number. You must make sure you are identifiable to your patients and colleagues, for example by using your registered name when signing statutory

documents, including prescriptions. **You must make your registered name and SLMC registration number available to anyone who asks for them.**

Consent

35. You must be satisfied that you have consent or other valid authority where appropriate in writing before you undertake any examination or investigation, provide treatment or involve patients in teaching or research. Usually this will involve providing information to patients in a way they can understand, before asking for their consent Ethical consideration must be given with regard to patients who are not able to give consent.

Confidentiality

36. Patients have a right to expect that information about them will be held in confidence by their doctors. You must treat information about patients as confidential, including after a patient has died (refer chapter on confidentiality in medical practice pages 42-47).

Ending your professional relationship with a patient

37. In rare circumstances, the trust between you and a patient may breakdown, and you may find it necessary to end the professional relationship. For example, this may occur if a patient has been violent to you or a colleague, has stolen from the premises, or has persistently acted inconsiderately or unreasonably. You should not end a relationship with a patient solely because of a complaint the patient has made about you or your team, or because of the resource implications of the patient's care or treatment.

38. Before you end a professional relationship with a patient, you must be satisfied that your decision is fair and does not contravene the guidance in paragraph 7. You must be prepared to justify your

decision. You should inform the patient of your decision and your reasons for ending the professional relationship, wherever practical in writing.

39. You must take steps to ensure that arrangements are made promptly for the continuing care of the patient, and you must pass on the patient's records without delay.

Working in teams

40. Most doctors work in teams with colleagues from other professions. Working in teams does not change your professional accountability for your professional conduct and the care you provide. When working in a team you should act as a positive role model, and try to motivate and inspire your colleagues. You must:

    a) respect the skills and contribution of your colleagues,

    b) communicate effectively with colleagues within and outside the team,

    c) make sure that your patients and colleagues understand your role and responsibilities in the team, and who is responsible for each aspect of patient care,

    d) participate in regular reviews and audit of the standards and performance of the team, taking steps to remedy any deficiencies and

    e) support colleagues who have problems with performance, conduct or health.

Conduct and performance of colleagues

41. You must protect patients from risk of harm posed by another colleague's conduct, performance or health. The safety of the patient must come first at all times. If you have concern that a colleague

may not be fit to practice, you must take appropriate steps without delay, so that the concerns are investigated and patients protected where necessary. This means you must give an honest explanation of your concern to an appropriate person from your employing or contracting body, and follow their procedures.

42. If there are no appropriate local systems or local systems do not resolve the problem, and you are still concerned about the safety of patients, you should inform the relevant regulatory body. If you are not sure what to do, you should discuss your concerns with an impartial colleague or a professional organization or contact the SLMC for advice.

Respect for colleagues

43. You must treat your colleagues fairly and with respect. You must not bully or harass them, or unfairly discriminate against them by allowing your personal views to affect adversely your professional relationship with them. You should challenge colleagues if their behavior does not comply with this guidance.

44. You must not make malicious and unfounded criticism of colleagues that may undermine the patients' trust in the care or treatment they receive, or in the judgement of those treating them.

Arranging cover

45. You must be satisfied that when you are off duty, suitable arrangements have been made for your patients' medical care. These arrangements should include effective handover procedures, involving clear communication with healthcare colleagues. If you are concerned that the arrangements are not suitable, you should take steps to safeguard patient care and you must follow the guidance in paragraph 6.

Sharing information with colleagues

46. Sharing information with other healthcare professionals is important for safe and effective patient care.

47. When you refer a patient, you should provide all relevant information about the patient including their medical history and current condition.

48. If you provide treatment or advice for a patient, but are not the patient's general practitioner you should tell the general practitioner the result of the investigations, the treatment provided and any other information necessary for the continuing care of the patient, useless the patient objects.

Delegation and referral

49. Delegation involves asking a colleague to provide treatment or care on your behalf. Although you will not be accountable for the decision and action of those to whom you delegate, you will still be responsible for the overall management of the patient, and accountable for your decision to delegate. When you delegate careor treatment you must be satisfied that the person to whom youdelegate has the qualifications, experience, knowledge and skills toprovide the care or treatment involved. You must always pass onenough information about the patient and treatment they need.

50. Referral involves transferring some or all the responsibility for the patient's care, usually temporarily and for a particular purpose, such as additional investigation, care or treatment that is outside your competence. **You must be satisfied that any healthcare professional to whom you refer a patient is accountable to a statutory regulatory body or employed within a managed environment.**

Being honest and trustworthy

51. Probity means being honest trustworthy, and acting with integrity. This is the heart of medical professionalism.

52. You must make sure that your conduct at all times justifies your patients trust in you and the public's trust in the profession.

53. You must inform the SLMC without delay if, anywhere in the world, you have accepted a caution or being charged with, or found guilty of a criminal offence, or if another professional body has made a findmg against your registration as a result of fitness to practice procedures.

54. If you are suspended by an organization from a medical post or have restrictions placed on your practice you must, without delay, inform anyother organization for which you undertake medical work and any patients you see independently.

Providing and publishing information about your services

55. If you publish information about your medical services, you must make sure the information is factual and verifiable.

56. You must not make unjustifiable claims about the quality or outcomes of your services in any information you provide to patients. It must not offer guarantees of cures, nor exploit patient's vulnerability or lack of medical knowledge.

57. You must not put pressure on people to use a service, for example by arousing ill founded fears for their future health.

Writing reports and CVs, giving evidence and signing documents

58. You must be honest and trustworthy when writing reports and when completing or signing forms, reports and other documents.

59. You must always be honest about your experience, qualificationsand position, particularly when applying for posts.

60. You must do your best to make sure that any documents you writeor sign are not false or misleading. This means that you must takeresponsible steps to verify the information in the documents and that you must not deliberately leave out relevant information.

61. If you have agreed to prepare a report, complete or sign a document, or provide evidence, you must do so without unreasonable delay.

62. If you are asked to give evidence or act as a witness in litigation or formal inquiries, you must be honest in all your spoken and written statements. You must make clear the limits of your knowledge or competence.

63. You must co-operate fully with any formal inquiries into the treatmentof a patient and with any complaints or procedures that apply to your work. You must disclose to anyone entitled to ask for it, any information relevant to an investigation into your own or a colleague's conduct, performance or health.

64.. You must assist the coroner or magistrate in an inquest or inquiry into a patient's death by responding to their inquiries and by offeringall relevant information. You are entitled to remain silent only when your evidence may lead to criminal proceedings being taken against you.

65. A doctor's signature is required by statute on certificates fora variety of purposes, on the presumption that the truth of any statement which a doctor may certify can be accepted without question. Doctors are therefore 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 a professional capacity signs any certificate or similar documentcontaining statements which areuntrue, misleading or otherwise improper, may be liable to disciplinary proceedings.

66. A doctor must not use the seal or stamp of another doctor when signing certificates or prescriptions.

Research

67. Research involving people directly or indirectly is vital in improving care and reducing uncertainty for patients now and in the future and improving the health of the population as a whole.

68. If you are involved in designing, organizing or carrying out research, you must:

a) put the protection of the participants' interest first,

b) act with honesty and integrity, and

c) follow the appropriate national research governance guidelines and the guidance in research, the role and responsibilities of doctors.

Financial and commercial dealings

69. You must be honest and open in any financial arrangements with patients. In particular:

a) you mustinform patients about your fees and charges, wherever possible before asking for their consent totreatment,

b) you must not exploit patients' vulnerability or lack of medical knowledge when making charges for treatment or services,

c) you must not encourage patients to give, lend or bequeath money or gifts, that will directlyor indirectly benefit you,

d) you must not put pressure on patients or their families to make donations to other peopleor organizations,

e) you must not put pressure on patients to accept private treatment, and

f) if you charge fees, you must tell patients if any partof the fee goes to another healthcare professional.

Medical practitioners and private enterprise

70. Lending one's name as a respected medical practitioner to the directorate of a business establishment should not be done in a casual or frivolous manner, since the expectations of the public as regards honesty and financial propriety are high. The respect and regard that the profession has earned over the years justifying the faith and trust placed in it should not be compromised.

As directors of a company with ultimate responsibility for the conduct of business of a company, medical practitioners cannot disclaim respoilSlbility by stating that they were ignorant of the manner in which thecompany conducted business, as in law the Board of Directors can be held accountable for any misdeeds perpetrated bythe company.

The Sri Lanka Medical Council does not subscribe totheview that 'infamous conduct' on the part of a practitioner should beconfined to conduct only pertaining to the profession, or conduct during the course of one's duties as a medical practitioner. It holds that 'infamous conduct' on the part of the practitioner can be 'in any professional respect' and, therefore, personal dishonesty or financial misappropriation should also fall within thedefinition ofconduct 'in any professional respect'.

When dealing with members of the public even in matters strictlynot medical, the Sri Lanka Medical Council expects its members to conduct themselves in a manner that would not diminish the credibility and reputation they enjoy in the eyes of the public.

71. You must be honest in financial and commercial dealings with employers, insurance and other organisations or individuals.

