

○ A review of professional codes and standards for doctors in the UK, USA and Canada

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CONTENTS

1	What are the aims of the patient-centred professionalism programme?	1
1.1	The two arms of the programme	1
1.2	Aim of this paper	2
2	What are professional codes and why are they important?	3
2.1	Content of the code: medical professionalism	4
2.2	Content of the code: patient-centredness	5
2.3	Purpose of the code: wording	5
2.4	Purposes of the code: implementation	6
2.5	Summary	8
3	Selection and analysis of nine professional codes	9
3.1	UK	10
3.2	USA	11
3.3	CANADA	11
4	What topics are included in each of the codes?	13
5	What are the overlaps and differences between codes in relation to medical professionalism?	17
5.1	Technical/scientific issues	17
5.2	Ethical issues	18
5.3	Relationships: Individual and collective	21
5.4	Summary	25
6	What are the overlaps and differences between codes in relation to patient-centredness?	26
6.1	Patient engagement and autonomy	26
6.2	Consent	27
6.3	Moral basis of doctor-patient commitment	28
6.4	Patient input to the codes	29

6.5	Summary	30
7	What are the overlaps and differences in the codes' usefulness as guides to action and in their application/implementation?	31
7.1	Wording of the codes	31
7.2	Implementation	34
7.3	Summary	37
8	Discussion	39
8.1	Content: medical professionalism	39
8.2	Content: patient-centredness	40
8.3	Purpose	42
8.4	Similarities, differences, tensions and strengths	44
8.5	Conclusions	45
9	References	48

1 What are the aims of the patient-centred professionalism programme?

Patient-Centred Professionalism is an international research and development programme which aims to bring together evidence about the experiences and expectations of health care service users in order to: (i) help improve patient care by enhancing doctors' understanding of the patient's perspective, and (ii) help the medical profession shape its roles and responsibilities in delivering patient-centred care. The project is funded by a generous core grant from the Picker Institute Inc, an international non-profit-making organization based in Massachusetts which supports research in the field of patient-centred care. The programme's objectives are to:

- learn more about what patients and the public expect of doctors, their training, professional standards and regulation, for example by investigating the concepts of patient-centredness and professionalism and the connection between the two; examining existing evidence on patient and public views on doctors' training, practice, professional standards and regulation; carrying out original research to fill gaps in knowledge about patient and public views and experiences of doctors and the way they practise;
- collaborate with researchers in North America and elsewhere to facilitate comparative studies on patient and public views on, and potential contribution to, medical education, standards and regulation;
- disseminate research results to inform and influence principles and, most importantly, attitudes and practice;
- share experiences and ideas of good practice widely amongst an international network of interested individuals, and thereby encourage debate and policy recommendations.

1.1 The two arms of the programme

The Evidence Base: a programme of research that will identify more clearly and precisely patients' expectations, show how they are or are not already being accommodated in different contexts of medical practice, and identify important factors that ease or impede a patient-centred approach. The research programme includes conceptual reviews, evidence reviews, documentary analysis, and primary studies.

The Forum: a web-based information exchange to help our network of partners learn about our research findings and share knowledge, experiences and good practice ideas. Forum membership is free and open to everyone with an interest in medical practice, standards, education and regulation, especially members of professional and patient organisations.

1.2 Aim of this paper

This paper examines professional codes of medical bodies which perform the *de facto* regulatory functions of certification or licensure in the UK, USA and Canada. The choice of these three developed countries with long-established healthcare systems allowed us to focus on a particular set of commonalities and differences. We acknowledge that this limits the range of countries and cultures to which the findings of this paper can have direct relevance, but argue that the diversity of codes chosen from within the three countries allows an interesting analysis which may illuminate an understanding of codes beyond the UK and north America. Our aim was first to assess how patient-centred the codes are, and whether some are more patient-focused than others and can therefore serve as models of good practice. Second, we wanted to understand how the codes were developed and to find out how far they are, or can be, used as a practical guide for education and regulation (certification or licensure) to help safeguard the interests of patients and the public.

Codes are compared in two respects:

1. their content: specifically the way in which they portray both medical professionalism and the patient role. This includes how they address both the scientific/technical and ethical elements of medical *professionalism*, and their emphases on individual doctor-patient interactions or the responsibilities doctors have to patients collectively and to their colleagues and the profession. In examining the codes' portrayal of patients, the review concentrates particularly on the '*patient-centredness*' of their content, examining for instance how far they demonstrate respect for and support of patient autonomy.
2. their purposes: first, their *wording*, including whether they represent a wish-list of aspirations or non-negotiable imperatives; the stringency of their thresholds for acceptable practice; how specific or general their statements are, and whether they provide a clear guide to action; and, second, their *application*, in particular their relationship to regulation; whether they are embedded in licensing or certification systems and whether these can offer patients credible assurance that the codes will be implemented and the standards within them will be met.

2 What are professional codes and why are they important?

During the course of our lives we will encounter many codes – of conduct, practice, or morality. They are issued by many types of organisations and people: churches, movements such as the Boy Scouts, head-teachers, employers, nursing home managers. They tell us how we might try to behave, ought to behave, or how we must behave if we are to continue to belong to a group or not to incur some dire penalty.

Professional codes are guides to members about how they should behave in their professional capacity, and as with other codes they vary widely. Harris (1996) distinguishes codes of ethics from codes of conduct and codes of practice, although these terms are used in ways that overlap. According to his typology, codes of *ethics* generally consist of a short set of ethical principles expressed as statements which refer to some quite general type of conduct and begin “Every member shall (not)...” Codes of *conduct* are frequently more detailed and likely to specify, for example, circumstances in which a general duty should be overridden. Codes of *practice* often contain ethical principles as well as rules governing how technical duties should be carried out in order to benefit both members of the profession as well as of the public.

Sometimes these documents are referred to as ‘guidance’ or ‘advice’ rather than ‘codes’. To some, the term ‘code’ implies a rigid set of rules, a breach of which automatically incurs a particular sanction. However, the scope of our exploration is wider than this, and in this paper we use the term ‘code’ to denote any document which sets out guidance or rules on the standards or principles to which doctors should or must practise.

The Hippocratic Oath, a code of conduct for doctors formulated in the fourth century BC, is one of the earliest of many such codes. Harris (1996) charts the more recent development of the professional code from the publication in 1803 in the UK of Percival’s *Medical Ethics or a Code of Institutes and Precepts adapted to the Professional Conduct of Physicians and Surgeons* to their significant proliferation, revision and expansion in the second half of the twentieth century. But why do professional bodies need codes? The Law Society’s (1986) account of what distinguishes a profession from other occupational groups specifies that its members are:

“(a) identifiable by reference to some register or record; (b) recognised as having a special skill and learning in some field of activity in which the public needs protection against incompetence, the standards of skill and learning being prescribed by the profession itself; (c) holding themselves to standards of ethical conduct beyond those required of the ordinary citizen by law; (d) undertaking to accept personal responsibility to those whom they serve for their actions and to their profession for maintaining public confidence.” (The Law Society, 1986 p. xl)

The function of a body’s professional code, then, is to set out the standards of knowledge, competence, skills and conduct expected of those professionals on its register and the responsibilities they have towards the people they serve and to the profession. The purpose of doing so may be various; for example it may be to:

- Demonstrate to the outside world that the group constitutes a profession. The act of publishing a code has come to be seen by many as a mark of professional status, and the dissemination of a code as one of the core functions of a professional regulatory body. For example, Cruess & Creuss's account of a profession says: *"Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain."* (Cruess & Cruess, 2004, p74)
- Inform aspirant members of the way in which they will be expected to behave if they wish to join the group
- Make clear to members the type of conduct expected of them and the consequences of not adhering to the code
- Help to clarify the objectives of medical education and underpin an academic teaching curriculum to influence the development, training and education of professionals
- Show others that the group can be trusted, and/or to improve its public image. Codes are often held up as a guarantee of propriety and a sign that the professional body takes its public protection role seriously (Stone, 2002). Those who feel their occupation is undervalued by the public may see the adoption of a code as a means of improving its image, particularly if someone in the field has acted in a way that has led to public criticism (Harris, 1996).

Of course, many factors influence the standards to which doctors practise, including other codes of conduct, employer's expectations, values inculcated whilst in medical school, and so on. A professional code may reflect rather than influence standards of practice. However, codes have at least the potential to influence practice, and the more they are used as a guide in processes such as education and regulation the more they may be expected to do so.

2.1 Content of the code: medical professionalism

There have been several recent attempts to define the new medical professionalism. For example a King's fund enquiry led to a paper entitled 'On Being a Doctor: redefining medical professionalism for better patient care' (Rosen & Dewar, 2004) which acknowledged that medical professionalism is

"a dynamic concept, rooted in a long tradition of service and high ethical standards, and shaped by public expectations" (p 10).

More recently in the UK a Working Party on the subject led by the Royal College of Physicians (RCP, 2005) agreed the following definition of medical professionalism:

"A set of values, behaviours and relationships that underpins the trust the public has in doctors."

This definition and a more detailed description of it embody the three aspects of:

- knowledge, clinical skills and judgement, maintained by continued effort towards improvement and excellence
- a set of moral values, involving respect for others, integrity, compassion and altruism
- a relationship with patients, as well as other healthcare staff, involving service and partnership.

We find this a useful framework, and have developed it in our analysis of the codes. The first aspect captures the **technical/scientific** focus of medical professionalism which includes such things as being clinically competent, keeping up-to-date with developments in medical science, record-keeping and taking part in audits. The second corresponds to the **ethical** dimensions of professionalism, which also may incorporate issues of resource allocation, access to care, confidentiality and trust. The third aspect alludes to the **relationships** doctors have with patients and colleagues, and embraces a potentially wide range of associations between individual doctors, between doctors and their individual patients, but also between doctors and their patient population or community, between individual doctors and the profession as a whole, and between the medical profession and patients collectively or the public.

