CODE OF CONDUCT

Caribbean College of Surgeons

2019

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Introduction

The Code of Conduct contained in this document provides a guide for conduct acceptable to the Caribbean College of Surgeons for the Fellows and Associates of the College and surgeons in practice in the Caribbean. It is also a guide to the conduct that is expected of surgeons, for the public, patients, other professionals, and administrative, financial and other staff employed in institutions involved in medical and health care delivery in the Caribbean

A Code of Conduct and Ethical Behaviour is based on the principles that govern conduct between professionals and others, and in particular those with whom they come into contact in the course of their work. In this code this not only means patients, it means colleagues, other workers in health institutions and businesses, government, third party payers, and at times the courts. Observance of the principles in this Code of Conduct is particularly important, when dealing with sick or disabled persons and their relatives, who in their time of need may be anxious and vulnerable to exploitation, abuse or neglect.

The principles of Ethical Conduct by the medical professional are usually summarised as being guided by Beneficence; Non-malfeasance; Autonomy and Justice. It is therefore appropriate that this document be introduced with a Charter of Patients' Rights adopted by the Caribbean College of Surgeons.

2019

The Rights of Patients

Access to Care
Patients have the right to timely access to health care regardless of their age, race, religion, gender, class, and political or other affiliations.

Respect
Every person has the right to be addressed and treated with respect and dignity.

Religious and Cultural Expression
Each person has a right to their cultural and religious practice; including modes of dress, grooming and symbols; provided they are legal, not offensive, are hygienic and safe.

Identification of Health Personnel
Patients have the right to the identity of any health worker involved in their care.

Confidentiality
Patients have the right to privacy; including all information related to their health care

Access to Information
All patients are entitled to access the information about their condition for the purposes of insurance or any other legal purpose, including second opinions and referrals.

Other Opinions
Patients have the right of access to other opinions, and should be facilitated in doing so.

Consent to Treatment
Patients have the right to participate in decisions about their care. Explicit consent should be obtained for any intervention that may cause harm, physical, mental or social.

Refusal of Treatment
Any legally competent patient can refuse to be treated, and must be informed of the medical consequences of their refusal.

Freedom from Abandonment
No patient should have their care abandoned unless arrangements have been made for their care to be taken over by competent health care workers or institution.

Provision of Basic Necessities
Patients are entitled to be provided with basic hygiene facilities at health premises

Security
Patients have the right to be protected from physical, verbal or mental abuse, when attending health facilities. Patient records should be secured from unauthorised persons

Right of Complaint
Patients have the right to bring before an appropriate authority complaints, grievances and criticisms; and to feel free from any threat of reprisals, or denial of care

Ethical Conduct of Surgeons and Medical Practitioners

The Hippocratic Oath is often referred to as the guideline for conduct of the medical profession and the first law of therapeutics "Primum non nocere" - *First do no harm* is considered the most important guiding principle for the surgeon. The broad principles enunciated in that oath can be applied to all medical practitioners or specialists, their staff in offices or health care facilities where they work. They are summarized in the terms of ethical conduct towards patients, namely:

Beneficence – do good,
Non-malfeasance – do no harm,
Justice – equality under the law, and
Autonomy – the right of the individual to decide what is done to them.

These principles are expressed through: -

- Access to a high standard of care, including the availability and use of modern technology in diagnosis and treatment
- Availability of treatment choice and alternatives, including the equipment and supplies appropriate to different health care settings
- Avoiding unnecessary or unsafe procedures, treatments, equipment and medical supplies
- Professional, administrative and other health worker interrelationships
- Not associating with unlicensed persons claiming to be health professionals
- Informed consent to surgical or medical treatment at all stages of care
- Respecting the religious, cultural and human rights of everyone
- Attention to End of Life issues, respecting the right to die without unwanted and ineffectual treatments or procedures.
- Confidentiality within the health professional – patient relationship.
- Availability of health information, including timely certification and reporting
- Precluding unnecessary or excessive charges.
- Adherence to health legislation and avoidance of litigation
- Security of patients and others in the workplace
- Avoidance of improper relationships with patients or their dependents
- Observance of ethical principles in biomedical research

With these principles in mind the following expands on these principles and guides the practising into safe professional and ethical conduct.

1. Registration of Medical Practitioners and Specialists

The rights of patients and those of medical practitioners and specialists cannot be realized without assessment of their training, qualifications and continuing professional development. The Councils/Boards in different countries register practitioners following the provisions in the law in each jurisdiction.

Registration to practice in one country is not transferable from one country to the other. Surgeons undertaking to do procedures in another country should ascertain that they are in compliance with local law and regulations

1.1. Annual Registration and Continuing Professional Education

Some countries require the annual renewal of registration, and may require satisfactory participation in CPE and payment of an annual registration fee. The requirements for CPE vary for practitioners in the countries where it applies.

Currently CPE requirements for registration apply in Antigua and Barbuda; Bahamas; Barbados; BVI; Cayman Islands; Guyana and Jamaica

1.2. Specialists Listing/Registration

There are specific provisions for the registration/listing of specialists or additional qualifications in the following Caribbean countries - Antigua and Barbuda; Bahamas; Barbados; BVI; Cayman Islands; Guyana; Trinidad and Tobago

In Barbados the medical council register consists of separate lists of medical practitioners and specialists. Specialists may appear on both lists, but those specialists whose names appear on the specialist register ONLY, may see patients on referral only. This designation reflects the fact that these specialists have only been in specialist training and practise after their basic qualification. Such specialists are deemed not to be experienced in the diagnosis and treatment of the generality of patients.

1.3. Temporary and Special Registration

Some territories have provision for a specialist practising temporarily or to be specially registered to do specific tasks.

2. The Responsibilities of Medical Practitioners to Patients

Surgeons and other medical practitioners should function in a manner that is above reproach and does not take advantage of patients in physical, emotional or financial terms. In all their dealings practitioners should identify themselves, listen to patients, respect their views, and treat them with dignity and respect. A practitioner's dignity and respectfulness must be maintained even under provocation from patients, or their relations.

All medical practitioners and specialists should identify themselves and their role whenever they are providing a service for, or making an enquiry of a patient.

2.1. Access to and Provision of Care

All medical practitioners, specialists and the staff who work with them, are expected to facilitate access of patients to care in a timely manner, and must not exploit publicly funded patients by asking them to pay for services.

2.1.1. Advertising and Solicitation of Patients

Advertising by medical practitioners or specialists is not encouraged in Caribbean countries and is unlawful in some jurisdictions. For example, Section 23.2.c. of the Medical Professions Act in Barbados states "any form of advertising, canvassing or promotion, either directly or indirectly, for the purpose of obtaining patients or promoting his own professional advantage that is contrary to the provisions and rules in the act" is professional misconduct; and sections 24 -31 of the Act and the Guidelines published by Council provide a guide to medical practitioners and specialists as to what is permissible in advertising.

Practitioners are advised to determine what the law states in the jurisdiction where they practice and seek to comply with their professional colleagues in respect of advertising.

Practitioners should not solicit patients either directly or indirectly, including the splitting of fees with other practitioners for the referral of patients.

2.1.2. Patients' Right to Service

Practitioners must recognize and respect the patient's right to choose their physicians, and to accept or refuse treatment. Patients have the right to seek a second opinion if they so desire, and should be facilitated in doing so.

Patients are entitled to medical services irrespective of their race, colour, religion, sexual orientation, age, political affiliations or perceived socio-economic or immigration status. Practitioners must ensure that their personal or religious beliefs do not prejudice their decisions in the provision of care. A practitioner cannot withdraw from the responsibility of continuing a patient's care on the basis of their personal beliefs, unless and until they have made adequate arrangements for the continuation of that patient's care.

2.1.3. Prisoners and particularly Vulnerable Patients

Medical practitioners involved in the care of prisoners, detainees and other

institutionalized or disadvantaged patients, have a duty to provide them with treatment and protection of the same quality and standard as is given to others.

Practitioners should not order, condone or participate in the restraint or interrogation of any person under their care. Ordering that a patient be restrained must only be done on medical criteria for the protection of that patient's physical or mental health.

Retrieval of 'evidence' such as bullets or suspected an illegal drug cache from a patient must only be done in the patient's best medical interest**.** Such evidence must be identified labelled and signed by the responsible physician/surgeon and handed to an identified police officer

Writing a report on findings in a patient who is in custody should like any other report be done at the request of the patient or on the written request of the Commissioner of Police or on an order from the Court. Such reports should state the history given and the findings in fact and should not seek to interpret the causation of any injury found. Any opinion as to causation should be reserved for direct questioning in a Court or a written request from the patient's legal representative or a Court.