Conflicts of interest

72. You must act in your patient's best interest when making referrals and when providing or arranging treatment or care. You must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect the way you prescribe, treat or refer patients. You must not offer such inducements to colleagues.

73. If you have financial or commercial interests in organizations providing healthcare or in pharmaceuticalor other biomedical companies, these interests must not affect the way you prescribe, treat or refer patients.

74. If youhave financial or commercial interests in an organization to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest.

75. You should havea general practitioner outside your family to ensure that you have access to independent and objective medical care. You should not treat yourself.

76. You should protect your patients, your colleagues and yourself by being immunized against common serious communicable diseases where vaccines are available.

77. If you know that you have or think that you might have, a serious condition that you could passon to patients, or if your judgement or performance could be affected bya condition or its treatment, you must consult a suitably qualified colleague. You must ask for and follow their advice about investigations, treatment and changes to yourpractice that they consider necessary. You must not rely on your own assessment of the risk you pose to patients.

OBLIGATION OF MEDICAL PRACTITIONERS

- Make the care ofpatients the first concern.
- Treat every patient politely and considerately.
- Respect patient's dignity and privacy.
- Listen to patients and respect their views.
- Give infonnation to patients in a way they can understand.
- Respect the rights of patients to be fully involved in decisions about their care.
- Keep professional knowledge and skills up to date.
- Recognise the limits of their professional competence.
- Be honest and trustworthy.
- Respect and protect confidential information.
- Make sure that personal beliefs do not prejudice patients' care.
- Act quickly to protect patients from risk if thereis good reason to believe that they ora colleague may not be fit to practice.
- Avoid abusing their position as a doctor.
- Work with colleagues in the ways that best serve patients' interests.

DIBCIPLINARY PROCEDURE

It is mandatory for all medical and dental practitioners to register with the SLMC to practise their profession in Sri Lanka. The SLMC also has the authority to discipline errant members of the profession. For this purpose, disciplinary procedures have been laid down.

The Council is empowered to investigate complaints made on the following grounds:

1. Conviction of a criminal offence
2. Evidence of serious professional misconduct.
3. Physical ormental incapacity to practice.
4. Evidence of seriously deficient orincompetent performance.

The President of theCouncil will consider every complaint and decide:

- whether there isevidence ofaserious problem, andhow theSLMC should proceed, and
- which ofthe procedures would bemost relevant.

The Preliminary Proceeding Committee (PPC), will consider the nature and gravity of the complaint or misdemeanor and will decide whether a formal inquiry should be held. If this be the case, the Professional Conduct Committee (PCC) would then hold an inquiry and decide on the neceessary courseofaction. Ifpunishment is tofollow, this could include for example, cancellation of registration, suspension of registration, and/ or issue of a reprimand or warning.

PRESCRIPTION WRITING AND RATIONAL PRESCRIBING

"Prescriptions measure physicians' therapeutic knowledge!"

General rule- The legal responsibility for prescribing lies with the medical practitioner (Consultant/ General Practitioner/ Medical Officer) who signs theprescription.

General requirements in a prescription

Exercise great care in prescribing drugs.

(i) Write legibly in ink

(ii) Write the date

(m) Write the full name of the patient

(iv) Preferably, include the address of the patient

(v) (a) Age of the patient (preferable to have the date of birth of the patient specially in children)

(b) An alternative is to add the word "infant", "child" "baby" or "adult" after the patient's name.

(vi) Write the weight of the patient especially in children (useful to calculate the dose)

(vii) Write the number of medicines in sequence- one below the other and preferably in block letters.

(viil) The prescription should be signed in ink by the Consultant/ Medical Officer

(ix) Below the signature - name, qualifications registered with the SLMC and SLMC registration number should be stated, preferably placing a rubber seal.

(x) The Consultant's specialty should be one which is accepted by the SLMC / PGIM or Ministry of Health.

(xi) The prescription should preferably contain the address of prescribing doctor or address of the dispensary / hospital.

Specific requirements in **a prescription**

(i) (a) Names of drugs should be written out in generic names, but you have the freedom to specify a preferred brand in parenthesis.

(b) If a brand nameis used, it should be carefully and fully writtenbecause many are similar and confusing.

(ii) Names of drugs and preparations should be written clearly andnot abbreviated, using approved titles only.

(iii) Specify the type of medicinein theprescription-examples capsule / tablet / caplet/ oral suspension/ dry powder inhaler/ metered dose inhaler/ drops/syrup/ lotions/ gargles/ mouthwash/ cream /ointment etc.

ADVERTISING BY DOCTORS AND INSTITUTIONS

1. GENERAL

1.1 It is ethical for doctors registered by the SLMC under section 29 of the medical ordinance to advertise the services they offer, subject to restrictions.

1.2 It is also ethical for institutions, where doctors registered by the SLMC under section 29 of the Medical Ordinance practice, to advertise the services theyoffer and professional qualifications of the doctors who provide these services, subject to restrictions.

1.3 As Sri Lanka does not have a referral system, both family physicians and specialists are available for "primary care" i.e. available for consultation by the public directly as well as following referral by other doctors or institutions. The paragraphs dealing with 'Advertising by Doctors' is applicable to both family physicians (with and without their own dispensing and laboratory facilities) as well as to specialists (whether working from their homes or from channel centres or private hospitals and whether in full time private or part time practice, being in employment with the government orother health services or defence services).

2. ADVERTISING BY DOCTORS

2.1 It is the dutyof doctors to ensure the veracity ofinformation that is published and that it conforms to these guidelines, whether such information is published by the doctor himself or has acquiesced in itspublication by others.

2.2 Ideally, information about services available in a particular area should be made available to the public by organisations that may represent the interests of the public or those that represent the

interests ofdoctors. This information could be in the form of a list of doctors' names with their professional qualifications and the `services they offer subject to principles set out in paragraphs 2.3 to 2.5.

2.3 Whether information ismade available by organisations or by the doctors themselves, only factual information should be publicised. This should include the name, professional qualifications, and areas of specialisation and practice information such as place, days of week and times of availability.

2.4 All information should be factual, there should be no exaggerations or misleading statements, guarantees of cure, claims of superior qualifications, experience or skill. There should also be nothing disparaging about the services offered by other doctors (or institutions) or their qualifications, experience and skills. Information should not be presented in such a manner that it exploits the lack of medical knowledge of prospective patients. No person should claim that he is the sole authority on a particular subject or is the only person who could perform a particular surgical procedure.

2.5 Professional qualifications displayed should be restricted to those obtained by examination recognized by the Sri Lanka Medical Council.

2.6 A doctor should only use qualifications that have been registered with the Medical Council. Addition of"honours" and "classes" at the M.B.B.S examination is not permitted.

2.7 Aspecialty when mentioned should be one in which the practitioner has obtained Board Certification from the Postgraduate Institute of Medicine. Alternatively, he should have worked in a State hospital as a specialist in that field. University teachers occupying

positions of senior lecturer and above may be permitted to carry the title of specialist in the field in which they are Board Certified. Those in the private sector could inquire from the Medical Council whether they meet the criteria of a specialist.

2.8 Articles should be written as far as possible in lay language that the public could understand. Articles written for Medical Practitioners and other healthcare personnel may not be appropriate for publishing in the lay press.

2.9 Surgical operations and technical procedures shown on TV should be kept to a minimum. However, diagrams and anatomical models could be used for illustration when needed.

2.10 In television and radio broadcasts, the announcing of names, specialties and registered qualifications of the participants, should be confined to the commencement and the end of the programme.

2.11 In discussion on TV and radio it is preferable if more than one doctor participate in the programme.

2.12 No doctor should advertise his successes in treatment.

2.13 The place of work of the doctor should not be mentioned unless this is relevant to the subject, as this may be construed as a form of advertising.

2.14 Pictures shown on TV or published in newspaper articles should not be repulsive or unpleasant to the public eye.

2.15 Those who write articles or are interviewed by the press should refrain from publishing their photographs.

3. ADVERTISING BY INSTITUTIONS

3.1 Institutions such as hospitals and nursing homes, consultation, diagnostic and treatment clinics etc. may advertise the services they offer to public. Such information should be factual and confonn to principles set out in paragraphs 2.3 to 2.5 above concerning services provided by doctors.

3.2 The names of doctors who practice in any institution may be advertised in the form of lists of names with professional qualifications and specialties. Such lists in private institutions containing names of doctors should not include the names of government institutions where they may also be practicing. Days and times when they are available may also bestated. The principles set out in paragraphs 2.3 to 2.5 apply.

4. ADVERTISING IN THE MEDIA

In general, information regarding services offered by institutions and by doctors may be publicised in numerous ways: by means of notices (including name boards) displayed within oroutside institutions or places where services are offered; by means of notices displayed or available in public places where the public may seek such information; in professional journals and newsletters intended for circulation to members of the medical profession; by means of circulars mailed to members of the medical profession; in newspapers and electronic media (subject to restrictions as in 4.3). In all instances, information published should be factual with no guarantees of cure or claims of superiority over other doctors or institutions. The principles set out in paragraphs 2.3 to 2.5 and 4.3.4 apply as appropriate.