2.2 Content of the code: patient-centredness

A particular and important aspect of the medical codes is how patient-centred they are. Like 'professionalism,' patient-centredness is also a dynamic concept, with a long history, meaning different things in different contexts. These concepts are both explored in detail in *Patient-Centred Medical Professionalism: towards an agenda for research and action* (Askham & Chisholm, 2006). Patient-centredness may be used to mean

- working in patients' best interests, with best interests defined by either the patient or the doctor
- working in accordance with patients' preferences. This is a challenging concept because patients and circumstances vary, evidence about preferences may be limited, patients may not know what they prefer, may have limited evidence by which to formulate a preference, or they may want what would be hard to justify against other criteria
- working in partnership with patients or involving them – as autonomous beings – in decisions, treatment and management of their conditions
- working with the 'whole person' of the patient, assessing and acknowledging his/her values, emotions and social circumstances, rather than merely focusing on the disease or symptoms.

2.3 Purpose of the code: wording

The purposes of a code can be examined by looking specifically at how the standards are phrased; for example whether they are expressed as ideal conduct which can be achieved only by the best, or represent a minimum safety-net level, which the average doctor would meet (Walshe, 2003). Irvine & Irvine summarise a three-step classification: ideal, optimum and minimum.

'An ideal standard describes the care it should be possible to give under ideal conditions where there are no constraints on resources of any kind... A minimum standard describes the lowest acceptable standard of performance... An optimal standard lies between the minimum and ideal, and represents the standard of good practice most likely to be achieved by a conscientious doctor under normal conditions of practice (Irvine & Irvine, 1997, 43-44).

We can examine how explicit they are in setting thresholds of acceptable and unacceptable practice, and how **stringent** these thresholds are. Also, do they provide general statements applicable to most doctors in most settings or clear guidance for doctors in particular circumstances? As Walshe (2003) says, increased **specificity** may result in greater **reliability** but reduce **generalisability**.

2.4 Purposes of the code: implementation

The extent to which a code can be relied on to promote good professional practice and to protect the public from sub-standard practice will depend not only on its content and style, but also on the extent to which the members of the profession will abide by its requirements (Harris, 1996).

The adoption of a code may, in itself, exert moral pressure on doctors to behave in a professional way. Some medical schools foster compliance with a code by a ritual declaration or 'white coat' ceremony at entrance to medical school, or at graduation. However, its influence on doctors' practice depends largely – although by no means completely – on its position in relation to wider regulatory, legal and educational structures and processes.

A professional code may occupy a more or less dominant position in a professional body's regulatory framework, and there is a tension between its role in fostering collegiality and the enforcement of compliance with it. Enforcement may take the form of persuasion and informal influence, or incentives or sanctions such as financial penalties, the publication of results, restriction of activity or removal of a doctor's certificate or license. Regulatory systems can be characterised in three main ways: they may be based on compliance or deterrence, assessed by summative or formative means, and may be restrictive or indicative.

Walshe (2003) contrasts **compliance** with **deterrence** regulation. Deterrent regulators tend to adopt a punitive, adversarial approach to regulation and make use of sanctions and penalties. The standards they use are likely to be highly specified, oriented towards measurement. This approach is likely to be associated with **summative** assessment, which evaluates competence or performance and may make pass/fail judgements against these standards.

Compliance regulators take a more supportive, developmental approach to regulation, using punitive measures and sanctions only as a last resort. They tend to use descriptive, aspirational standards directed at development; assessment is more likely to be **formative**, concentrating on providing feedback on an individual's strengths and weaknesses, and on clarifying areas of concern or excellence for doctors.

According to Walshe (2003), compliance approaches to regulation are more common where there is a strong ethical or professional culture, and in these situations may better secure co-operation and support. However, they risk being so comfortable for the regulators and those they regulate that the protection they provide for the public is compromised.

If a code's purpose is to provide a general statement of the profession's values, measuring performance against it may not be important. However, if it is to claim influence as a means of ensuring patient safety or assurance of fitness-to-practise, the standards or principles set out in a code must be operationalised into explicit criteria, then thresholds of acceptable and unacceptable practice, against which doctors can be

assessed. Baker (2006, p231) defines standards as “general statements of what is expected of doctors”; criteria as “statements derived from the standards that detail the exact requirements”; and threshold as “the level of non-compliance with a criterion that leads to specific action.”



The bodies which regulate and assess doctors may operate either through licensing or certifying systems. Irvine (2004) summarises the distinction between **licensure** and **certification** in the UK, USA and Canada:

“Licensure is restrictive i.e. a doctor cannot practise without it. Licensing bodies ensure that only properly qualified doctors are allowed to practise medicine, and can remove any who cease to be fit to practise. They may be national, like the General Medical Council (GMC) in the UK, or they may be regional where the jurisdiction rests with a State or Province (as in the US and Canada respectively). They implement their statutory functions by maintaining registers or lists of practitioners whom they have licensed to practice...”

“Specialty-specific professional bodies decide the standards needed for practice in their respective fields and the training necessary to achieve those standards. Their grant of certification, which may or may not be within a statutory framework, marks the satisfactory completion of training and therefore eligibility to practice as an unsupervised specialist in the doctor’s chosen field. Certification is indicative, that is to say it is not – like licensure – absolutely restrictive. So for example, in the USA it is possible to practise as a general practitioner whilst not being Board - certified in Family Medicine. (Irvine, 2004)

Licensure has legal authority: it is statutory, restrictive and applies to all practising doctors. Certification, being voluntary and indicative, may appear to wield less influence over doctors’ practice. However, certification may be used in a restrictive sense when it is given authority by an agent, whether this is an employer, an insurance company or a licensing body. For example, many provincial licensing bodies in Canada will license doctors to practise only if they are certified by either the Royal College of Physicians and Surgeons of Canada (RCSPC) or by the College of Family Practitioners of Canada (CFPC). In the UK, the NHS has a near monopoly on the employment of doctors and many positions are open only to doctors certified in a specialty by one of the Medical Royal Colleges. In the USA, hospital privileges are granted only to doctors certified to practice by one of the ABMS member specialty boards and, similarly, the major health insurance companies (Medicare and Medicaid) will only cover care provided by a certified doctor.

Initial certification or licensure evaluates the training, qualifications and competence of doctors at the outset of their career. The assumption that a license or certificate issued at this point is valid for the rest of a doctor’s working life is losing credibility and many of the professional bodies in the three countries covered by this review have adapted – or are in the process of adapting – to this by introducing ongoing systems of licensure and/or certification.

2.5 Summary

This paper explores the content and purpose of a selection of codes. It examines the interactions and overlaps between the professional values in the codes, where they conflict with each other, and whether, or how, codes address the tensions and contradictions inherent within them. For example, how are professional duties to individual patients balanced against their responsibilities to communities or systems? How are potential tensions between fairness in allocation of resources and respect for patient autonomy reconciled? It also examines the prominence of concepts related to patient-centredness such as patient involvement, partnership or autonomy and the moral requirements of the doctor in his or her relationship with the patient (e.g. whether or not the doctor is expected to demonstrate altruism, or to promote patient autonomy).

The purposes of codes are examined in two ways: First, we look specifically at how the standards are phrased or worded in the code, analysing the statements' generalisability and specificity, and the stringency of the standards they set. Second, we investigate what it states or what is otherwise known about its implementation or use in education or regulation. Beyond the wording of the standards we look at accompanying documentation, etc. to obtain information on the functions and implementation of the codes.

3 Selection and analysis of nine professional codes

This review involved careful textual analysis of a selection of codes, together with investigation of their uses and implementation, through an examination of appropriate documentation. Table 1 summarises the codes which are the subject of this analysis, and the remainder of this section sets out the rationale by which the nine were chosen.

Table 1: Selection of codes

Code	Year of publication	Specialty-specific or general	Issuing body	Regulatory function of issuing body
<i>Good Medical Practice</i>	1995, 2001, currently under review	General	General Medical Council	Licensure
<i>Good Medical Practice for General Practitioners</i>	2002	Specific to general practitioners (family doctors)	Royal College of General Practitioners	Certification
<i>Good Psychiatric Practice</i>	2000, 2004	Psychiatrists	Royal College of Psychiatrists	Certification
<i>Physician Charter</i>	2002	General	American Board of Internal Medicine (ABIM) Foundation, American College of Physicians & European Federation of Internal Medicine	ABIM has a certifying role (NB <i>Physician Charter</i> was published by ABIM Foundation)
<i>Code of Ethics</i>	2002, 2003	Specific to plastic surgeons	American Board of Plastic Surgeons	Certification
<i>Disruptive Physician Behavior</i>	2001	General	Commonwealth of Massachusetts Board of Registration in Medicine	Licensure
<i>CanMEDS</i>	2001, 2005	Applicable to all specialists (physicians & surgeons)	Royal College of Physicians and Surgeons of Canada	Certification
<i>Four Principles of Family Practice</i>	1985	Specific to family doctors	College of Family Practitioners of Canada	Certification
<i>Code of Ethics of Physicians</i>	2002	General	Collège des Médecins du Québec	Licensure

The plethora and diversity of codes published by the wide range of bodies which train, support, defend and regulate doctors in the three countries, means we could not include them all as this would have made meaningful comparison between them impossible. We did not include codes or standards published by non-professional bodies which have, for example, a quality assurance role in the delivery of health care, or medical associations whose primary purpose is to represent the interests of doctors. We therefore confined our attention to those issued by professional bodies with a regulatory function of certification or licensure. All medical bodies with a certification or licensure function in the three countries were identified. A purposive selection of nine codes of practice and statements of professional standards published by them was made for closer comparison. The selection was designed to include:

- one code from each country which is widely recognised to be a particularly important, high-profile or dominant code for doctors in that country
- at least one code published by a licensing body and one by a certifying body in each of the three countries
- both general codes which apply to all doctors and those which are specific to certain specialties or to general practitioners/family doctors only

3.1 UK

Good Medical Practice (General Medical Council)

Good Medical Practice for General Practitioners (Royal College of General Practitioners)

Good Psychiatric Practice (Royal College of Psychiatrists)

Good Medical Practice was selected because it is published by the General Medical Council, the body with statutory responsibility for licensing all practising doctors in the UK. It is the unifying guidance for medicine throughout the UK, and is the foundation of licensure for all UK doctors, including possible disciplinary action. In the main document are the "Duties of a doctor" and the basic principles of good medical practice. Further explanatory text and guidance on specific aspects such as consent, confidentiality etc are referred to in the main document and provided in separate booklets.