2.1.4. Referrals for Care

Practitioners should recognize when their own knowledge, skill, competencies and experience are inadequate for the care of a particular condition or patient. In this eventuality the practitioner or specialist have a duty to refer patients to suitably qualified and experienced colleagues where available.

2.1.5. Effective Communication with Patients

Medical practitioners and first contact personnel [i.e. receptionists, clerks and nurses] must have communication skills that allow them to successfully relate to patients, regardless of their education, or socioeconomic level. Sensitive, compassionate and temperate language avoids offence, and should not heighten the anxiety that affects patients and others about their illness.

When it is necessary to translate another language, a practitioner or the administration of an institution or clinic should request and attempt to obtain a suitable person to do so.

Wherever possible a practitioner should act as the patient's advocate, guiding them through the unfamiliar procedures and places that the patient encounters in the course of health care.

2.1.6. Intimate Contacts, Examinations and Sexual Misconduct

Doctors, nurses and other health professionals are required to have 'intimate' contacts with their patients, during taking a history, examination, investigation, treatment and nursing care. To avoid any perception of improper sexual conduct, all intimate contacts such as vaginal, rectal, or breast examinations should be chaperoned. This applies whether the contacts are male/female or same sex contacts. Another health professional, a parent/guardian or a relative approved by the patient may act as the chaperone.

When a chaperone is not available, the health professional should either defer the

procedure or ascertain whether they wish the procedure to go on without a chaperone. If during the procedure the patient expresses any anxiety, disquiet or sign of sexual stimulation, the health professional should cease the procedure and resume only when a chaperone is available.

Patients grant doctors and other health professionals privileged access to their confidences; and some patients may become emotionally involved with them. Good practice depends upon the maintenance of trust between doctors and other health professionals and their patients and families. All medical practitioners, specialists and members of staff associated with the care of patients, must exercise great care and discretion and should not seek to exploit or damage the doctor-patient relationship by engaging in sexual or other intimate relationships with patients or their relations. Improper relations leave the other party uncomfortable, offended, disrupt the person's family life, or damage the trust between the practitioner and the patient.

Any sexual act, sexual advance or indecent exposure committed by a medical practitioner that involves patients may be considered a criminal act, as well as serious professional misconduct.

2.1.7. Quality of Service

Medical practitioners should provide the best standard of care attainable. This includes: -

- the conscientious recording of patient data such as name, address, insurance status
- an accurate assessment and recording of a patient's clinical condition,
- competent and considerate professional management;
- recognition and appropriate responses to patients requiring urgent intervention
- seeking advice and consultation with colleagues when necessary
- acknowledging when their skill and experience is inadequate
- promptly acceding to a patient's right of access to information from their records.
- being considerate and understanding of the anxiety of patients and their families,
- providing care that allows life to end with dignity, respect and in comfort.

2.1.8. Adherence to the Law

Medical practitioners shall adhere to the law in the jurisdiction in which they practise, even when the law is not consistent with their personal or religious beliefs. Laws that impact on medical care differ in different countries and jurisdictions, and practitioners should acquaint themselves with the laws in the jurisdiction that relate to health issues. These usually include those governing termination of pregnancy, the protection of children and the mentally ill. Practitioners whilst respecting the wishes of the patient when dealing with issues such as termination of pregnancy, must keep within the provisions of the law.

There are some countries that have mandatory provisions in their law for reporting possible crimes, e.g reporting of Child Abuse in Jamaica; reporting of Cocaine possession in Trinidad. However, where there are no mandatory provisions in law, the physician/surgeon has a duty as a citizen to report to the police suspected crimes such as wounding by knives and guns, as well as the transportation of illegal drugs in body

cavities [drug mules].

When reporting a suspected felony, the physician/surgeon should adhere to the findings in fact and should not speculate as to their causation. Retrieving possible evidence such as a bullet or suspected illegal drugs must only be done in the best medical interest of the patient. When such evidence is retrieved it should be labelled and signed by the responsible physician/surgeon and handed to identified police officers. All unsolicited reports to the police should be done with the prior knowledge/consent of the patient or their next of kin when they are not in a mentally competent state.

Police should not be offered or allowed access to patients who are not in custody against their will. Such access should only be granted when the physician has decided that the patient is in a fit state to be interviewed.

2.1.9. Refusing to Treat

It is breach of the duty of care for a practitioner or their staff to refuse treatment or investigation to a patient. Medical practitioners and other health care professionals have the right to conscientious objection and may refuse to participate in procedures such as termination of pregnancy. However, such refusal must not place the patient in danger, and arrangements must be made for the patient to be treated by a competent practitioner or health professional that has no such conscientious objection.

A practitioner has no right to refuse to care for patients on the basis of a fear of ‘contagion’ or possible injury. Practitioners should have received sufficient training to allow them to protect themselves from the transmission of commonly feared diseases. Adherence to the principles of surgical disinfection and sterility during procedures protects the patient, the surgeon and staff.

It is unprofessional to withhold treatment from any patient on the basis of a moral judgment_that the patient's behaviour or lifestyle contributed to their condition. A practitioner who has had a personal or legal issue with a prospective patient may decline to care for the patient after they have given the reasons why, and made a referral to a suitably qualified colleague to undertake the person’s treatment

2.1.10. Safe Equipment, Supplies and Medications

Practitioners must practice to the best of their ability, and never expose patients or fellow staff, to avoidable risks. Therefore, practitioners must ensure the maintenance and availability of essential equipment, supplies and medications.

Except in a life threatening emergency, a practitioner should defer treatment where essential equipment is either unavailable or is known to be unsafe.

2.1.11. Risks to Patients from Health Staff

Medical practitioners, and other health workers should not expose patients to risks, from their personal health. This includes dependence on alcohol, drugs or medications, and transmissible diseases such as hepatitis.

Risks to patients from acquired infections must be minimised through the proper

maintenance of buildings and equipment, hand washing and the use of sterilized instruments. It is recommended that surgeons be immunised against hepatitis B.

2.1.12. Up-to-Date Care

A surgeon like other medical practitioners and specialists has a responsibility to keep up-to-date with relevant developments in their fields. In particular, patients should not be subjected to risks from unnecessary or out-dated procedures, or equipment. Evidence of continued professional education before reregistration to practise is required in some jurisdictions. Nevertheless, practitioners in all jurisdictions should ensure that their CPE is most appropriate to their practice.

2.1.13. Costs of Services

Patients should be advised in advance about any charges they will incur, and of any public or other third party payer available to them. No patient requiring life threatening emergency care should be denied such care for lack of an ability to pay at the time of the emergency.

2.1.14. Appropriate Use of Resources

Medical practitioners and specialists and all others involved in patient care should recommend only those diagnostic and therapeutic procedures believed necessary for the care of the patient; taking into account the availability and costs of the resources needed.

Patients must be made aware of their findings and be given recommendations for their care in a timely manner. Patients should be informed about the alternatives to the care recommended, to allow them to reach an informed decision.

2.2. Religion and Culture

A medical practitioner must respect the right of patients to their religion and culture; this includes modes of dress and food prohibitions. This right can be denied if its observance is unlawful, or violates the rights or safety of others in a health facility

Proselytising of a practitioner's religion to patients or their relations is not allowed during the process of patient care. This does not preclude a practitioner taking part in the patient's own religious observance, or making arrangements for the general religious comfort and solace of institutionalised patients.

Modes of dress and grooming are cultural choices that should be respected unless they offend decency, are unhygienic, or interfere with medical management.

2.3. Identification of Practitioners

Medical practitioners and specialists must be identifiable to patients and other members of staff in institutional settings. Such identification may be in the form of a nametag or identification badge, and displaying their Registration Certificate in private offices. Except in dire emergencies, all medical practitioners and specialists must dress in a manner befitting their professional status. It is particularly important that surgeons and

other practitioners identify themselves to patients when wearing masks.

Practitioners are entitled to privacy of their personal matters including contractual conditions within an institution or business. The involvement of identified practitioners in the proceedings of meetings, a case conference etc. is confidential.

2.4. Confidentiality

All information about patients in the course of medical care is confidential and cannot be divulged without the explicit consent of the patient or their legal guardian; or as a result of a court order. Medical practitioners and specialists are obligated to ensure that other members of their staff have an obligation to the patient's confidentiality.

2.4.1. Patient Records

All patient information, including financial information is confidential. Patient notes must only be handled by relevant staff and the health professionals taking care of the patient. Staff should not allow access to a patient's notes by any staff or other health professional without the permission of the patient and the physician in charge of the patient's care. Patient notes should not be removed without the knowledge of the patient's physician, and/or the supervisor of the patient care area. Patient records being used for report writing, etc. must be kept secure and confidential at all times and should be returned to their secure location as soon as possible.