4.1 Advertising to the general public (name boards and notices)

4.1.1 Name boards should not be ostentatious and should be restricted to names, professional qualifications, services offered and practice times.

4.1.2 Institutions may display the services they offer on boards visible to the public.

4.1.3 Doctors who work full time in their own clinics, surgeries, nursing homes etc. may display their names, professional qualifications, services offered and practicetimes on thesame boards that display to the public the services offered by the institution or surgery (as set out in 3.2) .

Where (part time) doctors are available only at specific times, as for example at consultation clinics and private hospitals and nursing homes, their names and times of availability should be displayed only within the premises. They should not state their designation e.g. house officer/ registrar/ MO/ SHO / children's hospital/ womens' hospital/ cardiology/ neurology/ oncology etc.

4.1.4 The public would be benefited information regarding the services available in their area is readily available to them. The services provided by the government health institutions in the area may be publicised by means of sign boards displayed at these institutions. They may also publicise the services available at institutions peripheral to them, such as dispensaries, MOH offices etc.

4.1.5 Directories of medical services and personnel should be made available to the general public at public libraries.

4.2 **Advertising within the profession**

4.2.1 Family physicians would be in a better position to advise their patients about the specialist, diagnostic and treatment services available in their areas if up to date and factual information about such services is made available to them.

This could be achieved by mailing circulars containing such information to the doctors in the area by the managers of institutions and clinics or by the doctors themselves if they practice from their own clinics.

4.2.2 The absence of prior information regarding the cost of diagnostic and treatment services often places patients and their relatives in difficult situations. Such information should be made available to patients through their family physician or directly by means of public notices or take away leaflets at the institutions offering these services.

4.2.3 It would be appropriate for associations of doctors to publish factual information about their members in the form of lists of names with professional qualifications, area of specialisation and practice information in newsletters and journals published by them. Directories containing the same information may also be published. These publications should be available to the profession at medical libraries.

4.3 **Advertising in newspapers and through the electronic media**

4.3.1 Doctors may not advertise in newspapers or the electronic media

4.3.2 Institutions may advertise the services they offer in newspapers without the names of service providers.

4.3.3 Institutions may advertise the services they offer in the electronic media without the names of service providers.

4.3.4 All information should be factual: no exaggerations or misleading statements, guarantees of cure, claims of superior qualifications, experience or skill of their staff are permitted.

There should also be nothing disparaging about the services offered by other institutions or the qualifications, experience and skill of their staff. Information should not be presented in such a manner that it exploits the lack of medical knowledge of prospective patients.

4.4 Articles, books, broadcasting by doctors

4.4.1 Books and articles written by doctors may include their names, qualifications, designation and details of other publications.

4.4.2 Similar information may be given where doctors participate in broadcast presentations or discussions on medical or related topics. Such information should not be broadcast frequently or presented in such a manner as to imply that the doctor concerned is especially recommended for patients to consult in general, identifying the doctor/s at the beginning and the end of the programme is sufficient.

4.4.3 Doctors in clinical practice may write columns or make broadcast presentations in programmes offering advice to the public on medical or health problems, provided that such publicity does not result in material advantage to them.

4.4.4 Articles written by doctors should not be accompanied by advertisement of services referred to in such articles in the same publication.

RESEARCH SPONSORSHIP, CONFLICT OF INTEREST AND PUBLICATION ETHICS

The publication of clinical research findings in reputed peer reviewed journals is often the ultimate basis for most treatment decisions. Professional discussion about the published evidence of safety and efficacy rests on the assumption that clinical trial data have been gathered, and are presented in an objective and dispassionate manner. There is concern that the current intellectual environment in which some clinical research is conceived, study subjects are recruited and the data analysed

- and reported (or not reported), may threaten this precious objectivity.

The International Committee of Medical Journal Editors (ICMJE) has examined this question of conflict of interest and developed a document that is worthy of adoption by anyone who wishes to strike a balancebetween the need for the investigators to act in the best interests of patients and their desire to serve the interests of the product they are developing or of the sponsors funding the research.

The Council is of the opinion that conflict of interest can never be eliminated completely, certainly not in academic medicine. Those that cannot be eliminated must therefore be recognised, disclosed fully in a transparent manner and managed appropriately. While directing the members to these documents for guidance and edification, the Council has reproduced a section on Conflict of lnterest from the "Uniform Requirements for Manuscript Submitted to Biomedical Journals; Writing and Editing for Biomedical Publications". This document was developed by the ICMJE and was published in the *New England Journal of Medicine,* 11th of September 2001 *(N Eng. J Med.* Vol. 345, No. 11, p 825-27)

Conflict of interest

Public trust in the peer review process and credibility of published articles depends in parton how well conflict of interest is handled during writing. Conflict of interest exists when an author or his institution, reviewer or editor, has financial or personal relationships with other persons or organisations that inappropriately influence (bias) hisactions. The potential of such relationships to create bias varies from being negligible to extremely great. The existence of such relationships doesnot necessarily represent true conflict of interest. Relationships that do not bias judgement are sometimes known as dual commitments, competing interests or competing loyalties. The potential for conflict of interest can exist whether or not an individual believes that the relationship affects his scientific judgement. Financial relationships such as employment, consultancies, stock ownership, paid expired testimony etc. are most easily identifiable conflicts of interest and the most likely to undermine the credibility of the journal, the authors, and the science itself. Conflict can occur for other reasons however such as personal relationships, academic competition and intellectual passion.

All participantsin the peer review and publication process must disclose all relationships that could be viewed as potential conflicts of interest. Disclosure of these relationships is particularly important in connection with editorials and review articles, because it can be more difficult to detect in those publications than in reports of original research. Editors may use information disclosed in conflict of interest and financial interest statements, as a basis for editorial decisions. Editors should publish this information if they believe it will be important to readers in judging the manuscript.

Potential conflict of interest related to individual author's commitments

When authors submit a manuscript, whether an article or a letter, they are responsible for disclosing all financial and personal relationships

between themselvesand others that might bias their work. To prevent ambiguity, authors must state explicitly whether potential conflicts do or do not exist. Authors should do so in the manuscript on a "conflict of interest notification" page that follows the title page, providing additional detail, if necessary, in the accompanying covering letter.

Investigators should disclose potential conflict to study participants, and should state in the manuscript whether they have done so.

Editors also need to decide when to publish information disclosed by authors about potential conflicts. If doubt exists, it is best to err on the side of publication.

Potential conflict of interest related to project support

Increasingly, biomedical studies receive funding from commercial firms, private foundations and government The conditions of this funding have the potential to bias and otherwise discredit the research.

Scientists have an ethical obligation to submit credible research results for publication. As the persons directly responsible for their work, researchers therefore should not enter into agreements that interfere with their access to the data or their ability to analyse the data independently, to prepare manuscripts, and to publish them. Authors should describe the role of the study; sponsor(s) if any; study design; thecollection, analysis and interpretation of data; the writing of the report; and the decision to submit the report for publication. If the supporting source had no such involvement, the authors should so state. Biases potentially introduced when sponsors are directly involved in research are analogous to methodological biases of other sorts. Some journals therefore choose to include information about the sponsor's involvement in the methods section of the published paper.

If a study is funded by an agency with a proprietary or financial interest in the outcome, editors may ask authors to sign a statement such as "I

had a full access to all of the data in this study and I take complete responsibility for the integrity of the data and the accuracy of the data analysis". Editors should have been couraged to review copies of the protocol and/or contracts associated with project specific studies before accepting such studies for publication. Editors may choose not to consider an article if a sponsor has asserted control over the author'sright to publish.

Conflict of interest related to commitment of editors, journal staff or reviewers

When selecting external peer reviewers, editors must be wary of those having obvious potential conflicts ofinterest. Authors often provide editors with the names of persons they feel should not be asked to review a manuscript because of potential conflicts of interest, usually professional. When possible, authors should be asked to explain or justify their concern; that information is important to editors in deciding whether to honour such requests.

Reviewers must disclose to editors any conflict of interest that could bias their opinions of the manuscript, and they should disqualify themselves from reviewing specific manuscripts if they believe such disqualification would be appropriate. As in the case of authors, silence on the part of reviewers concerning potential conflict may mean either that such conflict exists and that they failed to disclose, or that conflict does not exist. Reviewers must therefore also beasked to state explicitly whether a conflict does or does not exist. Reviewers must not use knowledge of the work before its publication to further their own interests.

Editors who make final decisions about manuscripts must have no personal, professional or financial involvement in any of the issues they might judge. Other members of the editors' staff, if they participate in editorial decisions, must provide editors with a current description of

their financial interests (as they might be related to editorial judgements) and disqualify themselves from any decisions where they have conflict of interest Editorial staff must not use the information gained through working with manuscripts for private gain.

Editors should avoid submitting to their own journal, reports of original research to which they have contributed as authors. If they do so, they should remove themselves from the editorial process and delegate editorial decisionson those manuscripts to other members of the editorial staff.