Medical Royal Colleges certify doctors in their respective specialties, and were charged with writing derivatives of the code for their specialties which follow broadly similar structures as *Good Medical Practice*. *Good Medical Practice for General Practitioners* and *Good Psychiatric Practice* were published by two of thirteen Medical Royal Colleges. They were selected because their interpretations and operationalisations of *Good Medical Practice* contrast in terms of their structure and aims. *Good Psychiatric Practice* addresses particular issues concerning patient autonomy, since psychiatrists sometimes have to act, legitimately, against the stated preferences of patients.

3.2 USA

Physician Charter (ABIM Foundation, American College of Physicians, European Federation of Internal Medicine)

Code of Ethics (American Board of Plastic Surgeons)

Disruptive Physician Behavior (Commonwealth of Massachusetts Board of Registration in Medicine)

Twenty-four member boards of the American Board of Medical Specialties (ABMS) certify doctors in particular specialties and sub-specialties. Two of these boards have published their own professional codes: the American Board of Internal Medicine (ABIM) and the American Board of Plastic Surgeons (ABPS). The ABIM Foundation's *Physician Charter* is the product of the 'Medical Professionalism Project,' and is the most high-profile, widely disseminated medical professional code in the USA. It was published by the ABIM Foundation in conjunction with American College of Physicians (ACP) Foundation and European Federation of Internal Medicine. All 24 ABMS member boards have "endorsed" *Physician Charter*. The ABPS has published a *Code of Ethics* which is also reviewed as it is the only other professional code published by a member board of the ABMS that was identified, and contrasts with *Physician Charter* in some significant ways.

In the USA, licensure is the responsibility of state licensing bodies. They produce sets of legal standards which, if contravened, can result in non-renewal or revocation of a doctor's license. Although these cover many of the same issues as the professional codes, they are presented mostly in terms of what practices are prohibited, and thus do not constitute a professional code. The Commonwealth of Massachusetts Board of Registration published a document called *Disruptive Physician Behavior* to stimulate discussion about professional conduct which presents a different approach to setting out and implementing guidance for doctors. It differs in style and objectives from the other codes, and is included in the review because it contrasts with the more directive codes in ways which illuminate their commonalities.

3.3 CANADA

CanMEDS (Royal College of Physicians and Surgeons of Canada)

Four Principles of Family Practice (College of Family Practitioners of Canada)

Code of Ethics of Physicians (Collège des Médecins du Québec)

There are only two major certifying bodies in Canada, the Royal College of Physicians and Surgeons of Canada (RCPSC) and College of Family Physicians of Canada (CFPC), so the codes published by each of them were selected for review. The development of the original *CanMEDS* roles framework was underpinned by the *CanMEDS 2000* project, a large-scale, ongoing project designed to identify the key roles and competencies of a physician, explicitly predicated on meeting the needs of society. *CanMEDS* is described as "the RCPSC flagship standards document" which helps "articulate what it means to be a competent physician" (Frank, 2005). Produced by the RCPSC Office of Education originally to inform training, education and accreditation processes, it is firmly competency-based and outcomes-oriented. In this sense it differs from a traditional code of ethics but, as a document which sets out guidance on the standards to which competent doctors are

expected to practise, it meets our definition of a code and merits inclusion in this review. Licensure in Canada is the responsibility of provincial licensing bodies, some of which have published their own professional codes, and some of which adopted the Canadian Medical Association's *Code of Ethics*. The Collège des Médecins du Québec's *Code of Ethics of Physicians* was selected as it contrasts in content and style with the other two Canadian codes.

4 What topics are included in each of the codes?

This section gives a brief description of each of the codes.

Good Medical Practice

Good Medical Practice was first published by the General Medical Council (GMC) in 1995 and revised in 2001. It is currently under review, and a revised version is due for publication in 2006. It was written

“to inform doctors and the public of the standards and values of a 'good' doctor. It provides principles which underpin our fitness to practise decisions, and a framework for use in undergraduate education and in the revalidation and appraisal of doctors” (GMC website).

After listing twelve ‘Duties of a doctor’ the main body of the code is arranged under the following seven principles of good medical practice:

- Good clinical care
- Maintaining good medical practice
- Teaching and training, appraising and assessing
- Relationships with patients
- Working with colleagues
- Probity
- Health

Six further guidance documents supplement *Good Medical Practice*, offering specific guidance on consent, confidentiality, research, management, serious communicable diseases and withholding and withdrawing life-prolonging treatments.

Good Medical Practice for General Practitioners

Within the overarching framework of *Good Medical Practice*, each of the Medical Royal Colleges was asked to complete the detailed criteria, clinical standards and thresholds for unsupervised good practice in their speciality. *Good Medical Practice for General Practitioners* was written expressly to contribute to the process of the revalidation of GPs, and published by the Royal College of General Practitioners in 2002. It follows the same headings as, and draws heavily on, *Good Medical Practice*. Within these headings, it specifies the practice of GPs which constitutes good, excellent and unacceptable practice.

Good Psychiatric Practice

Good Psychiatric Practice was originally published by the Royal College of Psychiatrists in 2000, and updated in 2004. Unlike *Good Medical Practice for General Practitioners*, its relationship to revalidation procedures is not made explicit in the document itself. It states that unacceptable psychiatric practice will include failure to adhere to the precepts

outlined in the document, but says nothing of the consequences of unacceptable practice. It quotes *Good Medical Practice* extensively but is organised under different headings:

- Core attributes
- The trusting relationship
- Good clinical care
- Consent to treatment
- Note-keeping and inter-agency/ inter-professional communication
- Confidentiality
- Availability and emergency care
- Working as a member of a team
- Referring patients
- Clinical governance
- Teaching and training
- Research
- Being a good employee and employer

Physician Charter

The *Physician Charter* was the principal product of the Medical Professionalism Project. This project was set up in 1999 and combined the efforts of American Board of Internal Medicine (ABIM) Foundation, American College of Physicians (ACP) Foundation and European Federation of Internal Medicine. The Charter, published in 2002, is a code of conduct which was written in response to perceived threats to the values of professionalism presented by changes in healthcare delivery systems.

It sets out three fundamental principles:

- Principle of primacy of patient welfare
- Principle of patient autonomy
- Principle of social justice

These are followed by a set of ten professional responsibilities:

- Commitment to professional competence
- Commitment to honesty with patients
- Commitment to patient confidentiality
- Commitment to maintaining appropriate relations with patients
- Commitment to improving quality of care
- Commitment to improving access to care
- Commitment to a just distribution of finite resources
- Commitment to scientific knowledge
- Commitment to maintaining trust by managing conflicts of interest
- Commitment to professional responsibilities

American Board of Plastic Surgeons Code of Ethics

The American Board of Plastic Surgery first published this *Code of Ethics* in 2002 and revised it in 2003. Its six sections are General principles; Specific principles; Specific offenses; Conflicts of interest; Officers, directors, advisory council members, consultants and examiners for the oral examination, recertification process and maintenance of certification; Enforcement. The general principles can be summarised thus:

- Render services to humanity with full respect for human dignity
- Strive continually to improve medical knowledge and skill
- Responsibilities of the physician extend to the individual but also to society
- Provide services with compassion and respect for human dignity as well as the rights and privacy of their patients
- Behave honestly and bring to the attention of the Board those deficient in character or competence
- Obey the civil law and safeguard the best interests of patients

Disruptive Physician Behavior

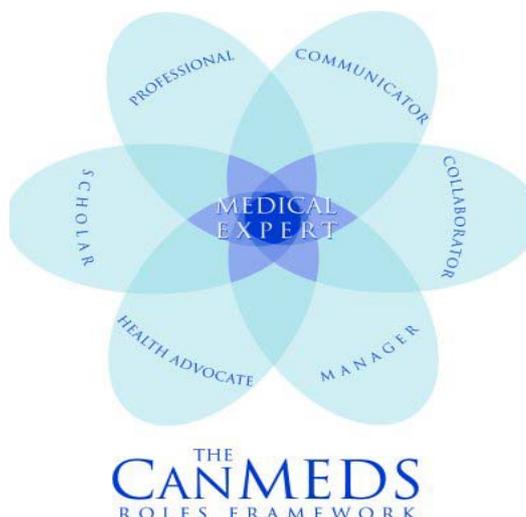
This was adopted by the Commonwealth of Massachusetts Board of Registration in Medicine in 2001. It was published in response to concerns amongst licensees that disruptive physician behaviour was having a deleterious effect upon the health care system and increasing the risk of patient harm. Its purpose was to provide information, to stimulate discussion and education.

CanMEDS

The Royal College of Physicians and Surgeons of Canada (RCPSC) commissioned a project entitled *CanMEDS 2000: Skills for the New Millennium*. It began in 1993 and was revised in 2005. It was premised on the idea that systematic intervention in the education system was the way to bring specialty care in line with Canadian societal health care needs. The Societal Needs Working Group produced a 'roles framework' called *Skills for the New Millennium* which delineates each of seven key roles of a specialist physician, the competencies associated with it, and the specific objectives of medical education associated with each role.

The seven CanMEDS roles are presented diagrammatically to demonstrate their interrelationships:

- Medical Expert
- Communicator
- Collaborator
- Manager
- Health advocate
- Scholar
- Professional



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Four Principles of Family Medicine

The College of Family Physicians of Canada (CFPC) developed the *Four Principles of Family Medicine* in 1985 to provide a definition of family medicine as a distinct discipline within the broader practice of medicine.