Patient clinical records/information kept in electronic form must have a unique identification number, and must be password protected. Electronic and other records must be kept for reference, research and legal purposes for the lifetime of the patient and after the patient's death. Records should only be destroyed when the period called the statutory period of limitation has passed; and in such a manner that preserves confidentiality of the information.

The statutory period of limitation should be ascertained in each jurisdiction, but surgeons are warned that it usually runs from the date of any identifiable complication of a procedure, however remote it may be.

Surgeons are reminded that the decision-making, consent process for and description of an operative procedure must be recorded in sufficient detail that they can defend any legal challenge they may face.

2.4.2. Exceptions to Non-Disclosure

A medical practitioner or specialist must be prepared to justify their actions if they have disclosed confidential information about a patient. Written consent to such disclosure from the patient, or their legal representative should be obtained. In the event of the patient's incapacity, information may be divulged on the written consent of the patient's next of kin or a person with a legal power of attorney for this purpose. In such circumstances only the information to which the consent refers should be disclosed.

Other health care professionals who are participating in, or are assuming responsibility for the management of a patient, should receive confidential information about patients from

the practitioner of record. It is the practitioner's responsibility to ensure that those professionals appreciate that the information imparted during care, review and training activities is in professional confidence.

Disclosure to an appropriate authority such as a court must be done for specific statutory requirements, and for death certification. Disclosure in the public interest may be justified on the grounds that it is required by the police, e.g. in the investigation of a grave or very serious crime, such as life threatening wounding, or poisoning.

If there is any doubt about whether information should be disclosed, advice should be sought from the practitioner's legal advisor or the appropriate institutional ethical committee. Practitioners in surgical practise are advised that they should be part of an insurance scheme that offers prompt legal advice and covers the possibility of an adverse legal judgement or settlement.

2.4.3. Disclosure for Legal Purposes

If a doctor is directed to disclose information by a judge or a magistrate in court, only the specified information should be disclosed. Information must be disclosed to a coroner to enable the determination of whether an inquest should be held.

When confidential information must be disclosed for public health notification or other lawful reason, without a patient's consent, the following principles should be observed:

- Disclosure must be necessary in law or regulation or for a public health purpose.
- The patient should be told that disclosure is to be done, and the reason therefor
- Care must be taken to avoid any damaging consequences for the patient, in particular any interference with the rights and dignity of the patient.

2.4.4. Issues in Maintaining Confidentiality

Most difficulties that arise with confidentiality in practice, can usually be overcome when practitioners and other health professionals are prepared to discuss openly and honestly with patients the implications of their condition. In particular, where the importance for their continuing medical care of ensuring that other health professionals involved know the nature of their particular needs.

If after having carefully discussed the matter and the patient refuses to allow their diagnosis or treatment to be disclosed, the patient's request for privacy must be respected; unless the patient's condition or their intended action poses a mortal threat to a third person.

2.4.5. Withholding Information from a Patient

In should be a very unusual circumstance when a practitioner believes it is in a patient's best interest to withhold medical information from a patient. If this occurs the practitioner should seek the advice of colleagues or an ethical committee of an institution or professional association with which they are associated. If such action is considered justifiable, the practitioner should consider giving the information regarding the patient's health in strict confidence to a close relative or person in a similar relationship.

2.4.6. Mature Minors

A medical practitioner must take particular care to respect the confidentiality of adolescents and mature minors; notwithstanding the fact that confidential information is necessary for their parents or guardians to make decisions about the minor's care.

Where a minor presents for advice or treatment, and is not accompanied by a parent or guardian, the practitioner must have in mind the need to foster and maintain parental responsibility and family stability. However, the practitioner must take into account the gravity and sensitivity of the minor's illness, and the wishes of the minor to have their illness remain confidential from their parents.

Before offering advice or treatment to the minor a medical practitioner or specialist must satisfy themself that the minor has sufficient maturity and understanding of their condition to appreciate what is involved. If after every effort has been made to have the minor agree to have the parents or guardian informed, and the practitioner is satisfied that it is in the minor's best interests to offer advice or treatment and preserve the minor's confidentiality, they may do so without the parent/guardian's consent.

2.4.7. Confidentiality after Death

Patient information should remain confidential after death. Only the information that is necessary for legal purposes should be disclosed; i.e. death certification; or proceedings in court.

When difficulties arise about disclosure of information after death, such information can only be disclosed on the written authorization of the executor of the patient's estate or their next of kin.

2.5. Access of Patients to their Records

Patients have the right to access all information about their medical condition for the purposes of insurance or any other purpose. In order to maintain the confidentiality of the patient, information should only be made available on their explicit authority or their legally authorised representative.

When a patient is not legally or medically competent to access information themself, the next of kin or legal guardian of the patient have the rights of access to the information.

2.5.1. Relatives and Patient Information

The involvement of family is highly desirable in managing a patient's illness. However, information can only be given to relatives [including spouses and close relatives] with the clear consent of the patient when they are, or were competent to do so.

2.5.2. Medical Certificates

Medical certificates are given to patients at their request for presentation to employers, school authorities, examination boards, etc. Improper certification is against the law and may attract prosecution for fraud

Certificates may state fitness or unfitness on medical grounds, but should not indicate the

nature of the medical condition, unless specifically requested by the patient. Requests from the patient to include their diagnosis should be in a written consent form, which is usually contained in insurance claim forms or similar documents.

Practitioners should ensure that patients understand the nature of the consent that the patient may unwittingly sign.

2.5.3. Medical Reports

A patient is entitled to have the written opinion of their physician in relation to the diagnosis, prognosis and advice on treatment. Medical reports are statements made with the patient's consent and are usually made for presentation to another physician, an insurance company or a legal representative.

Medical reports can be vital to the health and wellbeing of patients and should be provided expeditiously. In Barbados the Medical Profession Act requires that such reports should be furnished within 3 months.

Where a report is requested for other urgent medical advice, the responsible practitioner should supply the report as soon as possible; preferably within five working days.

Medical reports for use by the police or attorneys-at-law should be primarily factual and should not contain opinions on any matter not obtained directly during assessment and treatment of the patient.

When a medical report is being done on behalf of a third party, e.g. an insurance company, the physician must ensure that the patient understands that they consent to the report being done, and the practitioner's legal responsibility to be truthful, before proceeding with the examination or treatment.

Expert opinions are distinct from medical reports in that they are an opinion by the practitioner on the medical management of other practitioners or specialists.

2.6. Other Opinions

Patients have the right to access other opinions. Practitioners should facilitate access to a ‘second’ opinion by other suitably qualified practitioners. Patients should be made aware of the process of consultation and be asked to make clear if they are asking for their care to be taken over by another practitioner.

If the patient requests a second opinion from a person who is not a medical practitioner, the practitioner of record should make clear to the patient if they have any objection to taking part in the consultation and why. Practitioners are reminded that in many jurisdictions it is improper to associate ‘with unqualified or unregistered medical persons’

Patients must be made aware when there will be charges for a second opinion and if known what the charges are.

Practitioners should record the request for an opinion in the patient notes, in addition to any other form of communication. Where the consultation is external to an institutional setting, a medical report containing all the relevant information should accompany the patient. The physician of record should receive the ‘second’ opinion and discuss it with

the patient, wherever possible jointly with the second physician.

2.7. Consenting to Investigation and Treatment

Patients have a right to receive all relevant information about their condition, including the examination, investigations, the treatment proposed and the risks involved. Except in a life threatening emergency treatment should not be undertaken without the free and informed consent of any patient who has the legal and mental capacity to do so. Surgeons are advised that specific major risks of a procedure should be disclosed and recorded, irrespective of how rare they are. Written and witnessed informed consent forms should be retained for medico-legal purposes.

2.7.1. Right of the Patient to Question

It is essential that both the medical practitioner and the patient feel free to exchange information before investigation or treatment is undertaken. Patients have the right to question the practitioner or any other person rendering investigation or treatment, on their training, experience and ability to give such investigation or treatment. Practitioners and other staff should be tolerant of such questioning and attempt to answer all such questions as clearly and honestly as possible.

2.7.2. Minors and Consent

Unless under the conditions exempted by law and precedent, all persons under the age of 18-years should have their consent given by a parent or a legally appointed guardian. Minors like any other patient must be treated in a life-threatening emergency with or without the consent of their parents or guardian. A parent under the age of 18 yrs. may consent for their child, and the mother should be considered a 'liberated minor' in consenting for herself.