Editors should publish regular disclosure statements about potential conflicts of interest related to the commitments of journal staff.

CONFLICT OF INTEREST IN PATIENT CARE

You must act in your patient's best interests when making referrals, and providing or arranging treatment of care. Hence, you must not ask for or accept any inducement, gift or hospitality, which may affect or be seen to affect your judgement. You should not offer such inducement to colleagues.

Financial interests in hospitals, nursing homes and other medical organisations

- If you have financial or commercial interests in organisations providing healthcare or in pharmaceutical or other biomedical companies, these must not effect the way you prescribe, treat or refer patients.
- If you have financial or commercial interest in organisations to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest.
- Treating patients in an institution in which you or members of your immediate family have a financial or commercial interest may lead to serious conflict of interest. If you do so, your patients and anyone funding their treatment must be made aware of the financial interest. In addition, if you offer specialist services, you must not accept patients unless they have been referred by another doctor who will have overall responsibility for managing the patient's care. If you are ageneral practitioner with a financial interest in a residential or nursing home, it is inadvisable to provide primary care services for patients in that home, unless the patient asks you to do so or there is no alternative. If you do this, you must be prepared to justify your decision.

ETHICS AND MEDICAL RESEARCH

General ethical considerations

1. All research involving healthy volunteers should be approved by an Ethics Committee.

2. All studies should be scientifically and ethically justified.

3. Confidentiality of healthy volunteers should be maintained.

4. The recruitment of some groups, e.g. students, women, children, the elderly, the mentally handicapped and prisoners, raises scientific and ethical issues which should be given special consideration.

5. If the Ethics Committee does not feel competent to consider difficult scientific data or difficult ethical issues (e.g. the use of prisoners), it should seek appropriate advice or co-opt people with the necessary expertise.

6. There shall be no deception that might effect a volunteer's willingness to participate in research, nor should be there any deception about the possible risks involved.

7. Relevant information about significant ethical problems should be supplied to Ethics Committees.

Recruitment and fmancial consideration

1. Initial recruitment of healthy volunteers should be *via* anotice or if verbally, through a group approach rather than to individuals.

2. The Ethics Committee should be given full details of the background, nature and object of the study, how healthy volunteers are to be

recruited, and their age and sex. It should also be informed from which section of the community it is proposed to recruit them in case this raises ethical issues.

3. When students are used as healthy volunteers, the Dean or designated alternate should be informed in writing, giving details of the students, the project and which Ethics Committee has approved the study.

4. It is normally undesirable to recruit students in close contact with the investigator, e.g. on his medical teaching firm or in his class, unless the project is educational.

5. There should be no financial inducement or any coercion that might persuade a volunteer to take part in a study against his better judgement.

6. Any payment to a healthy volunteer should be for expenses, time, inconvenience or discomfort, and never for risk. Increased payments may be reasonable for procedures requiring extra care or involving more discomfort.

7. There should be no financial reward when children areused as healthy volunteers.

8. All payments should be declared to the Ethics Committee, not only those to healthy volunteers, but also those to the investigator, his staff or his department.

Safeguards

1. No study on healthy volunteers should involve more than minimal risk.

2. For most medical research, particularly drug studies, the investigator responsible should be medically qualified and with experience appropriate to the study concerned.

3. Any significant untoward event occurring during or after a study affecting a volunteer should be communicated promptly to the Ethics Committee and the volunteer's general practitioner. Appropriate action to safeguard the volunteer's health should be taken and the study should be stopped in that individual.

4. If a volunteer drops out of a study, for whatever reason, the investigator should take reasonable steps to find out whether harm has come to him as a result of participation in the study.

5. The premises where research takes place should be appropriate to the type of study and to the risk involved.

6. Where drugs are new chemical entities or new combinations of established drugs, and where there is any risk of serious adverse reactions, there should be facilities and appropriately trained staff for full resuscitation.

7. For some types of study further medical help and intensive care facilities should be available.

Design, consent and contract

1. An investigator should keep full records of all studies performed and should keep a register of healthy volunteers used.

2. An investigator should give full details in writing to healthy volunteers explaining the nature, object and duration of a study. The volunteer should be informed of any risk and told what the study will involve,

e.g. number of blood tests or injections, and whether there are any restrictions, for example, on driving or taking alcohol.

3. The volunteer should be asked for permission to contact his general practitioner and if appropriate an insurance company or other medical officer, for details of past history. Where necessary, e.g.in the event of any ill health as a result of the study, there should be further communication. If this permission is not given it is advisable not to use the volunteer.

4. Having been given appropriate information and having given his consent, the volunteer should sign a consent form.

5. Where appropriate, but particularly before taking part in any drug trial, a healthy volunteer should be asked about any relevant medical history which should include smoking, taking of alcohol, drugs and medicines, and whether he had participated in previous studies.

6. Where appropriate a healthy volunteer should be medically examined and have relevant blood, urine or other tests. These may need to be repeated during or after the study.

7. The volunteer should give a commitment to the study and also report any unexpected or unusual symptoms, but he should have the right to withdraw from the study at any time without giving a reason.

8. Volunteers, who participate more than once in drug trials, should be provided with a card or booklet giving details of studies in which they have participated.

9. The Ethics Committee should be informed when a study has been completed and be supplied with any relevant publications.

Ethics related to compensation and insurance

1. The sponsors, whether this be a commercial organisation, university or state sector institution, should agree to pay compensation for injury, accident, ill health or death caused by participation in a research study without regards to proof of negligence and delay. Provision for arbitration in case of disagreement should be included.

2. Where there is any doubt about causation, the benefit of the doubt should begiven to the volunteer.

3. Where necessary the sponsor should take appropriate insurance to cover compensation independent of proof of fault.

4. Where ill health or injury to a healthy volunteer may be due to negligence by a third party, the sponsor should compensate the volunteer. The sponsor should protect his right to claim against other parties in the research.

5. Whether or not they have been notified, insurance companies should honour life and sickness policies of healthy volunteers effected by participation in research that have been passed by an Ethics Committee, and considered to involve no more than minimal risk.

PUBLICATIONS

Conflict of interest

The credibility of an article published in a scientific journal or paper depends on how well conflict of interest is handled during writing, peer review and editorial decision making. Such conflict of interest can occur when the author or his attached institution, reviewer or editor has financial or personal relationships with other persons or organisations that influence his actions. Such basis can vary from being negligible to extremely grave. Financial interest such as employment, consultations, ownership, honoraria and paid expert testimony are easily identified. Personal and family relationships, academic competition, and intellectual passion are other reasons.

People who participate in the peer review and publication process must disclose all relationships that could be viewed as potential conflict of interest.

Potential conflict of interest

It is the responsibility of the author to disclose all financial and personal relationships when writing articles or letters. It should be expressed clearly whether such conflicts exist or not.

Increasingly, biomedical studies receive funding from commercial firms, private foundations and the government. The conditions of this funding have the potential for bias and otherwise discredit the research.

Scientists have an ethical obligation to submit credible research data for publication. *As* they are personally responsible for their work, they should not enter in to any agreements that would change the available data or interfere with independent analysis. The role of sponsors of the study should be disclosed, even if there was no direct involvement of the sponsors.

Conflict of interest related to commitment of editors, journal staff or reviewers

Editors should avoid selecting external peer reviewers with obvious potential conflicts ofinterest, for example, those who work in the same department or institution as any of the authors.

Reviewers must disclose to editors any conflict of interest that could bias their opinions and should be asked whether such conflict exists or not.

Editors who make a final decision must not have any personal, professional, or financial involvement about the manuscript. The editorial staff should not be involved if they have any conflict of interest and not use the information available for personal gain.

Sponsorship by pharmaceutical companies

Sponsorship by pharmaceutical companies has always been a contentious and emotive subject. Nevertheless, the Council is of the opinion that it should make its views known to the medical profession.

1. The pharmaceutical industry today is oneof the most profitable of business enterprises. The industry makes enormous profits some of which is ploughed back for research and development. The industry also sets aside a part of its budget for purposes of promotion and continued use of its pharmaceutical products. In carrying out these promotional activities the industry often targets the medical fraternity by offering inducements**. If such inducements are offered to the profession they should be channeled through professional organisations.** In some instances, a few members may be singled out for preferential treatment, in which case one may argue that such recipients are being favoured for unethical promotion of their products. The medical profession should therefore, take great pains to avoid working, or seen to be working in collusion with drug companies to

promote their wares or products. This is especially so when prescribing drugs by brand names only, without any obvious justification for doing so. We should bear in mind that the public today are quite aware of the unethical promotional activities of drug firms and how some doctors fall easy prey to such inducements. As patient's welfare at all times should be foremost in our minds, we have a great responsibility to see that we do not yield to such inducements by promoting one brand or another for personal gain.

2. The Council is aware of the thin line that at times separates ethical from unethical conduct and of the difficulty in making all members fall in line. In the final analysis, it is the conscience of the doctor that should guide him in a manner that determines whether his conduct is ethical or defensible, when all aspects have been given due consideration.