While they are not accorded status of a professional code, they serve many of the functions of a code, including steering many of the activities of the CFPC, and they underpin the Continuing Professional Development (CPD)/Continuing Medical Education (CME) programmes. The four principles are:

- The family physician is a skilled clinician
- Family medicine is community based
- The family physician is a resource to a defined practice population
- The patient-doctor relationship is central to family medicine

Code of Ethics of Physicians

This *Code of Ethics of Physicians* was adopted by the Collège des Médecins du Québec and approved by the Government of Quebec in 2002. It is organised under the following headings:

- General obligations of the physician
- Quality of the professional relationship
- Freedom of choice
- Consent
- Medical management and follow-up
- Quality of practice
- Independence and impartiality
- Integrity
- Accessibility and rectification of records
- Fees
- Relations with colleagues and other professionals
- Relations with the college

5 What are the overlaps and differences between codes in relation to medical professionalism?

This section considers the content of the nine codes in relation to medical professionalism: the scientific/technical, ethical and relationship-related aspects of a doctor's role.

5.1 Technical/scientific issues

Differences between the scientific or technical scope of the codes lie largely in the level of detail of the guidance they offer on the substance of doctors' basic scientific knowledge and technical skills and how they should be maintained.

Good Medical Practice for GPs, for example, offers the most detailed guidance on a large range of issues to do with clinical care such as diagnosis, keeping good medical records, alleviation of pain, prescribing, reporting adverse drug reactions. Another section details how doctors are expected to keep up to date and maintain their performance through education, keeping up to date with the law and statutory bodies, taking part in audit, training, appraisal and adverse event reporting.

The Physician Charter, in contrast, conveys the message that doctors should be committed to improving quality of care, to scientific knowledge and to professional competence, through more general statements which often use grander rhetoric, but with no prescription of how this should be achieved.

The second of the *Four Principles of Family Medicine* covers the technical aspects of professionalism and acknowledges the breadth, complexity and ambiguity of the problems that may present to family practitioners. It does not attempt to offer guidance specific to the range of problems. *CanMEDS* places the role of Medical Expert at the centre of its roles framework as the integrative role which most distinguishes physicians from other professionals. This role requires the possession of "a defined body of knowledge, clinical skills, procedural skills and professional attitudes, which are directed to efficient patient-centred care" (*CanMEDS*) as well as the maintenance of competence and knowing limits of expertise. As with all the *CanMEDS* roles, it elaborates its associated key competencies and enabling competencies to address the needs of competency-based education.

.. take part in regular and systematic medical and clinical audit, recording data honestly. Where necessary, you must respond to the results of audit to improve your practice, for example by undertaking further training.
Good Medical Practice for GPs

Physicians must be committed to life-long learning and be responsible for maintaining the medical knowledge and clinical and team skills necessary for the provision of quality care." *Physician Charter*

5.2 Ethical issues

The ethical issues commonly addressed by the codes include ensuring fairness in patients' access to care, the decisions that are made about resource allocation, the trustworthiness of doctors, and the observance of confidentiality.

Access to care

Three discernible factors may influence patients' access to care: patients' characteristics, patients' behaviour and doctors' personal convictions.

Most codes acknowledge the potential impact of patient characteristics such as lifestyle, culture, religion and sexuality on patients' access to care and the way they are treated by doctors, and state that this impact should be minimised through more or less proactive efforts of doctors.

CanMEDS states that doctors should be aware of the influence of these factors on patients' illness and care. According to the *Code of Ethics of Physicians* a physician must not refuse to examine or treat a patient on the grounds of these attributes, but may refer to another physician if they think it is in the patient's best interests. *Good Medical Practice* underlines that these factors should not prejudice doctors' decisions about treatment and that priority should be given on the basis of clinical need and the likely effectiveness of treatment. *The Physician Charter* takes the issue of discrimination further than the other codes: not only must they themselves not discriminate on these grounds, but physicians must challenge any evidence of discrimination.

...work actively to eliminate discrimination in health care, whether based on race, gender, socio-economic status, ethnicity, religion or any other social category. Physician Charter

Some codes, for example the UK codes, stress that patients' rights to access treatment should not be conditional on their behaviour. *Good Medical Practice* encourages doctors whose patients pose a risk to their health or safety to take reasonable steps to protect themselves before investigating their condition or providing treatment. *Good Medical Practice for GPs* allows that if patients are difficult, threatening or violent this may compromise their right to access general medical services in a normal setting, but doctors in the NHS still have a responsibility to assist these patients to access care. Another factor which, according to *Four Principles of Family Medicine*, should not restrict the doctor's care of a patient is whether or not the patient complies with treatment: The physician's commitment to the patient's well-being should not be contingent on whether "patients are able to follow through on their commitments."

If a doctor's personal convictions conflict with providing a particular treatment, *Good Medical Practice* and *Good Medical Practice for GPs* say that doctors are not obliged to offer it. However, they still have a duty to help the patient find a doctor who will treat them. The *Code of Ethics of Physicians* further considers it the doctor's duty to advise the patient of the possible consequences of not being treated.

Good Psychiatric Practice makes no allowance for psychiatrists' personal convictions clashing with a patient's needs, nor for a patient to access a treatment via another doctor if this

"Where issues are complex, unclear or beyond an individual's competence, the psychiatrist should seek legal advice and a second opinion."
Good Psychiatric Practice

occurs. It recognises that it is often not possible for a psychiatrist to provide the treatment requested by a patient, but in this case the psychiatrist must explain to the patient the risks and benefits of acting as requested, in which case the psychiatrist can override the patient's stated preferences and act unilaterally in the patient's best interests. However, it does say that where there is ambiguity, a psychiatrist should seek advice from other professionals.

Allocation of resources

Most of the codes refer in some way to the doctor's responsibility for the distribution of resources. Three issues emerge: the tensions between individual and population interests, the principles which underlie decisions about resource allocation and the extent of doctors' responsibility for the allocation of resources.

The tension between the individual's and population's interests and how limited resources are to be allocated is alluded to in many codes. *Good Medical Practice*, *Four Principles of Family Medicine*, *Code Of Ethics Of Physicians* and *CanMEDS* all call for efficiency, effectiveness, fairness, wisdom and/or judiciousness in their allocation of resources.

Good Medical Practice for GPs acknowledges the necessity of balancing the needs of the patient against the needs of the population, but advises that the GP's primary responsibility is to the patient and if shortage of resources means the provision of inadequate care, this should be made explicit to the patient and to those in control of resources.

The principles which should guide decisions about the allocation of resources are rarely made explicit in the codes. The extent to which most doctors have strategic responsibility for the allocation of resources is variable, given the constraints placed upon their day-to-day practice by governments, managers and other factors. *Physician Charter* acknowledges the significance of the social, political and economic context within which the medical profession operates and, as Manager, *CanMEDS* advocates the "active engagement of all patients as integral participants in decision-making in the operation of the healthcare system."

The medical profession must contend with complicated political, legal and market forces.
Physician Charter

Insofar as the doctor has control over resource allocation, these judgements are often left to be made on the basis of whatever the doctor feels is fair. However, this may be too vague to constitute useful guidance or to hold a doctor to account when decisions are disputed. Only two codes offer more solid guidance in this respect: *Good Medical Practice for GPs* and *Physician Charter*.

"ensure that resources are allocated and used to reduce inequalities in health."
Good medical Practice for GPs

These two principles - the reduction of inequalities in health and the provision of uniform or equitable health care - are both defensible aims of a health care system, but they are based on different values and have different implications for doctors' practice.

Medical professionalism demands that the objective of all health care systems be the availability of a uniform and adequate standard of care. Physicians must individually and collectively strive to reduce barriers to equitable health care.
Physician Charter

Doctors are intimately involved in resource allocation, since their individual treatment decisions are key drivers of healthcare expenditure. The *Physician Charter* suggests that physicians can work towards equitable health care by contributing to the development of guidelines for cost-effective care, and avoiding superfluous tests and procedures. *CanMEDS* says physicians have a responsibility to influence the healthcare system within which they work.

“Understand the structure, financing and operation of the Canadian health system and its facilities, function effectively within it and be capable of playing an active role in its change.”
CanMEDS

Good Medical Practice for GPs points to the responsibility that some doctors hold due to their position in the health system. For example, general practitioners who sit on committees of Primary Care Trusts in England may take part in decisions about commissioning services for a wider population, and this could be a mechanism by which they work towards a reduction in health inequalities.

Trust

The nature of trust, how it is protected and nurtured and what to do when it breaks down, is touched on in most of the professional codes. Some codes list elements of the conduct of a doctor which are conducive to trust-building. For example, in *Good Medical Practice* trust is established and maintained through politeness, considerateness and truthfulness; good communication; respect for patients' privacy and dignity, for their right to decline to take part in teaching or research, and for their right to a second opinion. *Good Psychiatric Practice* adds further safeguards for establishing and maintaining trust, for example recognising and respecting patients' diversity, ensuring that patients understand their treatment plans and have access to information to help with this; facilitating expression of differences of opinion and constructive discussion around areas of disagreement. These and most other codes highlight the importance of trust not being undermined by the establishment or pursuit of *“a sexual or improper emotional relationship”* (*Good Medical Practice*).

The codes aimed at general practitioners or family physicians devote more attention to the issue of trust than the other codes, and view it most holistically, probably reflecting the longer term nature of most patients' relationships with their GP than with other doctors and their close connections with the community and, possibly, other family members.

[Family physicians] use repeated contacts with patients to build on the patient-physician relationship and to promote the healing power of interactions. Over time the relationship takes on special importance to patients, their families, and the physician.
Four Principles of Family Medicine

Good Medical Practice for GPs identifies the embeddedness of trust in all aspects of practice and adherence to standards. *Good Psychiatric Practice* touches more on the fragility of trust than the other codes. Given that psychiatrists may detain patients under mental health legislation against their wishes or treat without their consent, trust between psychiatrists and their patients may tend to be more fraught than in other doctor-patient relationships. A considerable proportion of the section on the trusting

Trust is not a separate part of being a good doctor. Trust is earned by practising to the standards implied by other sections of this booklet.
Good Medical Practice for GPs

relationship is given to the question of what to do when trust breaks down, and the duty to ensure continuing treatment where this is necessary.

