IMO Submission to the Medical Council on the New Draft Guide to Professional Conduct and Ethics for Registered Medical Practitioners

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The Irish Medical Organisation (IMO) is the representative body for all doctors in Ireland and promotes the highest level of professionalism among the medical profession in Ireland, for example, through IMO position papers on the Role of the Doctor and through CPD events. The IMO welcomes the opportunity to comment on the New Draft Guide to Professional Conduct and Ethics for Registered Medical Practitioners. Please find below comments and concerns collated from our members on specific paragraphs and sections of the new draft guide:

Chapter 1: Purpose of the Guide

Section 2: While it is not explicitly stated in Chapter 1, one of the aims of the guide is to help the community to know what they can expect of the medical profession in Ireland. Expectations of the community must be realistic and take into account the difficulties facing doctors working in a health system where resources have been significantly reduced. Some guidance may be required for the public to ensure that legitimate complaints are brought before the Medical Council and that frivolous matters which are costly, timewasting and stressful for the medical professional are discouraged. Additionally the community should be made aware that if a complaint is made against an individual doctor, it does not mean that he/she is guilty of professional misconduct or poor professional performance.

The Medical Council has an important role in fostering trust between the community and the medical profession and the IMO are calling on the Medical Council to review the complaints system to ensure that it is fit for purpose. As just 11% of all complaints made to the Medical Council are forwarded to a fitness to practice inquiry, doctors should not be labelled as "not in good standing" while under investigation by the preliminary proceedings committee.

Chapter 2: Professionalism

Paragraph 6.4 A doctor suffering from mental health issues may not be in a position to seek help due to lack of insight.

Chapter 3: Professional Identity

Paragraph 8.1 The doctor-patient relationship is built on mutual respect.
Paragraph 9.3 Doctors should not discriminate between public and private patients.
Section 10 There is some discrepancy between paragraph 10.2 and paragraphs 13.2 and 14.5. Paragraph 10.2 suggests that where a doctor refuses a treatment for a patient that the patient should be offered the opportunity to have that decision reviewed by another clinician. Paragraphs 13.2 relating to Nutrition and Hydration and 14.5 relating to End of Life Care do not suggest this. Additionally Section 10 suggests that by refusing one specific treatment a doctor is refusing to provide an alternative form of treatment. This section needs clarification as in such cases a patient would not necessarily require a second opinion.

Paragraph 11.2 ***"You should inform the child's parents or guardians of your intention to report your concerns taking into account that this may endanger you or the patient."***
This is unhelpful. This section should provide specific guidance as to what the Doctor should do in the eventuality that disclosure could endanger the patient or the Doctor.
Paragraph 14.1 Doctors have an important role in the care of patients nearing the end of life, however doctors cannot be held responsible for lack of resources in the area of palliative care.
Paragraph 14.6 There are cases where a doctor may override a patient's refusal to treatment. Further detail is needed here. (See comments on Paragraph 55).
Section 16 Careful attention must be given to this section to ensure that it does not conflict with legislation or DOH Guidance for healthcare professionals.
Paragraph 18.1 ***"You are not obliged to put yourself or others at risk of harm in the course of assessment or treatment. However, in such circumstances, you must make a reasonable effort to conduct a full and appropriate clinical assessment and treatment, taking appropriate measures to protect yourself and others."***
Clarification is needed on what constitutes "reasonable effort" and what "appropriate measures" are suggested.
Paragraph 18.2 Doctors must only use physical and chemical restraint if they have the appropriate expertise.
Paragraph 19.1 Prisoners are entitled to the same standard of care and treatment as other patients including the right to privacy and dignity. Where possible treatment should be provided within the prison and conditions of privacy should be available.
Both inside and outside the prison, prisoners should be examined without restraints or the presence of Gardaí or prison officers. It should be acknowledged that violent or potentially violent patients may require physical restraint as well as the presence of Gardaí or prison officers during their assessment. Guidance should be provided on how to assess the level of risk in each particular case.

Chapter 4: Practice

Sections 22 and 23 Doctors in management roles may be required to take actions which are not in the best interests of patients, particularly where budgetary constraints may impose managers to take decisions that impact on patient safety and quality of care. The current Guide to Professional Conduct and Ethics for Registered Medical Practitioners (7th Edition) states: *Your paramount professional responsibility is to act in the best interests of your patients. This takes priority over responsibilities to your colleagues and employers.* Sections 22 and 23 weaken this requirement. Greater guidance is required for doctors where conflict between their role as manager and their role as a doctor arises.
Paragraph 23.4.1 When advocating on behalf of groups of patients, doctors should openly declare any conflicts of interest.
Paragraph 25.6 Some reference is needed to legislation.
Section 28 "*Patient information remains confidential even after death*." This should be emphasised. Clarification is needed on how doctors should deal with questions raised by bereaved relatives, concerns of standards of care, genetic issues, Freedom of Information requests.
Paragraph 36.6 While doctors should take steps to ensure that patients with drug dependency are not inappropriately obtaining drugs from multiple sources**,** doctors cannot

be held responsible if a patient is deliberately drug-seeking and dishonestly obtaining drugs from multiple sources.