Refusal by a Minor of Parental Consent. A practitioner who has assessed, and can demonstrate, that it is in the best interest of a minor to be treated without the parents' consent or knowledge, may do so if the minor can be demonstrated to be sufficiently mature to understand their medical condition and its consequences, and to give informed consent to treatment. In carrying out such action, it is the responsibility of the practitioner to demonstrate that the parents or legal guardian are not acting in the best interest of the minor, either by neglect or the decisions they wish to make. These conditions also apply when the minor insists on confidentiality of their illness from their parents. Such action is based on legal precedent rather than statute law [Gillick 1985] Furthermore, practitioners have recourse to the courts , by petitioning to remove parental responsibility and make the minor a ward of the court.

2.7.3. Mental Incompetence

If a patient is unconscious, of unsound mind, or is otherwise unable to give valid consent, the attending surgeon has a responsibility to obtain the consent of the next of kin, appropriate relative, or legally appointed guardian.

If there is no known next of kin or legal guardian, consent may be sought from the Chief Executive Officer of the institution treating the patient, or through the court appointing a

legal guardian

Persons giving consent for a mentally or legally incompetent patient must do so solely in the patient's best interest and not that of themselves or the institution in which they work.

2.7.4. Consenting in Emergencies

In the event of a life-threatening emergency, no consent is necessary and health care professionals should act to save the patient's life. In dealing with any emergency a medical practitioner or specialist should act within the limits of their training and experience.

Similar conduct/rules apply in any Good Samaritan act that a practitioner may be involved in.

2.7.5. Advance Directives (Living Will)

Specific life-saving measures, such as the use of a ventilator, should not be undertaken where it is known to the medical practitioner or specialist undertaking a patient's care, that there is a prior legal instrument refusing consent to such procedures.

2.7.6. Disclosure of Risks and Alternatives

Medical practitioners, specialists, and other health professionals have a responsibility to:

- fully disclose the extent of the risks involved in any investigation or treatment of a patient, and should ensure that the patient understands the risks involved.
- provide information about alternative treatment that is appropriate and available.
- inform the patient if the proposed treatment or procedure is experimental, and if so of the protocol that is being followed.
- ensure that consent is not being given under duress, from staff or others.

2.7.7. Implicit and Explicit Consent

A patient's consent may be given implicitly, for example by their agreement to provide a specimen of blood for multiple analyses. In other circumstances consent needs to be given explicitly, for example before undergoing a specified operative procedure or providing a specimen to be tested for a specific condition such as a cancer or HIV.

Practitioners should be cautious about using the term 'routine' testing as a means of obscuring sensitive information from a patient, or simply not wishing to take the time to explain. For example, the use of the term 'opt out' in relation to HIV testing should not be construed to mean testing in secrecy from the patient, since one cannot 'opt out' without knowing what is proposed.

2.8. Refusal of Treatment by Patients

Any legally competent patient can refuse to be treated, including treatment previously agreed to and consented for.

2.8.1. Counselling re Refusal of Treatment

A patient who refuses to be treated should be counselled by the health professionals involved in their care, and informed of the medical consequences of their refusal. Counselling of the patient should include the possible alternatives for care. After the reasons for the patient's refusal have been clarified and all efforts to persuade them to accept treatment have been exhausted, the refusal of the patient should be recorded in the patient's notes.

2.8.2. Refusal Form

Where the patient's refusal to be treated poses a danger to the patient's life, either imminent or more remote, the patient should be asked to sign a witnessed form of refusal.

Where the refusal of treatment occurs during the process of therapy, including an operative procedure, the therapy should be stopped after explaining and carrying out any safety measures required in doing so.

A patient's refusal to be treated should not prejudice their treatment for any other condition, or subsequent treatment for the same condition

2.9. Abandonment of Care

It is improper for a practitioner to abandon a patient in danger without sufficient cause and without allowing the patient sufficient opportunity to retain the services of another medical practitioner or specialist.

Abandonment of a patient occurs when they are no longer given care. It applies whether the care is physical or mental, and includes the denial of the essentials of care, including sympathetic communication with the patient. No conduct of a patient or their relatives justifies the abandonment of the care of a patient. Where the conduct of a patient or their relatives is offensive, disruptive, or dangerous to others, the reason for such conduct should be determined and addressed by the practitioner and others involved in their care.

The care of patients who are considered incurable should not be curtailed in such a manner that the patient and/or their relatives feel that they have been abandoned.

2.9.1. End-of-Life Care

At the end of life a patient should not have their care curtailed until all avenues and arrangements have been explored for their care to be taken over by competent health care workers or by an appropriate institution. Care at the end of life includes sympathetic communication, prompt assistance with basic needs, as well as adequate relief of pain.

2.9.2. Isolation or Quarantine

Isolation or quarantine and fear of contagion must not be used as a pretext to curtail attention to the essential needs of a patient.

2.10. Basic Necessities in Offices and Institutions

Patients and staff are entitled to the basic necessities required for their toilet, hygiene and where necessary nutrition needs. Water, soap, towels and toilet paper must always be at hand.

2.11. Ethical Conduct and Organ Transplantation

Modern medical care involves the transplantation of many organs, the most common of which is the kidney. When patients are offered renal dialysis, consideration must be given to renal transplantation for those patients. Organs for transplantation may be obtained from a living related person; or may be removed from the bodies of deceased persons.

A registered medical practitioner certifies death; however, there is no current provision in statute law for certification of 'brain death' in most Caribbean countries. Guidelines do exist in Jamaica and Trinidad and Tobago's laws for how to handle organ donation from dead persons. Such guidelines state that a medical practitioner or specialist certifying the death of a potential organ donor should not be directly involved in organ removal, subsequent transplant procedures, or the care of the patient receiving the transplant.

Removal of a deceased person's organs for transplantation may only be done when:

- all bio-medical investigations are done to protect the health of a potential recipient
- there is a written advance / 'living-will' donation by the deceased; or
- written consent has been obtained from the next of kin, legal guardian, or legal executor appointed by the deceased specifically for this purpose; and
- permission has been obtained from the coroner, in cases of accidental and sudden unexplained deaths that would normally be open to a coroner's enquiry.

Organs may be transplanted from an adult living-donor if that donor gives free and informed consent, having regard to the immediate and long-term risks of such donation.

Physicians and other health care workers involved in such procedures must ensure that potential donors are free of any undue influence or coercion and are capable of understanding the risks, benefits and consequences of their consent.

2.11.1. Prohibition on the Sale or Purchase of Organs

A medical practitioner or specialist in their efforts to obtain an organ for transplantation, should not be involved in any direct or indirect financial transaction with the organ donor, their relatives, business associates or the institutions involved.

Where a medical practitioner or specialist has a good faith reason to believe that the organs procured have been the subject of a commercial transaction, or have been obtained through offering payment, reward or other compensation; and that such dealings involve another medical practitioner or specialist, they should report the matter to the medical regulatory body and any other appropriate Authority.

If a medical practitioner or specialist involved in the surgical or medical care of the

patient or donor is suspicious that an illegal transaction is occurring, they should seek legal or ethical advice as to whether they should continue to participate in such care.

2.12. Security

Patients and staff must be accorded basic security within a health care facility/office. Good security requires that both staff and patients cooperate with the rules of the facility.

2.12.1. Patient Identity Tags

Patients should have identity tags when they are admitted to an institution, or their consciousness will be impaired. It is the duty of a practitioner to ensure that such patients receive the correct investigation or procedure.

2.12.2. Weapons and other Security Risks

Weapons and animals of any description should be discouraged from being brought onto health care facilities by patients, visitors or by staff not authorized to do so.

If a patient or a visitor is in possession of a weapon when attending as an emergency, the weapon should be placed under the control of the appropriate staff whilst care is being administered.

2.13. Biomedical Research

Research is vital to improving care and must be based on generally accepted scientific and ethical principles. The interests of the human subject of any research must always prevail over those of science, society's interests, or that of the medical practitioner or specialist.

2.13.1. Approval of a Research Proposal

All medical research conducted should be approved in advance by the appropriate committee of the institution involved, or other appropriate authority. Only research proposals should be considered that are clearly formulated in a protocol that contains provisions for the informed consent and confidentiality of the subjects of the research.

In approving a research proposal, institutions and other authorities should be satisfied that the life and health of the individual patient/human subject is protected at all times. Where research involves the treatment of patients, they must remain under the supervision of the responsible medical practitioner or specialist.

2.13.2. Consenting to being a Subject of Research

Each potential subject of human research or their legal guardian must be adequately informed of the aims, objectives, methods, potential risks and benefits of the study; and of any discomfort it may entail. The subject must also be informed that he or she is at liberty to abstain from participation or withdraw from the study at any time, without a withdrawal of the usual treatment for their condition. Consent should be obtained in

writing.