Confidentiality

All the codes, except *Disruptive Physician Behaviour* and the American Board of Plastic Surgeons *Code of Ethics*, address the issue of confidentiality in some way. The Canadian codes (*CanMEDS* and *Four Principles of Family Medicine*) are vague: *Four Principles of Family Medicine* does not use the term confidentiality, but says family physicians “*respect the privacy of the person*,” while *CanMEDS* says doctors should recognise the principles and limits of patient confidentiality as defined by professional practice standards and the law, but does not elaborate on what this means in practice.

The UK codes offer more detailed guidance; saying for example that information about patients should be treated as confidential, other than in exceptional circumstances in which the doctor should be prepared to justify - to the patient and the authorities if necessary - the decision to share information without the patient’s consent. *Good Medical Practice for GPs* expands on this, underlining the proximity of general practice to the community, and the importance for the reputation of the practice that the whole team understands the principles of confidentiality. *Good Psychiatric Practice* highlights the potential conflict in psychiatry between respect for confidentiality and public safety, the importance of involving carers and relatives, and of sharing information between the police, courts and child protection agencies. These three codes refer readers to separate guidance: the GMC’s *Confidentiality: Protecting and Providing Information* and the Royal College of Psychiatrists’ *Good Psychiatric Practice: Confidentiality*.

The *Code of Ethics of Physicians* goes into considerable detail about what it terms “*professional secrecy*,” setting out six very specific directives. It also lists seven instructions detailing how to record instances in which a physician must communicate information protected by professional secrecy.

refrain from holding or participating in indiscrete conversations concerning a patient or the services rendered him or from revealing that a person has called upon his services.

[record] the identity of the person to whom the communication was made, specifying, according to the case, whether it was the person or persons exposed to danger, their representative or the persons likely to come to their assistance.
Code of Ethics of Physicians

5.3 Relationships: Individual and collective

All the codes focus on the individual doctor-patient relationship more closely than any other aspect of professional relationships, but they vary in terms of the relationships they cover beyond this. Some also refer to the responsibilities the doctor has

- to wider groups of patients or public (for example family, community, patient list, public generally)
- to their collective responsibilities towards colleagues or to the profession as a whole

Patients

In *Good Psychiatric Practice*, psychiatrists' responsibilities extend beyond the individual patient to their carers, while acknowledging the potential for conflict between the patient's and carer's view of the patient's needs.

...bringing empathy, encouragement and hope to patients and their carers.
Good Psychiatric Practice

American Board of Plastic Surgeons *Code of Ethics* underlines physicians' responsibility to the individual and to society. Similarly, *Code of Ethics of Physicians* refers, somewhat vaguely, to the duty of a physician to protect and promote the health and well-being of the persons he (sic) attends to, both individually and collectively.

Activities which have the purpose of improving both the health and well being of the individual and community deserve the interest and participation of the physician.
ABPS Code of Ethics

The professionalism conveyed by the Canadian codes is firmly community-centred. Both *Four Principles of Family Medicine* and *CanMEDS* emphasise doctors' relationships with patients, families and communities, and locate the family physician firmly within the community.

Family practice is based in the community and is significantly influenced by community factors. As a member of the community, the family physician is able to respond to people's changing needs, to adapt quickly to changing circumstances, and to mobilize appropriate resources to address patients' needs. *Four Principles of Family Medicine*

[the family physician] views his or her practice as a 'population at risk' and organizes the practice to ensure that patients' health is maintained whether or not they are visiting the office.
Four Principles of Family Medicine

Both also emphasise the preventive and public health role of the family physician. *Four Principles of Family Medicine* encourages doctors to use information and records in order to maintain the health of those in the population who do not present to them, as well as those who do.

Physicians recognize their duty and ability to improve the overall health of their patients and the society they serve. ... Health advocacy is appropriately expressed both by individual and collective actions of physicians in influencing public health and policy. *CanMEDS*

Colleagues and the profession as a whole

The codes vary in the way they address the contexts in which doctors work, in particular their responsibilities to and for other doctors and health professionals. One such responsibility is for the functioning and effectiveness of the clinical teams of which they are part, and for their interactions with doctors to whom they refer or from whom they accept referrals. Other duties are to support colleagues, or to report them if there are concerns about their practice or conduct. Some codes also highlight doctors' responsibilities to the profession as a whole.

Doctors increasingly work as members of teams, yet codes such as *Physician Charter*, American Board of Plastic Surgeons *Code of Ethics* pay little or no attention to this. *Good Medical Practice*, *Good Medical Practice for GPs*, *CanMEDS*, and *Code of Ethics of*

Physicians reflect the responsibilities doctors have to ensure the quality of their services when involved in collaboration within teams and the sharing of information between colleagues when a patient is referred from one to the other. *Good Psychiatric Practice* has a section devoted to note-keeping and inter-agency/inter-professional communication, which sets out how psychiatrists will keep complete and understandable records and ensure there is good communication with all agencies and between professionals.

CanMEDS acknowledges the increasingly multiprofessional environment in which modern healthcare is delivered, often through extended teams with a variety of perspectives and skills. Enabling competencies for the Collaborator role include to work with others to “*assess, plan, provide and integrate care for individual patients (or groups of patients)... assess, plan, provide and review other tasks, such as research problems, educational work, program review or administrative responsibilities*” and to “*recognize one’s own differences, misunderstandings and limitations that may contribute to interprofessional tension*” (*CanMEDS*)

Code of Ethics of Physicians touches on another issue related to the importance of collaboration. The degree of support doctors are expected to offer each other varies slightly between codes. *Physician Charter*, *Good Medical Practice* and *Code of Ethics of Physicians* say simply that physicians are expected to be respectful of one another, treat colleagues fairly and not undermine patients’ trust by making malicious or unfounded criticisms of them.

A physician must collaborate with his colleagues in maintaining and improving the availability and quality of the medical services to which a clientele or population must have access.
Code of Ethics of Physicians

a physician must not denigrate, abuse the confidence of, mislead, betray the good faith of, use disloyal tactics with, harass, intimidate or threaten colleagues.
Code of Ethics of Physicians

Good Psychiatric Practice pays considerable attention to the psychiatrist’s relationships with colleagues. It requires psychiatrists to be sensitive to the power differential and its potentially destructive influence on relationships with colleagues in other disciplines, with patients and with carers. As well as this, it expects psychiatrists actively to contribute towards an agreeable working environment.

Codes differ considerably in their approach to the question of reporting colleagues’ poor practice or conduct. *Four Principles of Family Medicine*

contribute to creating a warm atmosphere within a team where individual opinions are valued and team members have a sense of ownership of decisions.
Good Psychiatric Practice

does not deal with it, and *Physician Charter* deals with matters of underperformance only in the general sense that doctors should participate in the process of self-regulation, but offers no guidance on principles or mechanisms by which poor performance of colleagues should be dealt with. *CanMEDS* and *Physician Charter* are not very specific. *CanMEDS* says the specialist should be able to “*recognize and respond to others’ unprofessional behaviours in practice.*”

The American Board of Plastic Surgeons *Code of Ethics* instructs its members to bring colleagues’ incompetence or unethical behaviour to the attention of the Board. *Disruptive Physician Behavior* notes the obligation of all physicians, in their role as patient and peer advocates, to speak out when faced with disruptive behaviour. Physicians “*must consider that ‘the importance of respect among all health care professionals as a means of ensuring good patient care is at the very foundation of the ethics advocated by the AMA’* (*Disruptive Physician Behavior*)

The *Code of Ethics of Physicians* published by the Collège des Médecins du Québec are strict in their rules about reporting underperforming colleagues.

A physician must report to the College any physician, medical student, resident, medical fellow or any person authorized to practise medicine who he believes to be unfit to practise, incompetent or dishonest, or who has performed acts in contravention of the Professional Code, Medical Act or regulations ensuing therefrom. Code of Ethics of Physicians

In general, the UK codes are the firmest about duties to report under-performing colleagues and give the most detailed guidance on the mechanisms by which concerns about colleagues' conduct or performance should be handled. They are unequivocal that *"the safety of patients must come first at all times,"* and that *"serious concerns about a colleague's performance, health or conduct must be investigated without delay to protect patients."* (*Good Medical Practice*)

Good Medical Practice for GPs captures a telling shift in the balance of doctors' responsibilities towards their colleagues and patients.

It used to be regarded as unprofessional to "tell" on a colleague. You now risk an allegation of misconduct if you know a doctor is unsafe and you do nothing about it. Good Medical Practice for GPs

Good Psychiatric Practice reproduces *Good Medical Practice's* advice on concerns about colleagues' conduct or performance and adds to it an example of unacceptable practice which emphasises risks due to inexperience.

failing to intervene where necessary to ensure the safety of the patient or others, depending on one's seniority within the team (for example: it would be considered unacceptable for a consultant to fail to take appropriate action if he or she were aware of a patient being placed at risk by less-experienced members of the clinical team). Good Psychiatric Practice

Physician Charter is more conscious of physicians' relationship to the profession than the other codes. It refers repeatedly to such responsibilities, for example, to ensure members of the profession are competent; for the integrity of scientific knowledge; to collaborate for self-regulation, defining and organising education and standard-setting. Physicians have individual and collective responsibility to engage in internal assessment and accept external scrutiny of their performance.