3. The Council does not hold the opinion that all promotional activities of drug companies are to be condemned or spurned as only profit motivated. The pharmaceutical trade plays an important part in promoting continuing medical education (CME) and continued professional development (CPD) of the medical professional. The Council expects that such activities involving the promotion of drugs, devices etc. are carried out in an objective, impartial and unprtjudiced manner. Promotional material should not be garishly or obtrusively displayed, though it is a matter to be regretted that often limits are exceeded in this respect.

4. Promotion of CME and CPD activities such as organising lectures, workshops, seminars etc. or donation of books and grants to medical libraries are some of those activities which by themselves cannot be considered unethical. However, in the manner of its execution, some companies leave much to be desired, e.g. claims may be unsubstantiated, grossly exaggerated or misrepresented, or the promotional material given undeserved or undue prominence.

5. The majority are of the opinion that the medical fraternity should act responsibly when dealing with the pharmaceutical trade. Most, if not all, large scale drug manufacturers set aside funds for promotional activities around the globe. The highly competitive nature of the business, anticipation of quick returns on investments etc. make promotional activities also to be run in a very well organised and high profile manner. In this process, unscrupulous manufacturers may resort to offering inducements to the medical fraternity, which are obviously unethical, while others may resort to more subtle or covert ways of enticement. It is also a matter of concern that there is no way that the Council could rap errant doctors who engage in unethical activities in collusion with drug companies. It is here that the collective ethical practice or ethical culture of the profession must prevail.

6. Most doctors are of the view that support of drug companies is helpful in organising activities such as annual sessions, workshops and seminars in congenial surroundings, especially when input from foreign experts are also expected. The progress in therapeutics and new diagnostic technology in almost all specialties of medicine is so rapid, that professionals in the third world find it extremely difficult to keep pace with these advances. No government in these countries could afford to bring close to home these skills and knowledge, nor can they update the service providers in line with global trends. This is the reality in the professional world today, especially the third world. It has also to be borne in mind that if we spurn such offers from multinational companies, there are many other countries that would grasp such opportunities with both hands for the benefit of their professionals. It is in this context that the profession, starved of facilities to better itself, turns to the pharmaceutical trade for support and assistance. Though a minority hold extreme views on this matter, the majority are of the opinion that the medical profession and the pharmaceutical trade could work in close cooperation, without having to compromise patients' interests or the good name of the profession.

7. The medical profession in Sri Lanka has always been the proud boast of successive governments that its members are "second to none", or that "they are as good as the best in the world". Our members have had the benefit of participating in international conferences, workshops, seminars etc. and also interacting with professionals of world renown flown here, at times with the support of the pharmaceutical trade.

   Taking these issues into consideration, the Council wishes to lay down the following guidelines for the benefit of its members:

   a. Medical practitioners must ensure that patient care and medical judgment are not compromised or do not appear to be compromised by any type of incentive offered by the pharmaceutical trade. They should have the patient's best interest at heart at all times and should not accept gifts, grants, subsidies etc. if such acceptance influences clinical judgment, selection of drugs, devices or other modalities of treatment.

   b. Any gifts accepted by physicians individually should be of benefit to patients, and be of modest value such as textbooks, journals and audio-visual aids, if they serve a genuine educational function. Individual gifts of minimal value are permissible as long as they serve an immediate purpose, e.g. writing pads and pens. Physicians should not accept gifts if they are given in recognition of their prescribing practices. Any support to individual practitioners to participate in any symposium or seminar should not be conditional upon any obligation to promote any medical product or appliance.

   c. Contributions to defray cost of CME, conferences, professional meetings, workshops, seminars etc. can contribute to the improvement of patient care and therefore are permissible. **Such**

contributions should be made to the professional organisations or associations and not be in the name of individual doctors.

d. Fellowships, sponsored trips to attend conferences etc. should be channeled through professional organisations. The recipients too should be decided by the organisation taking into consideration their commitment or contribution to patient care, research, undergraduate and postgraduate training etc.

e. When symposia, seminars etc. are organised, the content of such meetings should be as objective and scientific as possible. Presentation by independent professionals or scientists, and organisation of such event by professional bodies, would enhance the educational value of such meetings.

f. The fact of sponsorship by a pharmaceutical company could be clearly stated at the meeting and in any proceedings published. The latter should accurately represent the presentation and discussions. Entertainment, hospitality or any gifts offered should be secondary to the main purpose of the meeting, and should not be ostentatious or extravagant.

g. All promotion-making claims in relation to drugs, devices etc. should be accurate, informative and up to date. The claims should be truthful, capable of substantiation and in good taste. They should not contain ambiguous or unverifiable statements, or omissions likely to induce the medically ignorant or uninitiated to be misled.

h. Incentives, bonuses offered by private organisations to practitioners employed by them, should not directly or indirectly decrease or limit medically necessary services to their employees.

Practitioners must not restrict patients' access to appropriate services ifmedically indicated, in order toplease their employers. Any conflict of interest should be resolved in the patient's favour.

i. Medical representatives should not offer inducements to prescribers, nor should the latter solicit such inducements. Inorder to minimise unethical promotion **the pharmaceutical trade should be urged not to couple remuneration of medical representative to the volume of sales they generate.**

The above are guidelines laid down by theSLMC for the benefit of medical practitioners. The Council expects them to follow these guidelines when dealing with members of the pharmaceutical trade. These ethical guidelines, if not adhered to, can bring disrepute or discredit tothe profession. In matters of doubt, the opinion of the Council can be sought, giving it a reasonable time to respond.

CONFIDENTIALITY IN MEDICAL PRACTICE

Introduction

In the course of a professional relationship, all that transpires between a doctor and patient are considered confidential. This principle can sometimes create conflict situations, notably with the law enforcement authoriteis.In somecountries,the lawis positive in makingit obligatory for medical practitioners to maintain confidentiality,with criminal sanction inthe eventof a breach.In SriLankathereis no suchspecificstatutory provision, but confidentiality is implied in the contract between doctor and patient, and any unauthorised disclosure of professional secrets would constitute a breach of contract, with grounds for civil proceedings against the doctor. However, this issue has not been contested in a court of law in Sri Lanka and confidentiality remains essentially anethical rather than a legal requirement

Principles of professional secrecy

- Patients are entitled to expect that information about themselves or others, during the course of a medical consultation, investigation or treatment, will remain confidential. Doctors therefore have a duty not to disclose to any third party, information about an individual learned in their professional capacity, either directly or even indirectly.

- When a patient or a person properly authorised to acton a patient's behalf consents to disclose in accordance with that consent an explicit request by a patient that information should not be disclosed to particular people, or indeed to anythird party, must be respected in the most exceptional cases, e.g., where health, safety or welfare concerns would constitute a risk.

- Doctors carry a prime responsibility for the protection of information given to them and must take steps to ensure, as far as possible, that patient's records, manual orcomputerised, to which they have access.

or which they transmit, are protected by effective security systems and adequate procedures, to prevent improper disclosure.

- Most doctors in hospitals and even in general practice work as health care teams, and some may need access to information, given or obtained in confidence about individuals, in order to perform their duties. It is for a doctor who leads such a team to judge when it is appropriate for information to be disclosed for that purpose. Those receiving such information must be in no doubt that it is given to them in strict professional confidence. The doctor also has responsibility to ensure that arrangements exist to inform patients of the circumstances in which information about them may have to be shared and to give patients the opportunity to state any objection to such disclosures.

- A doctor who decides to disclose confidential information about an individual must be prepared to explain and justify that decision, whatever the circumstances of the disclosure.

Exceptions to the general principle

Normally the principle of medical practice is that professional secrecy will be maintained, but under certain conditions the doctor is also duty bound to reveal confidential information to another person or third party, who has an equally binding legal, social or moral duty to perform. Under these circumstances, it could be considered desirable for the doctor to disclose the relevant information to the appropriate person, party or authority as the case may be.

Consent

The confidential information is that of the patient and not of the doctor, and, therefore, the doctor is perfectly entitled, perhaps as a duty, to disclose information if asked to do so by the patient or his legal advisor, preferably with written and valid aid consent for disclosure.

CONSENT IN MEDICAL PRACTICE

'No man is good enough to govern another man without that other's consent' **-Abraham Lincoln** (1854)

Introduction

An unlawful touching of someone's body may be construed as an assault, battery or illegal trespass. It cannot only bea crime or a civil offence or both, but also immoral and unethical. Most doctor-patient relationships involve some physical contact. In such relationship the doctor has a moral obligation to examine the patient where he has to touch the body of the patient, if only taking of pulse but legally speaking the doctor has no right to touch the patient without his/her agreement. Therefore, the doctor must be sure always to have the patient's CONSENT prior to any examination, procedure or treatment that bridges the gap between doctor's obligation and patient's right in medical practice.