Where a minor is capable of understanding the risks and benefits of the research, the minor's consent should be obtained as well as that of their legal guardian. Researchers should be cautious when obtaining consent from patients who may be construed as consenting under duress (e.g. prisoners) or those with a dependent relationship to the researcher.

2.13.3. Withdrawal from a Research Study

It is the duty of the practitioner to discontinue the study or withdraw patients from the investigation, if involvement in the study becomes harmful to the patient/s.

Patients can withdraw their consent and participation at anytime and are entitled to continue being treated for their illness by the standard treatments that are available.

2.13.4. New versus Standard Treatment

Practitioners are free to use new diagnostic or therapeutic modalities when in their judgment it offers hope of saving life, alleviating suffering, or restoring health. In using such treatments, physicians are expected to study the potential risks, and benefits of such modalities, and weigh these against those of the available standard treatment.

2.13.5. Research Funds and Payments

Except under an approved research protocol, it is improper for a practitioner to accept per capita or other payments from a pharmaceutical company, equipment manufacturer, or institution in relation to a research project.

2.13.6. Publication of Research.

Researchers should acknowledge the persons or institutions that have participated in or funded the study being published. They should also declare any conflicts of interest, particularly those that are financial. Research studies are best published in peer-reviewed journals.

3. Professional Relations and Conduct

Medical practitioners and specialists are expected to behave at all times in a manner that is above reproach. This means accepting responsibility for one's own conduct as well as that within any facility or office in which they work. While all health care staff are expected to be courteous at all times, medical practitioners as leaders in health care should seek to change behaviours that are not in the best interests of patients, the reputation of the profession, and of the institutions in which they work.

Internal mechanisms should be the first avenue for dealing with problems between health care professionals. However, when problems are unresolved and it is felt that some disciplinary action should be considered a complaint could be made to the appropriate regulatory body.

3.1. Working and Consulting with Colleagues

Effective communication and cooperation between practitioners, colleagues and the staff of an office or an institution is essential to provide the best patient care; and foster constructive interpersonal relations.

Practitioners working in multi-practitioner offices, or in departments in an institution should meet on a regularly scheduled basis to discuss workplace issues. Questions and concerns relating to a practitioner's work should be presented in the first instance through established administrative mechanisms. When issues of professional misconduct are raised about a practitioner and have not been resolved internally, a complaint may be lodged with the appropriate regulatory authority.

3.1.1. Consultations and Second Opinions

Practitioners are expected to consult with colleagues when they are dealing with difficult problems of diagnosis or care, and to make themselves available for such consultation. Whether inside or outside an institution, all the relevant history and findings must be made available at the time of the consultation.

Practitioners are expected to facilitate second opinions when requested by patients. The attending practitioner should voice their opinion to the patient if the practitioner of the patient's choice does not have the qualifications or the experience that the existing situation demands, and should offer alternatives for consideration.

When the attending specialist is requesting another opinion they should do so with the consent of the patient and indicate whether the specialist called upon is being asked to assume the continuing care of the patient.

After a second opinion, the attending specialist, supplemented if necessary by the specialist giving the second opinion, should communicate a joint decision to the patient. If an agreement as to diagnosis and treatment is not possible, the points of disagreement

should be conveyed to the patient with any suggestions for the resolution of the differences in opinion.

A medical practitioner or specialist should not give a second opinion on a hospitalised patient in the absence of a request from, or knowledge of the attending specialist. If a second opinion is given in the absence of a request from the attending p, the circumstances should be recorded, and the opinion should be communicated where possible directly to the attending physician.

A request for an opinion on a colleague may also occur when a patient seeks a second opinion, specialist advice, or an alternative form of treatment. Honest comment is entirely acceptable in such circumstances, provided that it is carefully considered, can be justified, is offered in good faith, and is intended to promote the best interests of the patient.

3.1.2. Comments about Professional Colleagues or Other Staff

A practitioner should not make unwarranted and unsubstantiated comments about a colleague; in particular when such comments are on their views about the colleague's lifestyle, culture, beliefs, race, colour, sex, sexual preferences or age.

3.1.3. Assessment of Colleagues

When required as part of an assessment or investigatory process to comment on a colleague, a medical practitioner or specialist should do so truthfully.

Health professionals are called upon to express a view about a colleague's professional practice, in the course of a medical audit, peer review procedures, or during an investigation being carried out by a lawful authority. Comments made in the process of assessment, medical audits, or similar forums and to the regulatory bodies, are confidential and should not be repeated outside of those forums.

3.1.4. Professional Conduct and Fitness to Work

It is the duty of a medical practitioner or specialist, where the circumstances warrant, to bring to the attention of the appropriate person or body a colleague whose professional conduct or fitness to work can be called in question. However, a practitioner should not make gratuitous or unsubstantiated comments which are intended, whether directly or by implication, to undermine trust in another medical practitioner's or specialist's knowledge or skill.

3.1.5. Nurses and other Health Professionals

The services provided by the nursing and other health professionals in the care and prevention of illness is essential and complementary to the work of the medical profession. Therefore, it is the duty of medical practitioners and specialists to support the work of nurses and other health professionals to the extent that these professions, while remaining true to their respective codes of ethics, will cooperate as a harmonious team providing optimal service to patients

3.1.6. Challenging an order of a Medical Practitioner or Specialist

When a medical practitioner, nurse, pharmacist or other health professional recognises that an order is unclear, incorrect or in their assessment dangerous, they have a duty to bring it to the attention of the physician who issued the order before carrying out the order. If the situation is urgent and the physician involved cannot be found another physician in the team or one on emergency duty should be contacted.

If the order is urgent and the health professional maintains that they will not carry out the order, the responsible physician must do whatever is necessary to treat the patient and make a formal complaint through any institutional mechanisms available, or to the appropriate regulatory body.

3.1.7. Delegation of Patient Care

Delegation of duties in relation to patient care carries special responsibilities that should only be carried out by professionals trained in the particular discipline. Whether the delegation occurs to another practitioner or another health professional, the attending physician retains the ultimate legal responsibility for the management of the patient.

Delegation of patient care duties to nurses and others health professionals is widely practised and constitutes an important contribution made to the health care of patients. Such delegation should not be done unless the nurses or other professionals so designated have been trained to perform the delegated function.

Except in clearly defined areas involving consent for care of the incapacitated patient without next of kin, patient care decisions cannot be made by, or delegated to, administrators or any other staff not trained in the particular discipline.

Delegation to Junior Doctors

Delegation of responsibility to a junior doctor does not absolve the senior person from responsibility in the care of the patients. This applies even if they are on leave and in contact by telephone. Therefore, deputizing arrangements should make provision for prompt and proper communication between the deputy and the doctor who retains primary responsibility for the patient's care.

In addition, it is appropriate to have someone at the same level of expertise as the senior person, which a junior can refer to if telephone communication proves to be insufficient in a particular situation. A junior doctor remains responsible for any neglect, breach of professional standards or any disregard of professional responsibilities on their part.

3.2. On Call

A practitioner may be on call for services in an institution or in their practices. Any roster for emergency duty must be made clear by the institution or the practitioner.

Senior staff in an institution may be required to make themselves available at all times for

mass emergencies or unexpected disaster situations which require their input.

3.2.1. Fitness for Duty

One of the most important needs of a patient is to be attended by a doctor or other staff who are fit and alert and not impaired by excessive tiredness, sleep deprivation, drugs or alcohol. Medical practitioners and specialists should therefore be mindful of activities in the period before they are on call that may impair their ability to respond effectively.

Medical practitioners are required to carry out their duties regardless of the time of day or night. Except in unusual situations, such as responding to a disaster, no practitioner should agree to or be required to work without adequate time for sleep or meal times.

3.2.2. 'Second' Calls

In the absence of the duty or attending physician and another physician is called upon to deal with an emergency, on the arrival and availability of the duty physician all care and responsibility for the patient should be handed over to the duty physician, and the patient made aware of the transfer of responsibility.

3.2.3. Emergencies and Telephone Consultations/Advice

When called upon to give advice over the telephone to patients or other health professionals, practitioners should be wary of the advice they give in emergency situations, particularly those occurring at night or when they have just been woken from sleeping.

Telephone consultations need to be particularly meticulous as regards the history of the condition, recognising that the practitioner has no access to an examination of the patients themself. Equal care must be taken in prescribing over the phone, so that there is no mistake made over the name or dose of the medication being prescribed.