Paragraph 37.2 Greater guidance is required for doctors providing telemedicine services to patients within the State. The IMO is calling on the Government to regulate the provision of telemedicine services as such services do not provide personalised, continuity of care, and do not necessarily adhere to best-practice guidelines. In addition telemedicine consultations may not even be provided by a registered physician but by other healthcare professionals. As such telemedicine services are open to abuse and are potentially damaging to long-term health outcomes.

Section 38 The IMO welcomes section 38 which reflects guidance on the use of social media in the IMO position paper on that topic. Guidance on social media does not conflict with the duty of doctors to advocate on behalf of their patients.

Paragraph 38.7 Doctors should routinely check that information about themselves on social media or other internet sites is factually correct.

Paragraph 39.4 The IMO are calling for the regulation of plastic surgery and non-surgery services in Ireland. More detailed guidance in relation to the advertising of these services is required here.

Section 48 The circumstances where doctors should declare potential conflicts of interest requires further elaboration for example to patients, when speaking at educational events, when publishing research.

Paragraph 48.3 The concept of "gifts" could be elaborated to include travel to attend medical meetings where sums involved are not negligible.

<u>Chapter 5: Partnership</u>

Paragraph 49.2 This paragraph should also reference emergency situations and situations where patients lack capacity.

Paragraph 50.5 In the event where a patient lacks capacity, a patient's healthcare decision making is rarely legally vested with anyone else. Even legal power of attorney does not include decisions on healthcare unless explicitly stated. Advice here requires greater clarification and should reflect legislation as well as the National Consent Policy.

Paragraph 51.5 ***"You must not withhold from a patient any information necessary for decision-making unless disclosure would cause the patient serious harm. In this context 'serious harm' does not mean the patient would become upset or decide to refuse treatment."***

It would be more useful to define what "serious harm" means rather that what it doesn't mean.

Paragraph 52.2 ***"Whenever possible, you should discuss treatment options and their risks at a time when the patient is best able to understand and retain the information, and sufficiently in advance of the treatment to enable them to consider their options and reach a decision. You should not usually seek consent from a patient when they are stressed, sedated or in pain and therefore less able to make a calm and reasoned decision."***

This is usually not possible in an emergency situation and this should be clearly stated.

Paragraph 55 There are extreme cases where a doctor may override a patient's refusal of treatment. For example refusal of treatment by a suicidal patient, where a patient with anorexia nervosa refuses feeding or a blood transfusion is refused on the grounds of religion. This paragraph requires some clarification.

Section 58 The guidance is inadequate for those working in mental health services. A separate section is required on the right of young people to consent/refuse mental health treatment in the absence of their guardian and children's rights to confidentiality and disclosure of information to parents and guardians. The Mental Health Act is in direct contradiction to other legislation in this area and doctors require clear guidance.
Paragraph 58.8 ***"You should tell children and young people that you cannot give an absolute guarantee of confidentiality."***
This advice is problematic and can compromise the doctor-patient relationship with vulnerable children. This paragraph requires careful consideration.
Section 60 This section should make a clear distinction between professional and personal relationships.
Paragraph 62.2 ***"When discharging patients back to primary care all relevant information must be provided in a timely manner."***
Due to cut backs it is now not infrequently the case that discharge letters wait months to be typed after they have been dictated. This is an issue for hospital administration.

Chapter 6: Performance

Paragraph 66.2 should refer to the specific responsibilities of trainee doctors which are referred to in paragraphs 60.3, 62.1, 62.2, 72.1, 72.2 and 72.3.
Section 69 Irish is the first official language in the constitution. Patients may also choose to be treated by a doctor who speaks Irish.
Section 71 Fear of litigation is a major barrier to apologising and communicating with patients following an adverse event and medical professionals are often the second victims of such events. The IMO supports open disclosure to patients following an adverse event. And is calling for the urgent publication of the Health Information Bill which is intended to provide protection to a health professional from admitting liability when apologising.

Aspects which have not been Sufficiently Addressed in the New Guide

The new guide makes clear the huge expectations placed on the profession and onerous nature of practicing medicine in Ireland. The guide fails however to sufficiently address the constraints placed on doctors due to the under resourcing of the health service. While reference is made to the advocacy role there is no guidance provided for what doctors should do where resources are insufficient to allow doctors to deliver on their role and this level of expectation. Where additional standards may be set by the Medical Council it would be prudent that a heath technology assessment is carried out to ensure that appropriate resources are made available.

The new guide fails to address the conflict of interest placed on medical practitioners working in a mixed public and private system. Greater detail is needed on how doctors should react when commercial imperatives conflict with professional duties.

Similarly where public payments are related to performance, for example length of stay, doctors may be unwilling to discharge patients where there is no appropriate rehabilitative care or care available in the community. Some guidance should be given here.

The IMO is happy to discuss any of the issues raised above.
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