General principles

Modern society recognises the general moral notion that all people are autonomous beings who have a right to, and indeed should, make their own decisions. In medicine this means that a competent adult person is entitled to decide what shall be done with his orher own body. The law reflects this principle as it is unlawful for a doctor to treat a patient without that patient's consent. To be valid, the consent must not only be voluntary, but also be based on full understanding of the nature and implications of the proposed treatment. The doctor should givea patient sufficient information for the patient to understand the nature of any proposed treatment, its implications and risks, and the consequence of not taking the treatment. In the light of that information the patient will either give consent or refuse to do so. A patient's requirements as regards information are particularly high when the treatment or operation will result in grave and possibly irrevocable consequences.

Therefore, there is more to consent than getting a patient's signature on a consent form or on the bed head ticket/ clinical notes. In seeking consent, the doctor is required toprovide sufficient details and information in non-technical language the nature, purpose and material risk of the proposed procedure to enable the patient to form a proper decision. The patient should be capable of understanding the nature of the treatment or procedures and their implications. A misinformed consent or one given without a proper understanding of what is involved is of little value. While it might protect against allegation of assault, unlawful trespass or battery, it would not afford a defense against allegation of negligence.

The extent of the explanation which the doctor should give when seeking consent will depend on many factors and may pose considerable problems, calling for fine clinical judgment The factors to be taken into account will include but not limited to:

- Patient's age and maturity.
- Physical and mental state.
- Intellectual capacity.
- Standard of education.
- Reason for the procedure, operation or the treatment.

For example, a routine cosmetic procedure may need to be discussed far more extensively than an emergency operation for life-threatening condition in an ill patient. The explanation which the doctor gives may also depend upon the questions asked by the patient. Generally, careful and truthful answers should begiven to a particular request by a patient for information. There is no requirement that every possible complication and side effect should be explained to the patient. Obviously a balance must be struck between telling patients enough to enable them to give a real consent and yet not so much as to frighten them needlessly from agreeing to treatment which is demonstrably essential for their well-being. Achieving that balance can bevery difficult, even for practitioners of many years of experience.

Patient's ageand maturity:

Considering the fact that provision of medical treatment is a kind of civil contract and in Sri Lanka the legal age of maturity is 18 years, any person of sound mind who has attained that age may givea legally validconsent to surgical, medical or dental procedure, or treatment. What has been less clear is whether a person under the ageof 18 years cangive consent. In 1985 in the UK the House of Lords held that, where statute otherwise provides, a minor's capacity to make his or her own decision depends upon the minor's having sufficient understanding andintelligence to make the decision, and is not to be determined by referencetoany judicially-fixed age limit It furtherheld thatit will beaquestionof fact, and notfaith, whether a child seeking medical advice hassufficient understanding of what is involved to give consent valid in law. Until the child achieves the capacity to consent, the parental right to make thedecision continues only in exceptional circumstances. However, where the minor is without that capacity any apparent consent by him or her will be a nullity, the sole right to consent be ingvested in the parent or guardian.

Material risk:

In a judgment in House of Lords in the UK in 1985, it was ruled that a doctor's duty to warn his patientof the risk of treatment is confined to material risks. The test of materiality is whether in the particular circumstances a reasonable person in the patient's position would be likely to attach significance of the risk. Even if the risks were material, the doctor would not be liable if, upon a reasonable assessment of the patient's condition, he considered that a warning would be detrimental to the patient's health.

In deciding what to tell the patient the doctor will be expected to asses the patient's ability to understand the significance of the information and to act in accordance with the standards adopted by a responsible bodyof medical opinion. His decision is however still open to the scrutiny of the court which may question the adequacy of the information.

Types of consent

- **Implied and expressed:**

  A valid consent maybe expressed or implied. In many consultations and procedures, the patient rarely agrees explicitly but will, instead, give implied consent, e.g., the patient will undress and lie on the examination couch when the doctor indicates the wish to examine himor her, or the patient may roll upa sleeve and offer an arm when the doctor indicates a wish to take the blood pressure or a blood sample. However, the doctor should know the limitation of implied consent and shall not overstep when it is necessary to obtain expressed consent

- **Oral and written consent:**

  A perfect valid consent may be given orally and there isno absolute necessity for it to be in writing. However, oral consent is usually not appropriate for major procedures and in special situations because it provides no documentary evidence of agreement. The problem is a practical one. Disputes over consent may arise much later after the event by which time memories of an oral consent are unreliable, or a witness to an oral consent may be dead or unreliable by the time allegation is made. Therefore, mainly fore vidential reasons it is wiser to have a signed document, the consent form, duly witnessed. However, if only oral consent is obtained it is recommended to makean entry (which may be abbreviated) in the clinical notes or in the bed head ticket which may confirm that the consent has been obtained.

- **Informed consent:**

  The need for informed consent to be obtained before any medical procedure is commenced, except in emergencies, has both moral and legal implications.

  Should the doctors treat patients without such consent?

If they do so and they mistreat they may be liable to compensate such patients for trespass.

Should the patient suffer harm, the doctor may also be liable for negligence or breach of contract.

Informed consent implies that patients really know and have an understanding of what they are consenting to. The medical practitioner must answer fully and frankly all questions that the patient specifically put to them concerning the risks of the treatment to be undertaken. Courts do not give much weight to an excuse that full disclosure of the risks involved was not made lest the patient's chances would be pre judiced by anxiety. It is the general view of the law that adult patients should decide these matters for themselves and not have them decided for them by the doctor, no matter how well intended such doctor might be. Several court cases have considered various matters that"reasonable" doctors should consider in deciding what information must be told to the patient and such matters include:

- The personality, temperament and attitude of the patient,
- The patient's level of understanding,
- The nature of the treatment,
- The magnitude of the possible harm, and
- The commonness of the risk.

Medical practitioners must always keep in mind that many patients have a gross lack of understanding or much less comprehension than one may ascribe to them. They frequently do not understand what has been told to them and often will not make their lack of understanding known. These facets in relation to proper communication must always be bornein mind when obtaining 'informed' consent about more complex procedures or those in which there are risks or possible complications. In addition, patients frequently 'forget' conversations with their doctors

concerning the outcome of the treatment, and in particular when there is a subconscious wish by the patient to suppressany undesirable results. The specific natureof the act to be performed must be made clear aspossible to the patient and doctors must never rely on blanket consent.

To be valid, consent from a patient must be:

- Competently given
- Freely given
- Informed
- Specific to the examination, procedure or the treatment being performed.

Obtaining consent:

- **From whom the consent is taken?**

  For it to be legally valid consent must be taken from the patient or in the case of a minor it shall be from a parent or guardian. Although it has no legal validity consent may be taken from the next of kin or arelative if the patient is of unsound mind or it is impossible to take the consent from the patient because of the prevailing medical conditionor it is medically not desirable to take the consent from the patient for his/her own interest.

- **Explanation by knowledgeable doctor**

  Consent must be taken by a medical or dental practitioner who should be familiar with the details and risks of the proposed operation or investigation. The task should no be delegated routinely to a juniorhouse officer, especially if a complicated or specialised procedure is contemplated. 1

- **Do not exceed your authority**

  Although consent to 'further or alternative operative measures or treatment' is normally and correctly obtained, **this covers** only what

becomes necessary during the operation for the preservation of the patient's life or health. It does not allow the surgeon to contravene the expressed wish of the patient or to undertake additional, albeit well-meaning, procedures for which the patient may not have given consent had he been consulted If, for instance, you intend to remove a patient's sebaceous cyst at the same time as an appendicectomy, pleaseobtain his consent before hand!

- **Do not alter the consent form**

  No alteration should be made to the consent form after it has been signed by the patient. If it proposed to alter the planned procedure the patient must be told and a new consent form should be signed.

- **When should consent be obtained?**

  Consent should be obtained preferably a short time before the operation (but before pre-medication is given) or the procedure. In the case of elective surgery or procedure, where no change in the basic condition requiring operative treatment or procedure is to be expected, there is no objection to obtaining the patient's signed consent during the outpatient clinic or consultation.

  If the patient's condition alters between the outpatient consultation and admission to hospital so that there is some material change in the nature, purpose or risk of the operation or the procedure, then the patient's consent should be obtained again. Afurther explanation should be given and a fresh consent form should besigned.

  Similarly, if a considerable time has lapsed between the outpatient consultation and admission it would be wise to obtain consent anew.

- **Inability to obtain consent**

  If apatient is unconscious or if there is a genuine emergency a doctor

may safely undertake whatever treatment is necessary to ensure the patent's life or health without waiting to obtain formal consent

Although the consent ofa relative to the treatment ofan adult patient has no legal validity (whether or not the patient is unconscious o rof unsound mind) it will not justify a doctor in treating such a patient unless he is otherwise justified because it is a situation of urgent necessity. However, it is a sensible precaution to obtain it, but the absence of it should not prevent the doctor from doing whatever is necessary for thehealth and safety of the patient. The doctor should do only what is immediately necessary for the patient's well-being. If during such an emergency procedure, some coincidental and non- urgent problem is encountered it should not be dealt with until later, after consent has been obtained.

- **Duress**

  Consent must be freely given after having fully understood the nature, purpose and material risk of the proposed procedure. It may notbe valid if it is obtained under any form of duress.