Whether the telephone consultation is with a practitioner or a patient, they must be reminded that should the advice be unclear or if the patient's condition does not improve, that they should call again, and the patient given clear instructions to get a face to face consultation.

Telephone consultations should be recorded in a patient's notes as soon as practicable.

3.2.4. Responding to Disasters

All practitioners have a responsibility to respond to emergency and disaster situations, and to contribute within the limits of a Disaster Plan of an institution or relevant authority responsible. Professionals who work in institutions or organizations dealing with disasters have a duty to familiarize and train staff about their responsibilities in emergency/disaster situations.

3.3. Dress Code

Medical practitioners are expected to dress in a manner that befits their professional

status, and appropriate to their working environment. All forms of dress must conform to accepted standards of hygiene, safety and decency. Except in emergency situations, a practitioner should not appear for work in casual beachwear, or that most suited to other non-professional settings. Jewellery and religious symbols should not be ostentatious when worn in the work place. Items of dress, e.g. t-shirts that carry political or cultural messages are not suitable for the workplace

Working dress such as used in operating theatres and other areas such as intensive care units, are designed to reduce the transfer of infections from outside those units; as well as avoiding soiling of the health workers clothes with blood or other body fluids. Such garb is not suitable in community settings. Practitioners, students and guests should adhere to any institutional or departmental rules regarding appropriate wear and procedures in operating theatres or other critical care units.

3.4. Personal Business versus Professional Work

Practitioners may need to conduct personal business on occasion during professional work hours. However, such business must be kept to a minimum and should not interfere with the practitioner's attention to patients. Practitioners should be cautious about directing personal mail to their place of work lest it be opened as patient related correspondence.

3.4.1. Personal Visitors

With the exception of personal emergency situations, practitioners should avoid having personal visits while at work. This prohibition includes the children of the practitioner. Visitors should not enter patient care work areas in the presence of patients.

If an unusual exception has to be made to the prohibition of children in the work place, it is the responsibility of the practitioner to seek permission within any organization in which they work. In such instances the practitioner must make arrangements to avoid accidents to the child, and allow the practitioner or fellow workers to perform the business of patient care without interruptions or distractions.

3.5. Confidential Matters and Correspondence

Apart from the confidentiality related to patient information, confidentiality applies to all information about other practitioners and staff in the workplace.

3.5.1. Confidential Correspondence

Confidential documents and material must be kept separate from open/general correspondence in an office or workplace. Confidential documents including patient records must be kept secure and should not be referenced in any open correspondence or document without the written permission of the administration of the organization.

Workplace letterheads should not be used for personal correspondence and should be protected to prevent their fraudulent use.

Files and working papers should not be made available to third parties_without the permission of the responsible person or organization.

3.5.2. Patient Records

Patient records are confidential and should not be read by any unauthorized person. Patient records are the property of the office or institution where the patient attends. A practitioner cannot claim records because they have seen the patient at some time. Patients may request in writing of the office or institution, a copy of their records.

Patient records should be kept after the patient's death for reference purposes, and in case the estate of the deceased makes a claim. The minimum period for the statute of limitation on claims varies in jurisdictions and is usually from 3-6 yrs.

3.5.3. Computers and Mobile Information Devices

Although there is an increasing use of computers in record keeping, practitioners are reminded that their use is more than the substitution of poor handwriting, or better appointment making. Practitioners are also reminded that like hand written notes, not all information may be recorded and they have a duty to review the record, and to correct gaps in information and assessment where they exist.

Practitioners are also reminded that any change in information, like in a written record, should be recorded with the date and time, and that such changes if contested can be detected.

Most importantly patient records should have a unique identifier other that the name of the patient. Unique identifiers assist in protecting the record from electronic intrusion from outside sources and must be carefully considered. The use of widely used national identification numbers is not good security for confidential information. All confidential work done on a computer must be backed up and password protected. Passwords that are unique to the individual practitioner or specialist are essential in institutional settings. This may become an issue when the single practitioner is unexpectedly incapacitated.

3.6. Personal Relationships and Harassment

All practitioners should be committed to maintaining a work environment free from discrimination and harassment. Practitioners must exercise great care and discretion in their relationships with patients and their relatives, as well as with other members of staff.

3.6.1. Improper Personal Relationships and Harassment

Improper conduct is that which leaves the other party uncomfortable, offended, disrupts work or the person's family life, and damages the contract of trust between the patient and a practitioner, other practitioners or staff. Such conduct consists of unwelcome, abusive or offensive conduct, whether verbal, physical, visual or 'social media' and based on a

person's race, colour, creed, national origin, ancestry, sex, religion, age or disability.

There must be no intimation of impropriety by a practitioner that can be construed as forced on another practitioner or other staff by the seniority of the practitioner involved.

3.6.2. Sexual Harassment

Unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature can constitute sexual harassment, and constitutes professional misconduct in most jurisdictions. It may include:

- jokes; and the display of posters, cartoons and magazines with sexual content;
- sexually derogatory, physically descriptive or suggestive comments about or towards another individual; including inappropriate use of communications including e-mail, telephone and social media;
- unwelcome touching or physical contact; and
- punishment or favouritism on the basis of an individual's sex.

Sexual harassment has occurred when submission to sexual conduct is made either explicitly or implicitly as a term or condition of employment or advancement in the workplace. Where one party is in a position to extend employment benefits to another, even a completely welcomed, consensual, sexual relationship has the appearance of impropriety and can create an appearance of favouritism. Such relationships can lead to allegations of harassment if the relationship becomes unwelcome.

Such harassment directed at a patient is subject to severe penalty by the regulatory bodies. Sexual acts involving practitioners and patients may be subject to criminal prosecution, as well as professional misconduct charges.

Practitioners may have cause for concern by unsolicited declarations of affection by patients, their relatives, and other staff members; or by threats that a complaint will be made on the grounds of a relationship that existed only in the accuser's imagination. Except in the case when the situation involves another practitioner, where the matter can be reported to the regulatory authority, a practitioner who is the victim of harassment should seek civil legal remedies.

3.6.3. Violence in the Workplace

Medical practitioners and specialists must be prepared to deal with acts or threats of violence in their workplace. Such acts threaten the practitioner, other staff and most importantly patients. When faced with threats of violence by patients, relatives or others, practitioners should try to determine the reasons for such threats and seek to diffuse the situation. Practitioners should be mindful that violent threats might themselves be manifestations of illness, which should be treated by medical means. Treatment may involve sedation and/or restraint.

3.6.4. Prohibition on Weapons

Medical practitioners and specialists in examining their personal security and that of their staff and patients are advised to consider among other measures, the prohibition of persons who enter their premises from carrying a handgun, firearm, a knife or any weapon, regardless of whether the person is licensed to carry the weapon. The only exceptions to such a policy should be law enforcement officers or other persons who are authorised to carry a weapon on the premises.

If a practitioner or staff member becomes aware of an individual carrying a weapon at their workplace, or if there is threatening behaviour-taking place, that person should call the security personnel to deal with the matter. If the situation warrants immediate attention, dial the emergency services.

3.6.5. The Violent Patient

Patients may be become violent for medical or social reasons; including the anxiety most patients feel when they are ill and are not getting the attention they feel is due to them. Such behaviour may be enhanced by the use of alcohol, drugs or medication. It is important wherever possible to form or seek an opinion on the cause of the patient's violent behaviour, so that an appropriate intervention or treatment may be given. Where the patient's behaviour is threatening their own safety of that of others, they should be brought under control like any other threatening person and an appropriate physician called to review the patient. A patient should not be placed in the hands of the police and arrested before a physician has reviewed their medical condition.

3.7. Alcohol, Drugs and Smoking

A practitioner's use of alcohol, illegal drugs as well as some prescription and over-the-counter medicines can pose a significant risk to the safety of patients, the practitioner themself and others. Section 23.2.h of the Act states that it is professional misconduct for 'the excessive ingestion of intoxicating liquor or drugs'. This prohibition relates not only to the health of the practitioner, but its possible adverse consequences on patients who are being treated by that physician. Similarly a practitioner should not smoke during the course of work for it may have a direct effect on the patient being treated. It also sets the poor example of a health practitioner who is not mindful of the generally acknowledged risks of smoking.

Medical practitioners and specialists have privileged access to controlled substances such as opiates for the treatment of appropriate patients. Practitioners should not use that privilege for the illegal use of these drugs by themselves, patients, friends or others. Such misuse is criminal and is subject to prosecution or disciplinary action by regulatory bodies.

Prescription Drugs – A practitioner taking prescribed medication whilst working, has a responsibility to find out from their physician whether or not the prescribed drug they are

taking would impair their job performance.