A physician must, as far as he is able, contribute to the development of the profession by sharing his knowledge and experience... Physician Charter

Physicians' dedication to the principles of professionalism entails *"their personal commitment to the welfare of their patients but also collective efforts to improve the health care system for the welfare of society."*

The profession as a whole must strive to see that all of its members are competent and must ensure that appropriate mechanisms are available for physicians to accomplish this goal. Physician Charter

5.4 Summary

Almost all codes emphasise the key importance of technical competence in medical professionalism. They vary in the detail with which they attempt to specify the elements of competence, and whether they acknowledge the ambiguities and complexities of being technically competent.

Certain ethical issues, for example the responsibilities not to discriminate unfairly against patients and to maintain patient confidentiality, are supported by most of the codes. The differences between the codes lie in the degree to which they explicitly state that doctors are expected to take responsibility for reporting other doctors' deviations from best practice, and to challenge unacceptable practice in colleagues or in the system.

Other ethical issues, such as allocation of resources, are addressed in varying depth. Some, but not all, acknowledge the inherent tensions between the interests of individuals and populations. Few offer firm guidance for resolving these tensions, while fewer still make explicit the ethical principles which should underpin doctors' judgement when faced with them.

Most codes acknowledge that the doctor does not necessarily have moral authority over the patient where conflicts in values exist, and allow that patients may have a right to access treatment which goes against the doctor's conscience, or to a second opinion. *Good Psychiatric Practice* tends more than the other codes to assume that the doctor may override patients' stated preferences to act in their best interests.

UK codes are relatively narrow in their scope with reference to patients and colleagues. They cover the immediate doctor-patient interaction and to some extent, family and carers, and immediate team members, although they are the most specific in their instructions on how to deal with underperforming colleagues.

The Canadian and American codes look more holistically at relationships between the doctor and the community and society. *Physician Charter* is also very concerned with the profession as a whole and doctors' responsibilities for self-regulation, defining education and standard-setting.

6 What are the overlaps and differences between codes in relation to patient-centredness?

This section discusses themes related to patient-centredness which are common to most codes: consent, patient engagement and autonomy, the moral basis of the doctor-patient relationship, and patient involvement in the development of the codes. Other issues such as continuity of care and privacy could have been included had they been addressed in the majority of the codes.

6.1 Patient engagement and autonomy

The codes vary in their attention to issues related to the promotion of patient autonomy: shared decision-making, access to information, good communication, consent, and instances where patient autonomy should be restricted.

Professional codes increasingly reflect the preferences of patients to be involved in making decisions about their care.

Physician Charter emphasises patient autonomy as one of three principles to be upheld above all, as long as it does not conflict with social justice.

Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical practice and do not lead to demands for inappropriate care. Physician Charter

Good Medical Practice says that doctors must respect patients' rights to be fully involved in these decisions and that doctors must satisfy themselves that the patient has understood what is proposed, why, and any significant risks or side effects associated with it. *Good Medical Practice for GPs* advocates more active encouragement on the part of doctors to involve patients in decisions about management, and is more specific about the ways in which patient autonomy can be promoted through access to information and skilled communication.

Your consulting style should be responsive to individual patients' needs, involving them in decisions about management. Good Medical Practice for GPs

Good Psychiatric Practice also encourages involvement of the patient in decision-making. However, the language used here is somewhat more tentative: the cases in which it is deemed not possible to provide the interventions requested by patients, the doctor must "Act decisively but sensitively and always in the best interests of the patient." There is a tension here between the requirement to respect patient autonomy and the assumption that the doctor knows what is in the patient's best interests, perhaps unavoidable for some psychiatric patients.

An intrinsic part of facilitating shared decision-making is enabling access to information, which may be carried out in a more or less effective way. For *Good Medical Practice for*

GPs this means giving up-to-date information on health problems, on prevention and lifestyle and on self-care, and having access to a variety of ways patients can get it. *Good Psychiatric Practice*

sets out a responsibility beyond the provision of information, to ensuring understanding.

the psychiatrist will ensure patients understand their treatment plans and have access to information or advice to help them develop that understanding. Good Psychiatric Practice

CanMEDS' roles go beyond the provision of information to patients to a more radical responsibility for physicians to “*facilitate learning,*” which is the closest this selection of codes comes to emphasising the doctor’s responsibility to educate patients and promote health literacy.

A prerequisite to sharing information and decision-making is doctors’ communication skills, which are emphasised most heavily in *CanMEDS* and in the codes for General Practitioners. *CanMEDS* Communicator competencies (which, it says, vary for different specialties and forms of medical practice) are “*essential for establishing rapport and trust, formulating a diagnosis, delivering information, striving for mutual understanding, and facilitating a shared plan of care.*”

The importance of patient-centredness in many forms is emphasised in the *Four Principles of Family Medicine* as part of describing the family physician as a skilled

“Family physicians are also adept at working with patients to reach common ground on the definition of problems, goal of treatment, and roles of physician and patient in management. They are skilled at providing information to patients in a manner that respects their autonomy and empowers them to ‘take charge’ of their own health care and make decisions in their best interests.”

Four Principles of Family Medicine

clinician. Similarly, in *Good Medical Practice for GPs* the statements about shared decision-making, information and communication are included in the section on Good Clinical Care. Both suggest that communication and information sharing are not ‘soft’ add-ons to the real job of a doctor, but are fundamental to good clinical care.

The excellent GP “*uses clear language appropriate for the patient,*” while the unacceptable GP “*consistently ignores, interrupts, or contradicts his or her patients, and does not explain clearly what he or she is going to do or why.*”

6.2 Consent

How a code treats the issue of informed consent may be thought of as a key barometer of its patient-centredness. The core ethical issue is coming to be treated as more than a requirement to obtain a patient’s signature on a form. The codes vary in their treatment of consent in terms of the detail in which it is addressed, the priority it is given and the angle taken.

Good Psychiatric Practice for example goes into some detail, devoting a separate section to consent, in which it illuminates particular issues. In psychiatry more often than in other specialties, the capacity for patients to give valid consent to treatment may be impaired, which may result in conflicts between mental health and human rights legislation, and capacity. Thus *Good Psychiatric Practice* states that the psychiatrist will obtain valid

consent of a patient to any proposed treatment where the patient is competent to make a decision, wherever possible. Further, a psychiatrist will “*facilitate the expression of differences of opinion with users, carers and colleagues and a constructive discussion around areas of disagreement*” (*Good Psychiatric Practice*). However, the American Board of Plastic Surgeons *Code of Ethics* states nothing specifically about consent.

Good Medical Practice does expand on the meaning of informed consent. It conveys the importance of respecting the right of patients to be fully involved in decisions about their care and states that, wherever possible the doctor should be satisfied before providing treatment or investigating a condition that the patient fully understands: “*what is proposed and why, any significant risks or side-effects associated with it, and has given consent.*” It refers to further guidance in *Seeking Patients’ Consent: The Ethical Considerations*. This is reiterated in *Good Medical Practice for GPs*.

The *Code of Ethics of Physicians* underlines the importance of obtaining informed and voluntary consent, considering from whom it may be obtained and when it need not be. Whereas many of the codes say that consent must be obtained “where possible,” this code specifies that it is required before undertaking an examination, investigation, treatment or research, but that it is not required in emergency situations, and that it may be given by the patient or the patient’s legal representative.

Occasionally restrictions to patient autonomy in consent are seen to be necessary. *Good Psychiatric Practice*, for example, advocates respect for patient’s choices in care, unless there is “*a clear clinical reason for overriding a choice and/or the patient lacks capacity to consent.*” *CanMEDS* states that the physician “*will effectively address challenging communication issues such as obtaining informed consent*” but does not expand on the meaning of the term. However, it also lists among the competencies of a specialist many of the components of obtaining informed consent: “*Effectively identify and explore problems to be addressed from a patient encounter, including the patient’s context, responses, concerns, and preferences... Engage patients, families, and relevant health professionals in shared decision-making to develop a plan of care*” (*CanMEDS*).

Four Principles of Family Medicine does not explicitly refer to consent at all, but implies a decision-making process of which the patient is in so much control, that the idea that a doctor should additionally ‘obtain’ a patient’s consent is almost superfluous.

[The family physician is] skilled at providing information to patients in a manner that respects their autonomy and empowers them to “take charge” of their own health care and make decisions in their best interests. Four Principles of Family Medicine

6.3 Moral basis of doctor-patient commitment

The basis of the commitment between doctor and patient is not covered by *Disruptive Physician Behavior*, but all the other codes reflect the duty of doctors to act in the patient’s best medical interests. This is expressed in a variety of ways, sometimes just that patient safety should prevail, but in other cases the language invokes the notion of altruism.

The codes use statements such as “*The safety of patients must come first at all times*” (*Good Medical Practice*); “*Protecting patients is not simply important, it is one of the prime directives of medicine. Patients have a right to compassionate, competent and safe*

treatment from doctors. The safety of patients must therefore come first at all times.” (Good Medical Practice for GPs); “Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.” (American Board of Plastic Surgeons Code of Ethics); “A physician’s paramount duty is to protect and promote the health and well-being of the persons he attends to, both individually and collectively” (Code of Ethics of Physicians).

On the other hand, doctors are not expected to treat patients at all costs. In *Good Medical Practice*, if trust in the relationship between doctor and patient has broken down, the doctor has a responsibility to ensure that arrangements are made quickly for the patient’s care, but is not expected to tolerate violence or persistently inconsiderate or unreasonable behaviour.

Physician Charter’s ethical demands of professional altruism are high. In the discharge of public health and public advocacy role, it states that a doctor should act “*without concern for the self-interest of the physician or the profession.*” Professionalism means “*placing the interests of patients above those of the physician.*” And “*The principle of primacy of patient welfare... is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician-patient relationship*”

The patient-physician relationship has the qualities of a covenant – a promise, by physicians, to be faithful to their commitment to patients’ well-being, whether or not patients are able to follow through on their commitments.
Four Principles of Family Medicine

(Physician Charter). Four Principles of Family Medicine states the commitment of a physician to the patient in terms not of altruism but of a one-sided promise.