Emergencies and consent:

In the case of a genuine emergency, the practitioner may safely proceed to do what is reasonably necessary to save the life or prevent deterioration in the patient's health without a formal consent. Medical and not legal considerations are of greater importance in life-threatening situations and the courts are most unlikely to censure a practitioner for proceeding to provide essential treatment in an emergency. However, the doctor should do only that which is immediately necessary for the patient's well being. If during an emergency procedure, some coincidental and non-urgent problem is encountered it should not be dealt with untillater, after consent has been obtained.

The principle to guide the practitioner is to act in good faith and in the immediate interest of the patient's health and safety. If there is any element of doubt, there should be no hesitation in seeking the advice and opinion of one or more colleagues.

If the emergency arises in an unconscious patient the practitioner should, if time permits, endeavour to obtain the assent of the next-of-kin, but if urgent treatment or investigation is essential the doctor should have no hesitation in proceeding to do what is necessary. The next-of-kin's consentis not legally necessary, nor will it justify a practitioner intreating an unconscious patient unless he is otherwise justified because it is asituation of urgent necessity.

Consent and mentally disordered patients

Except where other statutory law provides specific provisions (e.g. Mental Health Act) the general law of consent continues to apply, as before. Avalid consent can onlybe given by a patient who is mentally ill or impaired if the matter concerned is within his or her understanding. Not all patients suffering from mental disorder or impairment or psychopathic disorder are incapable of giving personal consent to treatment. Therefore, the fore going general considerations of the law cannot apply to them as to other patients. For those adult patients who, through mental illness or impairment, lack the necessary understanding to givea personal consent to treatment, there is a legal difficulty. As amatter of good practice however the doctor wishing to provide treatment should seek to obtain approval of his proposed course of action from the guardian, responsible medical officer or relative as appropriate. A second medical opinion as to the necessity of the treatment may also be desirable.

Consent in laboratory practice

All procedures carried outona patient require informed consent of the patient. Forcing someone to undergo medical testing of any kind is an

invasion ofprivacy and a violation of human rights. For most laboratory procedures, consent can be inferred when the patient presents him or herself at a laboratory with a request form and willingly submits to the usual collecting procedures, for example, venepuncture. Patient in a hospital bed should normally be given the opportunity to decide.

Special procedures, including the more invasive procedures will require a more detailed explanation and in some cases written consent. This is desirable when there is likelihood of complications following the procedure. In emergency situations, consent might not be possible and under these circumstances it is acceptable to carry out necessary procedures provided they are in the patient's best interest The laboratory should endeavour to see that results with serious implications are not communicated directly to the patient without the opportunity for adequate counselling.

In actual practice, most of the time the consent for the testor collection of samples are done NOT by the laboratory staff and this is usually performed by the ward staff in the case of in-ward patients, and by a phlebotomist or anurse in case of outpatients.

HIV testing:

Laboratories performinghuman immunodeficiency virus(HIV)testing shall follow the National AIDS Control Programme (NACP) guidelines, which include pre-test and post-test counselling. The laboratory shall not perform HIV test unless the individual has been given pre-test counselling and post-test counselling is ensured. Informed consent ofthe patient will be taken before the blood is collected.

Consent for treatment and religious beliefs:

Problems of consent can arise for the doctor faced witha patient, usually a Jehovah's Witness, who refuses treatment (usually to receive blood), when in the doctor's opinion it is necessary. However, the above

principles and the law on consent would be meaningless if the doctor could force blood into an unwilling patient.

In such adult patients the first decision for the doctors is whether they are willing to treat the patient at all in circumstances where treatment such as blood transfusion may be necessary. If the doctor is not prepared to allow the patient to die as a result of his/her belief, then it might be better not to accept the patient. If the doctor is willing to undertake treatment, then the nature of the illness and the need for possible treatment- may be blood transfusion - should be explained to the patient who should be warned, in clear terms, of the possible consequences of refusing it. This explanation should be given in the presence of a witness.

If despite an unambiguous warning, the patient adheres to his refusal to receive treatment (may be blood), he/she should be asked to sign a written declaration of his refusal. Alternatively, his/her oral refusal should be recorded by the doctor in the notes and countersigned by the witness.

In the case of children however the position is not so simple. No signed waiver can absolve the doctor from criminal proceedings. It would be an unlawful act for someone (including the doctor) to wilfully ill-treat, neglect or abandon that child or to expose him/her to unnecessary suffering or injury to health. Should the child die as a result of such ill treatment or neglect the facts could give rise to a charge of culpable homicide or rash, and negligent act.

It should be for the doctor in charge of the child patient to do what is genuinely believed to be best for the child. These decisions are not easy and should not be left to junior medical staff. While the doctor concerned will hesitate before overriding the wishes of the parents, ultimately a decision will have to made on the basis that it is the child and not the parent who is the patient. In reaching a decision the doctor will need tohave due regard to all thecir cumstances relevant to the individual case, and to consider possible alternatives to the treatment or blood transfusion

or its products. The doctor also may wish to consult with medical and nursing colleagues and perhaps others. If the doctor finally decides to proceed with the treatment or blood transfusion he or she should document the decision, the reasons for it, and the fact that one or more colleagues concurred.

Consent and research clinical trials:

Non-therapeutic procedures, research and trials pose very special problems over consent. The problems are much easier foradults than minors, the mentally ill or subnormal. The researcher and the doctors are advised to follow the guidelines published by locally or internationally recognised medical organisation(s).

Consent in forensic medical practice:

The requirement to obtain valid consent is especially important in the context of providing a forensic clinical service for the following reasons:

- The information (from the history taken, examination and the testing of specimens) may become available to a relatively wide audience. Prepared reports of testresults will enter not only the patient's medical record, but may also be required to be tendered in open court. Such information may include details ofpast medical history and photographs.

- The findings, or more particularly the interpretation of the findings, may not necessarily benefit the patient. The disclosure of certain details may be distressing and in some cases provide compromising or incriminating evidence against him orher. This possibility should be discussed with the patient before consent is obtained for the examination.

- Those who are clinically examined for medico-legal purposes are mostly referred by a law enforcement authority such as police, judiciary, quasi-judicial body or a lawyer (when in connection with a civil

matter). In any event the informed consent of the examinee shall betaken preferably in writing. However, if the person presents to the doctor with an appropriate referral (e.g. medico-legal examination form, judicial order) depending on the circumstance of the incident implied consent may be sufficient. However, if the person is produced by police or the incident is that of a major crime such as rape, informed written consent shall be taken.

- Judicial order to a doctor to do a medical examination does not preclude the doctor of his/her ethical obligation to obtain appropriate consent though the doctor may be relieved from legal liability by such anorder. Therefore, if the consent is not forthcoming the doctor shall explain to the patient about the legal implications and if the person is still not consenting shall not proceed with the examination. He/her may observe external findings and inform the court about patient's unwillingness.

Consent for autopsies and retention of body tissue:

There is still a doubt in law as to who, if anyone, is the lawful owner of a dead body. The corpse does not havea property value in law. Some have argued that no one can claim to own a corpse and that, at best, the issue is one of possession until it is disposed of rather than its ownership.

In the case of judicial autopsies there is no problem of consent. The judicial order is a complete authority to the doctor to perform the autopsy.

In the case of non-judicial (hospital/ pathological) autopsies performed for the purpose of finding out the extent of the disease process or of investigating th eexistence or nature of abnormal conditions, consent of the next of kin and the permission of the head of the public medical institution where the body is lying shall be obtained. In the case of unclaimed bodies, the head of the public medical institution can decide in accordance with the Human TissueTransplantation Act.

For removal and retention of tissues required for medico-legal investigation, the doctor performing the autopsy has the right to do so and no consent is required but a proper record of retained samples shall be maintained.

For any research using a corpse or samples obtained from a corpse ethical and legal clearance and appropriate consent of the next of kin shall be obtained in advance.

Colleagues

Information about a patient may be shared with another registered medical practitioner who assists with the clinical management. Information may also be shared, to the extent that the doctor deems necessary, with other professional persons who are directly concerned with the patient's health, e.g, dentist, nurse, paramedics and professionals supplementary to medicine. It is the doctor's duty to ensure that those with whom information is shared, appreciate the rule of professional secrecy.

Information to relatives

Traditionally, doctors are willing to discuss a patient's illness with the immediate relatives to a lesser or greater extent. In exceptional circumstances a doctor may consider it undesirable, for medical reasons, to seek the patient's consent to the disclosure of confidential information. In such case information may be disclosed to an immediate relative, but only when the doctor is satisfied that it is necessary and in the patient's best interests to do so.

If in the doctor's opinion, disclosure of information to a third party other than an immediate relative would be in the best interests of a patient, it is the doctor's duty to make every effort to persuade the patient to allow the information to be disclosed. If the patient steadfastly refuses to allow this, only in exceptional circumstances should the doctor override the refusal and be prepared to justify his action.