If a practitioner suspects that another practitioner's job performance is impaired by the use of medication or unauthorized drugs, they should first convey this to the practitioner, and report the matter to the appropriate person if working in an institution. Should these mechanisms fail, the practitioner may report the matter to the appropriate authority.

3.8. Advertising and Solicitation and of Patients

Practitioners are entitled to provide information to the public about the location and the services they provide. However, there are jurisdictions in the Caribbean where advertising by practitioners is forbidden in law. For example, the Medical Profession Act in Barbados section 23.2.c. prohibits 'any form of advertising, canvassing or promotion, for the purpose of obtaining patients or promoting his own professional advantage -----'; and in section 23.2.g. the Act prohibits 'the division with any person who is not a partner or assistant, of any fees or profits resulting from consultations or other medical or surgical procedures without the patient's knowledge or consent'.

Where such prohibitions exist it is prudent for the practitioner to adhere to any published guidelines as to the permissible forms of notice, signage etc. A practitioner should not directly or indirectly solicit a patient for care, particularly where the patient has already engaged another practitioner. Such conduct cannot be excused on the basis of seniority, knowledge or greater experience.

3.8.1. Advertising

Any advertisement of the services provided by a practitioner that makes invidious comparisons with the services of particular practitioners, with other organisations, or is contrary to the published guidelines by Council is liable for disciplinary action

Promotional material of individual practitioners or a health care facility should not claim the superiority of any practitioner's qualifications and experience over others. It is the duty of all medical practitioners or specialists to satisfy themselves that the content and presentation of any material published about the services they provide, and the manner in which it is distributed, conforms to any guidelines approved by the regulatory body in the jurisdiction. This applies whether the practitioner personally arranges for such publication, permits or acquiesces in its publication by others.

Practitioners can make available to patients their qualifications and the services they provide. Any publication of false qualifications or claims of specialist status is subject to disciplinary or criminal sanction

3.8.2. Press Interviews and Broadcasting

A medical practitioner or specialist in granting a press interview or appearing in a broadcast programme must ensure that the same general principles applicable to any prohibition on advertising are observed. In certain circumstances it may be preferable to offer a prepared statement rather than to give an impromptu interview; or to ask for an opportunity to approve an article before it is published.

It is desirable, that physicians and others who can speak with authority should discuss topics relating to both medical science and policy, and to public health and welfare. However, a practitioner must take care that on being introduced the announcer makes no comments or inaccurate display of their qualifications or appointments

3.8.3. Pamphlets and Circulars.

It is normally permissible for practitioners to distribute pamphlets, circulars or other written material to patients or in patient care areas to announce leave arrangements and any additions to their practice

3.8.4. Sale of Medicines, Products and Services

The sale of any medicine, or product used for medical purposes should not be undertaken by a medical practitioner or specialist without the necessary permit from the appropriate authority to do so.

Medical practitioners and specialists should consider with great care the ordering of tests and investigations as to their appropriateness to the patient's management. When tests are ordered in a business in which the practitioner has a financial interest, they are at risk of being in contravention of laws forbidding the promotion of services.

3.9. Professional Integrity and Conflicts of Interest

The confidence of the public in the integrity of medical practitioners and specialists is vital to the proper functioning of the profession itself. The following outlines the ways practitioners can avoid damaging the integrity of the profession. These involve:

- evidence of unethical or criminal behaviour
- avoidance of sexual or other improper conduct or association with a patient
- advertising canvassing or promotion
- wilful or reckless betrayal of a professional confidence
- abandonment of a patient in danger, either physically or mentally
- knowingly providing false certification
- the splitting of fees without the knowledge of the patient
- practising when intoxicated or when mentally or physically unfit to do so. impersonation of another practitioner
- representing themselves to be a specialist when not qualified to do so
- association with unqualified persons to promote unproven 'medicines', procedures, and secret remedies
- failure to provide a medical report in a timely manner
- solicitation of 'public' patients to attend the practitioner's private practise

3.9.1. Private Interests and Public Practice

Practitioners employed in the 'public' service must be clear that their private interests, do not conflict with their responsibilities in the public service. A conflict of interest can arise

when a practitioner has an economic interest that conflicts with their public service obligations. In particular, staff should not use their position within the public service or the service's property for their personal i.e. private business.

3.9.2. Association with Commercial Enterprises

It is considered improper for a practitioner to receive direct payment or benefits from a commercial enterprise to exclusively prescribe a drug or other product used in the care of their patients, or in the institution to which they are attached. .

3.9.3. 'Alternative Medicine'

Practitioners should be mindful of taking part in the promotion of any substance which is claimed to be of value in the prevention or treatment of disease and which is recommended to the public in such a fashion that encourages the practice of self-diagnosis, self-medication, or is of an undisclosed nature or composition.

A practitioner should take caution in recommending such practice to patients or other practitioners. Practitioners should also be cautious associating with any non- physician in a system or method of treatment which is not under medical control and which is advertised in the public press.

3.10. Medical Professionals and the Pharmaceutical and Allied Industries

The health professions, the pharmaceutical industry and medical equipment manufacturers have common interests in the research, development and sale of new drugs and devices of therapeutic value. Health care practice owes much to the important advances achieved by the health related industries.

3.10.1. Research Funds

Medical practitioners and specialists must only conduct research on drugs or equipment, and receive any associated remuneration, under research protocols approved by an appropriate Ethical Committee or Institutional Research Board.

3.10.2. Continuing Professional Education

Continuing professional education is often facilitated by financial support from the pharmaceutical and allied industries. Nevertheless, it is expected that medical practitioners and specialists will only prescribe drugs or appliances utilising their independent professional judgment, having due regard to costs and cost effectiveness.

Practitioners should avoid accepting any monetary or material inducements, which might compromise, or be regarded as likely to compromise, their professional judgment in promoting, prescribing or procuring drugs, equipment, or services.

3.11. Gifts, Donations

A medical practitioner may accept gifts and donations of money, equipment, services or property from any patient, relative, person or organisation, provided that the gift or donation has been legally obtained and is not associated with any unethical conduct by the practitioner.

It is improper for a practitioner to accept gifts of expensive items of equipment for their sole personal use within the services of a public institution.

3.12. Safety in the Workplace

Medical practitioners have a duty to provide safe treatment for their patients. This not only means safe medicines and procedures, it means ensuring the safety of the patient, themselves, and others. Practitioners who provide or tolerate unhygienic facilities, unsterilized equipment, malfunctioning equipment etc. are liable for a civil tort of negligence, should a patient become harmed as a result.

3.12.1. Buildings and Equipment

Medical practitioners and specialists must make every effort to keep buildings and their equipment in excellent condition and ensure that all safety devices and procedures are working properly.

In spite of all efforts to avoid dangers, if an accident occurs or someone becomes ill or is harmed in the process of patient care, the practitioner responsible for the care of the patient has an obligation to report the matter as appropriate.

3.12.3. Unauthorized Visitors

Because of the nature of health care in relation to safety as well as confidentiality, personal visitors, particularly children, should not be encouraged in a practitioner's office or other work facilities.

3.13. Practitioner's Health

A practitioner's health is important not only to themself but is of great importance to the patients they treat. Practitioners should not put their patients or colleagues at risk from transmissible disease, or any physical or mental illness that impairs their ability to work.

3.13.1. Physical Disabilities

Practitioners with physical disabilities capable of doing a particular job should not be restricted or denied the same opportunity as other practitioners.

3.13.2. Contagious Disease

A contagious disease can be transmitted by casual contacts or close association, such as touching, coughing, sneezing and handling food. A medical practitioner or specialist comes into contact with ill patients directly or indirectly, and any practitioner diagnosed

with a dangerous contagious disease should not work whilst they are contagious.

A practitioner should not return to work until they have a certificate of clearance from another practitioner or specialist who was responsible for their treatment. Practitioners are discouraged from undertaking to diagnose and prescribe for themselves, particularly when dealing with a potentially dangerous contagious disease.

3.13.3. Specified Diseases

There are some existing infectious diseases with which a practitioner may be affected.

- Tuberculosis - Practitioners with active tuberculosis should not work in direct patient care until certified to do so by a physician qualified to do so.
- Hepatitis B – Medical practitioners, in particular surgeons, and other staff who come into frequent contact with blood, such as in operating theatre, renal dialysis, obstetrics, accident and emergency and laboratory staff, have a particular responsibility to themselves and to patients to avoid the transmission of blood borne diseases in the settings in which they work. All such persons should be screened and immunised against hepatitis B.
- HIV – Practitioners who work in direct patient care are encouraged to undergo testing for HIV, and if positive to seek advice about any continued role in the performance of procedures which may cause injury to themselves. Practitioners and other health care staff who are involved in injuries, such as needle sticks, are encouraged to seek immediate advice on prophylaxis for HIV. In spite of concerns expressed there have been no proven cases of transmission of HIV in operating theatres.
- MRSA and other antibiotic resistant organisms, are a hazard in hospitalized patients. Practitioners, such as surgeons, and other staff who come into contact with such patients must be meticulous in carrying measures to prevent them carrying these organisms from one patient to another. Furthermore, they should submit themselves to appropriate screening to ensure that they are not a carrier of such organisms, and if so to be treated appropriately.