While competencies set out within the original version of *CanMEDS* called for doctors to behave well and ethically in their interactions with patients, there was no suggestion that patients’ interests are of more importance than doctors’. The doctor was expected to “*deliver the highest quality of care with integrity, honesty and compassion, and exhibiting appropriate personal and interpersonal professional behaviours.*” (*CanMEDS*). In the revised *CanMEDS* document, however, altruism is a key feature of the Professional Role.

6.4 Patient input to the codes

The codes vary in how much input patients had to their development. At one extreme there was virtually no direct input to *Code of Ethics of Physicians* (which was developed by physicians and has its roots in their conception of the ethics of the practice of medicine). There is no indication that patients or lay people had input to *Good Psychiatric Practice* (other than via the input they may have had to *Good Medical Practice*), or to American Board of Plastic Surgeons *Code of Ethics*, or to *Physician Charter*.

There is no indication that there was systematic patient input to the *Four Principles of Family Medicine*, which are taken from ‘*The Postgraduate Family Medicine Curriculum: An Integrated Approach*’.

Good Medical Practice for GPs was developed in consultation with a range of organisations and individuals, including the Royal College of General Practitioners’ Patients’ Liaison Group and the Patients Association.

The first edition of *Good Medical Practice* had limited lay input. However, in the current revisions of the guidance the GMC set out deliberately to ensure greater public

involvement through an extensive consultation with the public as well as the medical profession, incorporating public debates, an on-line consultation and a qualitative study of the views of a variety of members of the public, doctors and medical students.

At the other end of the spectrum there was lengthy and thorough research from the earliest stages of development of the *CanMEDS* roles. The *CanMEDS* project set out to change the focus of specialty training from the interests and abilities of providers to the needs of society and orienting these programs to consider the needs of individual patients in the context of the population at large. The development of *CanMEDS* roles was firmly rooted in an exploration of the needs of society, derived from reviews of literature including consumer surveys, as well as primary research with diverse groups of lay people and patients to explore their expectations of physicians.

6.5 Summary

Some aspects of patient-centredness rarely feature in codes, for example privacy and continuity of care. There is wide variation in the treatment of those issues related to the promotion of patient-centredness which are addressed by the majority of codes: patient autonomy, shared decision-making, access to information, communication skills, consent and instances where patient autonomy should be restricted.

Most codes reflect the importance of patient safety and the protection of patients from incompetence. Some, particularly *Physician Charter*, go much further and demand altruism and the placing of patients' interests above doctors'. *Four Principles of Family Medicine*, in contrast, conveys a powerful and unconditional commitment to patients' well-being with no mention of altruism. The Canadian codes imply most strongly the empowerment of patients: *CanMEDS* calls on doctors not only to give patients information, but actively to facilitate their learning. Similarly, *Four Principles of Family Medicine's* vision of empowered patients, in charge of decisions about their care, is so strong that any notion of passive consent to treatment seems irrelevant.

7 What are the overlaps and differences in the codes' usefulness as guides to action and in their application/implementation?

Professional codes can be useful as a guide to action if they are **worded** in such a way that the standards make clear to individual doctors how they should act in specific circumstances. They are most likely to influence doctors' practice if they occupy a place in an overall regulatory structure and are **implemented** in practice by relevant bodies.

7.1 Wording of the codes

This section explores variations between the codes in terms of their generalisability and specificity. It looks at the stance each adopts in the trade-off between a code's applicability to a large proportion of doctors, and how specific it can be in its guidance. It also asks how stringent they are: i.e. how high a bar the standards set, and whether the codes are explicit about how far doctors are expected to adhere to them.

Generalisability & specificity

General codes are written to apply to all practising doctors. *Good Medical Practice* is detailed and specific in the areas it covers. It is a generic document which covers areas that are applicable to all doctors, but not those that apply only to certain groups of specialists. It explicitly states that it is not exhaustive and cannot cover all forms of professional practice or misconduct and concludes that doctors must therefore always be prepared to explain and justify their actions and decisions. *Good Medical Practice* and *Good Medical Practice for GPs* are written in the second person, using 'you' to make it clear that each statement applies not just a hypothetical or 'other' doctor, but to each doctor who reads it.

The stated purpose of *Disruptive Physician Behaviour* was to provide information, to guide conduct and to stimulate discussion and education, rather than to provide a standard against which doctors would be assessed, so it is not designed, nor required, to be very measurable or specific. *Physician Charter* is intended to apply to all specialties, indeed to doctors in many countries, but the statements within it are very broad and overall the code lacks specificity. *Four Principles of Family Medicine* is specific to family physicians, but is not a detailed code of practice. It does not contain specific guidance on standards of practice or conduct, but more general principles which should guide family doctors.

CanMEDS competency framework delineates seven key roles which are common to all specialists. It makes explicit objectives and strategies for learning, and organises them into a framework that could be modelled nationally across the specialties. So it is very generalisable in its current form and, while it does not thoroughly delineate the skills of all the specialties, it is designed to be specifically operationalised by each of them.

The *Code of Ethics of Physicians* is a collection of 125 apparently very precise rules, most of which begin either “A physician must..” or “A physician may not...”. On issues such as consent and confidentiality they are very specific. However, the demands it makes of doctors’ interactions with patients is occasionally ill-defined and hard to operationalise.

A physician’s physical, mental and emotional behaviour toward all persons with whom he comes into contact in the practice of his profession, particularly towards all patients, must be beyond reproach. Code of Ethics of Physicians

Codes written for particular specialties have the potential to be more specific in their guidance, operationalising the standards within them as they apply to doctors in their particular field. *Good Medical Practice for GPs* and *Good Psychiatric Practice* are both specialty-specific and, therefore, less generalisable than *Good Medical Practice*. These two derivatives operationalise the principles of *Good Medical Practice* at the level of their specialties. *Good Medical Practice for GPs* ‘anchors’ the general descriptions of each aspect of care with illustrations of the excellent GP and the unacceptable GP. The accompanying *Portfolio of evidence of professional standards for the revalidation of general practitioners* sets specific criteria, standards and evidence required to demonstrate that their professional standards meet those set out in the code. This document was developed in consultation with the members of the Royal College of General Practitioners and a number of medical bodies but no patient or public organisations.

Good Psychiatric Practice sets out what is expected of the psychiatrist, and what constitutes unacceptable behaviour, but does not specify “excellent” practice. It refers to other, supporting publications on confidentiality, vulnerability, continuous professional development and commercial sponsorship which should be read in conjunction with *Good Psychiatric Practice*. The appendices of *Good Psychiatric Practice* list basic knowledge and skills which should be common to all psychiatrists, irrespective of the sub-specialty within which they work. It also details good practice within psychiatric sub-specialties such as forensic, liaison, old age and rehabilitation psychiatry.

Most of the standards in the American Board of Plastic Surgeons *Code of Ethics* specify unacceptable behaviour, and the circumstances under which disciplinary action will be taken against a physician. They set out, in considerable detail, unacceptable practices relating to advertising, solicitation and expert testimony.

Stringency

The opening statement of *Good Medical Practice* indicates that the standards within it are intended to be attainable by any doctor. Its aim is to reflect what society, and the profession, expect of doctors in all aspects of their professional work.

This booklet describes the principles of Good Medical Practice and standards of competence, care and conduct expected of you in all aspects of your professional work. Good Medical Practice

The wording was chosen deliberately by the GMC to reflect the optimal standard of practice (i.e. that which is most likely to be achieved by a conscientious doctor under normal conditions of practice) rather than the minimum standard. Patients, the GMC Standards Committee had argued, would want a good doctor, not the minimally acceptable.

Good Medical Practice for GPs describes under each heading how the standards set out within it would be demonstrated by an 'excellent' and an 'unacceptable' GP. It states in the synopsis that *"No GP can be expected to provide care described under all the headings of the 'excellent GP' all the time. We suggest that an excellent GP meets the 'excellent GP' criteria all or nearly all of the time; a good GP meets most of the 'excellent GP' criteria most of the time; and a poor GP consistently or frequently provides care described by the 'unacceptable GP' criteria. These are the doctors who are at risk of failing revalidation."*

The bar for unacceptable practice is set relatively low in *Good Psychiatric Practice* and appears to be loaded in favour of the doctor rather than the patient. Examples of what is deemed unacceptable are:

"attitudes leading to multiple justified complaints; repeatedly prescribing medication without justifiable reason; persistent lack of cooperation with tribunals; persistent refusal to abide by Mental Health Act Code of Practice relating to consent to treatment persistently breaching patient confidentiality."

Compared to the standards of unacceptability for GPs, these seem low. Psychiatrists apparently can fail to meet the standards repeatedly or persistently before their practice or conduct is considered unacceptable.

Physician Charter, in contrast, has been criticised for being too aspirational, ascribing to doctors responsibility for issues which are beyond their control, such as bringing about social justice in the distribution of resources, and ignoring the constraints on doctors' capacity to do so.

The rhetorical flourish of the General Principles of the American Board of Plastic Surgeons *Code of Ethics* makes apparently high demands on doctors.

[Physician] must render to each patient entrusted to their care a full measure of service and devotion. ABPS Code of Ethics.

Also, their rules seem uncompromising and their strictness lends a sense of stringency. However, the Specific Principles of the code are a list of practices from which the physician must refrain, all of which appear relatively undemanding. The stringency of the *Code of Ethics of Physicians* is high in the sense that the items within it are almost all worded as *"A physician must..."* or *"A physician may not..."*, with little room for compromise. However, the content of the items are, in the main, undemanding.

Disruptive Physician Behavior does not seem stringent on first reading, but the terms are defined sufficiently vaguely that interpretation could lead to more or less stringent implementation. Both *Four Principles of Family Medicine* and *CanMEDS* are more flexible in tone, but the standards are more demanding of doctors' interpersonal skills and the 'softer' areas of their practice.

7.2 Implementation

Good Medical Practice

The GMC, which published *Good Medical Practice*, is the licensing authority for all doctors in the UK. It has the power to impose restrictions on, or to remove, a doctor's license.