Difficulties may also arise when a doctor believes that a patient by reason of immaturity does not have sufficient understanding to appreciate what the treatment or advice being sought may involve. Similar problems may arise where a patient lacks understanding because of illness or mental incapacity. In all such cases the doctor should attempt to persuade the patient to call in an appropriate person to be also involved in the consultation. If the patient cannot understand or be persuaded, but the doctor is convinced that disclosure of information would be essential in the patient's best interests, the doctor may disclose to an appropriate person or authority, the facts of the consultation and the information gathered from it. A doctor who decides to disclose information must be prepared to justify that decision and must inform the patient before any disclosure in made.

Public interest

Cases may arise in which disclosure in the public interest orin the interest of an individual may be justified, for example, a situation in which the failure to disclose appropriate information about the patient, places someone else at risk of death or serious harm. This is perhaps the most contentious exception to the general rule of confidentiality.

The doctor is not merely a "healthcare professional" but also a citizen of the country in which he or she practices. There will at times be situations that create a conflict for the doctor as to whether the greater duty is to the patient or to the public, and there is seldom an easy answer to this dilemma. What seems a problem to one doctor may not be a problem to another! We offer no rules, no easy solutions. We recommend only that the doctor faced with such a dilemma, takes advice and consults senior colleagues of good repute with adequate experience, or a relevant professional body, without disclosing the identity of the patient. Ultimately however the individual practitioner must resolve the dilemma and act according to a combination of what is believed to be the patient's best interests and the dictates of the doctor's conscience.

Disclosure required by statute (statutory duties)

Information may be disclosed in order to satisfy a specific statutory requirement or regulation.

Examples include:

- Notification of communicable diseases.
- Notification of poisoning and accidents under the provisions of the Factories Ordinance.
- Notification ofbirths and deaths.
- Notification under the Prevention of Terrorism Act and other similar regulations.

Disclosure in connection with judicial proceedings

Despite a widely held belief to the contrary, confidential medical information is not privileged from disclosure to the courts. This contrasts sharply with the privileges accorded to legal professionals. Any information passed to them by a client in the course of a professional relationship can not be subject to an order for disclosure.

Where litigation is in progress, unless the patient has consented to disclosure or a court order has been made, information should not be disclosed by a doctor merely in response to a demand from others such as a third party or their lawyer.

The doctor may disclose such information as may be ordered by a judge or the registrar of the court acting on the orders of the judge, or the presiding officer of a court/ tribunal with necessary legal authority or an inquirer into deaths at an inquest. In such circumstances the doctor should first establish the precise extent of the information which needs to be disclosed and should not hesitate to make known any objections to the proposed disclosure of confidential information about third parties

Information may also be disclosed at the direction of the disciplinary proceeding committees of the Medical Council which is investigating a complaint against adoctor or his fitness to practice.

Disclosure for the purposes of medical teaching, research and audit

Medical teaching, research and audit necessarily involve the disclosure of information about individuals, often in the form of medical records, for purposes other than their own healthcare. Where such information is used in a form which does not enable individuals to be identified, no question of breach of confidentiality will usually arise. Where the disclosure would enable one or more individuals to be identified, the patient concerned or those who may properly give permission on their behalf must wherever possible be made aware of that possibility and be advised that it is open to them at any stage to withhold their consent to disclosure. It is ethical to disclose information in this manner only for the purpose of a proper medical research, which has been approved by a recognised ethics committee.

Disclosure to employer or insurance company or immigration authority

Special problems relating to confidentiality can arise where doctors have responsibilities not only to patients but also to third parties, as for example, where a doctor assesses a patient for an employer, an insurance company or an immigration authority. Insuch circumstances, the doctor should ensure that at the outset the patient understands the purpose of any consultation or examination, is aware of the doctor's obligation to the employer or insurance company, or immigration authority, and the consent to be given by the doctor on their terms. Doctors should undertake assessment for insurance orof an employee's fitness to work, or travel overseas, only where the patient hasgiven written consent for examination and disclosure of information.

Disclosure after patient's death

The fact of a patient's death does not of itself release a doctor from the obligation to maintain confidentiality. In cases where consent has not previously been given, the extent to which confidential information may properly be disclosed by a doctor after someone's death, cannot be specified in absolute terms and will depend on the circumstances. These include the nature of the information disclosed, the extent to which it has already appeared in published material and the period which has elapsed since the person's death.

Where information is sought by a third party about a dead person, the appropriate consent that needs to be given, is that of all the personal representatives of the estate of deceased i.e., his executors, or if none, those who take out "letter of administration".

Not infrequently a life instnance office will write to a doctor for informationbefore agreeing to pay out on a life policy, especially if it was taken out not long before death. The doctor will be wise not to release any details until the insurance office has provided the consent of the personal representative of the person concerned.

AIDS, HIV status and STDs

Neither AIDS nor positive HIV status arecstatutorily notifiable conditions yet.

Thus the ordinary principles of law and ethics apply to information about patients with AIDS or about HIV status. Particular care is necessary over confidentiality in view of the profound social consequences for the patient

If the doctor is the family physician for both husband and wife or sexual partners, and one of them is diagnosed to have AIDS or positive HIV status or a STD, the doctor must persuade him/her to disclose the

information to the other partner, or else the doctor may disclose the information with the consent of the patient. If he/she refuses to give consent or declines to disclose information to the spouse or the sexual partner, the doctor may disclose the information after informing the patient

Confidentiality and non-medical staff

If the ethical principle is to mean anything, it is clearly important that all members of the healthcare team should honour it. Medical practitioners should ensure that all members of the team are fully aware and constantly mindful of their duty to respect patients' confidentiality. Case notes should be kept secure and access to them should be strictly controlled. It is the clinician in charge of the care of patients who is ethically responsible for the confidentiality of medical records. This should not be overlooked even though tlie responsibility may, for example, be delegated to medical records officers or someone else.

Different members of the team may have loyalties that differ from those of the doctor. Social workers for example, may consider that their primary duty is to thec ommunity. Some caution may therefore be called for by the doctor when asked to participate in case conferences that are also attended by the police and/or social workers etc.

Tue principles of confidentiality applies not only to doctors and supportive staff who have received information in a clinical relationship with a patient, but also to doctors and other administrative staff who receive information indirectly, in the course of administrative or non-clinical duties.

Some practical problems associated with confidentiality

Not infrequently practical difficulties over confidentiality tend to arise over requests for medical reports usually by the police, lawyers, insurance companies and employers.

Where the police seek information about a patient from the doctor it maybe prudent in most situations to ask the police to provide the patient's informed consent before passing on information to the police. If the doctor examines a patient at the request of the police, in addition to thewritten consent normally taken prior to the examination, informed written consent should be taken to pass on information to the police. If such consent is not given the doctor should not divulge information to the police.

In a situation where a serious crime has been committed, the doctor is faced with his/her professional duty to the patient, who may even bea suspect to the crime and his/her public duty as a citizen. In such a situation, the doctor has to carefully assess the facts and take a decision about providing information and to what extent this should be done. However, the doctor will have to justify the decision.

Where a lawyer seeks information, the doctor should take care to check for whom he acts and what he asks. If he specifies that he acts for aparticular individual and seeks information only about him/her, the doctor may prepare a report after obtaining the written consent of the patient However, the doctor should confine the report only to the required information about the particular individual.

The same general principles apply to any one seeking information about a patient, that will require the patient's specific agreement prior todisclosure of any information by thedoctor.

IDegal abortion

Unless thelaw of thecountry allows termination of pregnancy under certain conditions, a doctor who aborts a woman does so on pain of criminal conviction and probably loss of his medical registration. Though adoctor may be motivated by compassion to help some unfortunate woman or girl, such an action is still illegal.

Conversely, where the law allows therapeutic abortion to save the life of a mother, if there is any religious or moral objection to abortion by a doctor, he cannot be forced to perform or assist in the termination of pregnancy. Procuring an abortion also still remains unethical.

Where a doctor learns that a criminal abortion has taken place, his obligations depend on the circumstances. If the act was performed by the woman herself, the doctor should confine himself to giving all necessary medical care. It is unethical for him to report this patient to the police or to anyone else, unless the patient's life is in danger or death occurs. However, if the same woman seeks treatment repeatedly after illegal abortion, the doctor may decide to inform the police.

The situation could be different if the abortion was carried out by another person. If that person is a member of the family, the doctor may decide not to disclose the information to the police or any other person without the consent of the patient.

A dilemma may occur when it is known that a "professional abortionist" is involved, particularly if using unsterile and dangerous methods that may put the lives of others at risk. However, unless the doctor is satisfied that his public duty overrides confidentiality to his patient, the doctor should not disclose the matter without the consent of the woman. If the doctor decides to disclose the information he should be able to justify the decision.

A judgement delivered in Britain in 1914 states: **"The desire for a doctor to preserve confidentiality must be subordinate to the duty which is cast upon every good citizen to assist** in **the investigation of a serious crime".**

In consequence to this judgement the British Medical Association and the Royal College of Physicians took legal advice to resolve that:

"A Medical Practitioner should not under any circumstances disclose voluntarily, without the patient's consent, information obtained from that patient in the course of professional duties"