3.13.4. Universal Prevention Precautions

All medical practitioners, specialist and other health care staff, are expected to adhere to and observe universal precautions in the prevention of the spread of disease. All persons involved in patient care should wash their hands before and after coming into contact with patients, any body fluid and food, and should wear protective gloves or masks when indicated. Practitioners should provide facilities in the office for hand sanitising.

3.13.5. Known Illness and workers in Health

A practitioner who knows that a medical practitioner, specialist or other health worker is infected with a dangerous transmissible pathogen, and is aware that the person has not sought or followed advice, has a duty to inform the appropriate institutional authority or the MOH and if they so choose the Council in a confidential manner.

A practitioner who becomes infected with a dangerous transmissible pathogen, or who is ill in other ways, is entitled to the confidentiality and support afforded to other patients.

Only in the most exceptional circumstances, such as the staff member refusing to follow advice, should such confidentiality be broken.

A practitioner should not continue to work in the direct care of patients merely on the basis of their own assessment of their risk to patients.

3.13.6. Care of Colleagues

Undertaking the care of a colleague is a privilege, and is a statement to patients and the community at large, of the esteem in which a practitioner is held within the professional community. Ill colleagues should be given expedited care, but not to the detriment of more urgent patients.

It is highly recommended that practitioner colleagues should not be charged professional fees; however, practitioners are under no obligation to provide private medical services, or reduced fees to their colleagues or their dependents. Any professional courtesy extended as regards private fees is a privilege, not a right., and is extended entirely at the discretion of the treating practitioner.

3.13.7. Inappropriate Certification /Prescribing

Practitioners should be wary of treating, prescribing for, or certifying illness for colleagues without assuring themselves as to the appropriateness of the treatment or certification. Physicians who are ill and require leave are subject to the requirements as any person.

3.13.8. Alcohol Use and Drug Abuse

Confidentiality of a colleague's illness is as important as that of any patient. However, unique responsibilities exist in handling practitioners with infectious disease, mental illness and substance abuse. Whilst it is the responsibility of a practitioner who uses alcohol for recreational purposes, to ensure that they are free of its effects when undertaking the treatment of patients, it is also the responsibility of colleagues to flag practitioners when they do not exercise that responsibility.

When all appropriate avenues have been exhausted in stopping a practitioner from treating patients whilst under the influence of alcohol or drugs, it is the duty of a practitioner to report the offending practitioner to the appropriate authority to be investigated for professional misconduct and/or their fitness to practise.

3.14. Practitioners engaged by Third Parties

Medical practitioners may be engaged by third parties, such as insurance companies, institutions [including government], and businesses to give opinions and/or render services to persons who are in their employ or are seeking their services. A practitioner's duty to a patient in these circumstances is no different from that of any patient, whose rights and welfare must be their first priority.

Patients rendered services under these circumstances, have the same rights as any patient irrespective of the source of fees. These rights, unless surrendered in writing, include the right of confidentiality of medical information from the third party, inclusive of the diagnosis in certification of leave

When engaged to do an examination or assessment for insurance or any other third party purpose, the consent of the patient must be obtained in writing. A patient has the right to know of the findings of the examination and /or assessment before it is sent on to the third party. Any false representation to the patient or the third party is serious professional misconduct.

Acting in the capacity of a third party's medical practitioner, the practitioner and any usual practitioner of the staff member have a common concern. As in all cases where two or more doctors are concerned, the greatest possible degree of consultation and co-operation between them is essential, subject to the consent of the patient. Such cooperation is essential to avoid any conflicts of advice or medication.

3.14.1. Expressing an Opinion on Liability

A medical practitioner or specialist has a duty to provide a detailed report on an injury or work related illness. However, without the consent of the parties concerned, a physician should not express an opinion as to liability in accidents at work, or work related diseases, except when so required by the court or a tribunal.

Similarly, the physician should not disclose knowledge acquired in the course of his duties, except with the consent of the third party concerned or by an order of Court.

3.14.2. Limitation of Examination

A practitioner examining a patient for a specific purpose should confine themselves to such investigation and examination as are necessary for the purpose indicated and agreed to by the patient. Any proposal or suggestion, which an examining practitioner may wish to put forward regarding treatment, shall be discussed with the practitioner designated by the patient.

When in the course of the examination there are material clinical findings of which the patient's physician is believed to be unaware, the examining practitioner shall with the consent of the patient, inform their practitioner of the relevant details.

An examining practitioner must avoid any word or indication which might disturb the confidence of the patient in their attending physician, and must not without the consent of the latter, proceed to do anything which involves altering the treatment of the patient.

3.14.3. Prohibition of Solicitation of Patients

An examining practitioner shall not utilize his position to influence the patient examined to choose him/her as their medical attendant.

3.15. Professional fees

Professional fees are chargeable for consultations, laboratory tests, investigations, special examinations or procedures, surgery and for medical reports.

3.15.1. Public/Exempted Patients

Public medical services are those provided in government institutions, and where services are provided without payment of a fee by patients exempted by citizenship, age and type

of condition.

Medical practitioners or specialists working in a public service should have no role in collecting fees from patients. It can be regarded as serious professional misconduct for any practitioner working in a public service who

- charges or collects fees from any patient in the public service
- solicits or persuades a public patient to become their private patient
- denies publicly available services to patients, and offers them the same service in their own private practice or that of other practitioners or specialists.

3.15.2. Medical Certificates and Reports

Certificates stating illness or fitness, incapacity etc. are an integral part of a consultation as are prescriptions for medicines, advice on diet, rest etc. A separate fee should not be charged for such services.

Medical reports for referral or second opinion purposes, which are requested by the patient may attract a professional fee, which should not exceed the consultation fee. Such reports should be provided expeditiously.

Reports for legal purposes, and those asking for an expert opinion are part of a separate contract, where the practitioner or specialist enters into an agreement on the terms of providing the report, and the scope of the report.

3.16. Continuing Professional Education

One of the greatest factors contributing to the skill and expertise of a medical practitioner and specialist is their ability to keep up to date through continuing professional education. The jurisdictions listed in section 1.1. require continuing professional education [CPE] as a condition for the annual re-registration of practitioners and specialists.

The Caribbean College of Surgeons endorses these requirements and provides CPE certification for all education activities held under its sponsorship.

4. Disciplinary Charges and Claims before the Court

A practitioner may be subject to disciplinary conduct charges before the disciplinary body in their jurisdiction, or charged before the courts in civil or criminal charges related to their practice. Some surgical specialties are at greater risk for charges of negligence related to the outcomes of operative procedures.

It is prudent that practitioners not only adhere to good practise but to have appropriate medical malpractice insurance.

4.1. Breaches of Conduct requiring Disciplinary Action

Disciplinary actions may be brought against a medical practitioner or specialist, who is directly or indirectly involved in patient care for:

- actions which endanger patients or others in the process of health care;
- actions that are demonstrated to be negligent, or dishonest.
- behaviour that brings the medical profession into disrepute.
- undertaking practices for which the person is not trained for, or experienced in
- supplying, dispensing or the administration of medicines, particularly controlled drugs and drugs of dependence, without the necessary statutory controls.
- falsification of any document, in the course of work,
- fraud or acceptance of fees/bribes for actions of professional misconduct.
- Indecent or violent behaviour
- Sexual conduct, or sexually explicit exposure with, or in the presence of patients

Some of these offences may also be subject to criminal investigation and prosecution.

4.2. Civil and Criminal Charges

A practitioner can be subject to charges of battery or negligence. Battery is a civil or criminal charge that may arise when a practitioner has carried out a procedure without the consent of the patient.

Negligent conduct occurs when a practitioner in carrying out care breaches the standard of care for that condition, and the patient suffers compensable harm as a result. If the harm to the patient results in death and the breach in the standard of care is gross, the practitioner could be subject to a charge of criminal negligence or manslaughter.

Practitioners can avoid or defend possible charges through adherence to good professional conduct; ensuring that patients give truly informed consent; that the medical record is accurate, timely and thorough; and that the treatment or procedures carried out are within the contemporary standard of care.