Good Medical Practice forms the basis of many of the processes in place to ensure high standards of medical practice. It is being tied to all dimensions of medical licensure and certification, and to clinical governance at the workplace, with the aim of providing the levers necessary for securing universal compliance from all doctors throughout their careers (Irvine, BMJ May 2005). Compulsory – but formative – NHS appraisal processes, and much medical education, are based on its seven principles.

The stringency is high: optimal practice is the objective, to reflect all patients' entitlement to a good doctor. However, this is slightly undermined by the statement at the beginning of the document: "Serious or persistent failures to meet the standards in this booklet may put your registration at risk," which implies that equally they may not. A stronger statement would be that such failures *will* put a doctor's registration at risk.

Until now, this has been enforced only when such failures have been brought to the attention of the GMC, usually through complaints procedures. This system would by no means catch all sub-standard practice. In the near future, decisions about the revalidation – the UK's assurance of a doctor's fitness to practice – will be made on the basis of doctors' performance against the principles and standards set out in the code. This is very significant: in effect, depending on the system of revalidation introduced, this mechanism may ensure that the license of any doctor who fails to demonstrate regularly that he or she meets the standards set out in *Good Medical Practice* will be removed or restricted.

Good Medical Practice for General Practitioners

Medical Royal Colleges in the UK offer certification for each medical specialty, and have direct responsibility for postgraduate medical education, continuing medical education and setting standards of medical practice. They thus have an important role to play in the implementation of Good Medical Practice. As was noted above, a key element of this implementation process is the development of revalidation, to which end Medical Royal Colleges were asked to describe in greater detail what *Good Medical Practice* means for their discipline. *Good Medical Practice for GPs* was designed to be used when considering revalidation for GPs as it sets the requirements for *Good Medical Practice* in the context of general practice. This has been taken a step further by the publication of a *Portfolio of evidence of professional standards for the revalidation of general practitioners*.

Revalidation procedures are designed to ensure that all doctors are fit to practise. This is reflected to some degree in the synopsis of this document, which states that those GPs who fall frequently or consistently below acceptable minimum standards, as set out within it, will be at risk of failing revalidation. This is a stronger statement than that at the beginning of *Good Medical Practice* but it still does not go as far as to say unequivocally that the license – or even the certificate – of those whose practice is sub-standard will be restricted or removed.

Good Psychiatric Practice

The regulatory system for psychiatrists is similar to that for GPs and other specialties, and will be defined more clearly once decisions about the nature of revalidation are finalised. However, the Royal College of Psychiatrists has identified much less specifically the link between its code and revalidation.

Physician Charter

Physician Charter was adopted by all the member boards of the American Board of Medical Specialties (ABMS), the umbrella organisation for 24 approved medical specialty boards. By 2003, more than 85% of licensed physicians in the US were certified by at least one ABMS Member Board. *Physician Charter* was also endorsed by at least 90 professional associations, colleges, societies and certifying boards, including the Federation of Royal Colleges of Physicians of United Kingdom and the Royal College of Physicians and Surgeons of Canada. In 2002 it was published simultaneously in thirty medical journals including *Annals of Internal Medicine* and the *Lancet*, with follow-up pieces published fifteen months later.

Physician Charter states that physicians have both individual and collective obligations to participate in regulatory processes. The section on commitment to professional responsibilities states: “As members of a profession, physicians are expected to work collaboratively to... participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards. The profession should also define and organize the educational and standard-setting process for current and future members.”

The ABIM Foundation has supported various initiatives to disseminate the *Physician Charter*, including presentations, publications, conferences and colloquia and projects to achieve institutional and departmental implementation of the charter. It has also supported work to develop tools for the assessment of both technical and ethical aspects of professionalism. In particular, patient questionnaires have been developed to assess doctors' communication skills. However, it is not employed as a framework for any regulatory system in the sense that doctors are routinely assessed against the items within it, and the certification and licensure of physicians has been carried out against criteria which overlap with *Physician Charter* but are not derived directly from it.

In the past, a major focus of ABMS and its twenty-four Member Boards has been in the realm of initial certification, a process that evaluates the training, qualifications and competence of physician specialists at the outset of their careers. Now, all member boards participate in a Maintenance of Certification (MOC) process that was developed according to standards originally developed by the Accreditation Council for General Medical Education (ACGME). MOC focuses on six major competencies integral to quality of care: medical knowledge, patient care, interpersonal and communication skills, professionalism, practice-based learning and improvement and systems-based practice. In addition all Boards have four major components to MOC: evidence of professional standing, of a commitment to lifelong learning, of cognitive expertise and of evaluation of performance in practice. These competencies and components overlap considerably with the content of *Physician Charter*, such as communication and professionalism as they relate to patient care, ethics and up-to-date practice-related knowledge.

Evaluation of these components and competencies varies between specialties, and is based on a combination of testing of knowledge and skills by examination, and

“participation in a valid process in which physicians are asked to demonstrate that they can assess the quality of care they provide compared to their peers and national benchmarks and then apply the best evidence or consensus recommendations to improve that care using follow up assessments.” (ABMS website)

Work began in 2004 on phase two of the project to use *Physician Charter* as a framework to link professionalism, quality and performance standards. This is not yet complete, but demonstrates a will to bring cohesion between standards, quality and professional code, and to link the charter to regulation through certification.

American Board of Plastic Surgeons Code of Ethics

The American Board of Plastic Surgeons certifies plastic surgeons. Candidates and diplomates are expected to act in accord with the Code in all contacts with patients, peers and the general public. The board carries out publicly accessible disciplinary procedures for those whose words, deeds or actions are deemed not to accord with these principles, in response to a formal complaint. These may include revocation of certification.

Disruptive Physician Behavior

The Commonwealth of Massachusetts Board of Registration in Medicine is the licensing body for doctors who practise in the Commonwealth. Disruptive behaviour, as defined in the code, could be grounds for Board discipline, but this is neither formatively nor summatively assessed. The policy was written with the view that the most effective way to respond to a challenging issue in health care is through increased education and discussion, which would be stimulated by the publication of this document.

CanMEDS

The Royal College of Physicians and Surgeons of Canada provides a certifying function for medical and surgical specialists. Fellows of the College are required to participate in the Maintenance of Certification (MOC) program for admission to, and renewal of, fellowship. This means engaging in continuing professional development (CPD), and *CanMEDS* forms the basis of this. MOC is described as a program which reflects the commitment of the Royal College to promoting life-long learning at all stages of specialized practice and being transparent and accountable to society as a profession. Physicians are required to submit a record of the CPD credits they have earned by participating in educational activities over a five year period, and a sample of doctors is asked to validate their self-reports of participation. However, the MOC program is not designed to confirm competence or continuing fitness to practise, and physicians are not summatively assessed against the competencies described in *CanMEDS* as part of MOC.

In Canada, licensure is the responsibility of provincial and territorial licensing authorities. A prerequisite of licensure with most of these authorities is certification from either the RCPSC or CFPC (although in the context of a shortage of physicians, some authorities also accept other credentials). The *CanMEDS* framework is thus indirectly linked to licensure for the majority of specialists.

Four Principles of Family Medicine

Certification is available to members who successfully complete the Certification Examination in Family Medicine. Those who attain this standard must maintain it through the Maintenance of Certification program. In 1995 an integrated CME/CPD program,

MAINPRO (Maintenance of proficiency), was introduced, underpinned by the four principles of family medicine.

MAINPRO is mandatory for all members of the CFPC who are in full or part time practice, whether or not they are certificant members. They are required to submit a minimum number of credits every five years. Self-evaluation is built into the process, where physicians use a reflective learning cycle to assess how their current knowledge and skills meet the changing needs of their patients. However, other than self-evaluation, there is no external formative or summative assessment of doctors against these principles.

Code of Ethics of Physicians

The Collège des Médecins du Québec is one of thirteen provincial medical regulatory authorities which license doctors to practise. Adherence to its code is obligatory, and physicians can be disciplined by the College for violation of the code. It has a legal force, and assures the population that all those who practise medicine must abide by it and that the acts about which they might register a complaint will be judged in the light of its requirements. However, its regulation is applied only in response to a complaint.

7.3 Summary

Wording

Specificity is necessary if the principles within a code are to be operationalised in order to hold doctors to account. Some codes are very broad in what they cover and to whom they apply, but are so vague as to be of limited use. There is some trade-off between specificity and generalisability, but a code meant for use with doctors of all specialties need not be vague: although *Good Medical Practice* is general enough to cover all licensed doctors, it is specific in its coverage of the standards it includes. *Good Medical Practice for GPs*, however, operationalises the principles of *Good Medical Practice* more specifically still, specifying unacceptable and excellent practice for GPs.

In some cases, clarification of terminology is required. For example, when touching on restrictions to patient autonomy, what constitutes 'ethical practice' and 'inappropriate care' is not defined well, and this vagueness may not offer clear guidance in circumstances where principles of patient autonomy, clinical judgement, ethical practice and appropriateness of care conflict. Ambiguity allows interpretation which may not be supportive of patient autonomy.

Physician Charter's emphasis on self-regulation, and the profession's role in defining education and standard setting reinforces an exclusive view of medical professionalism. This, together with its lack of detailed guidance throughout, suggests a reluctance specifically to pin down the essence of good practice.

Implementation

The mechanisms for implementing the codes, and the consequences for doctors of failing to adhere to them, vary from code to code. At present, none of the codes reviewed here is linked through a system of regular, compulsory, summative assessment to restrictive regulatory mechanisms, as illustrated here:

STANDARDS \implies CRITERIA \implies THRESHOLDS \implies ASSESSMENT

That is to say, there is no system which proactively and summatively assesses practising doctors against the standards in a code and removes or restricts their licence if they are found not to be adhering to the code. Some codes are enforced only reactively, if at all. However, in many cases, the links between professional codes and regulatory systems are being strengthened through undergraduate education, continuing professional development (CPD), and continuing medical education (CME).

The *CanMEDs Roles* and *Four Principles of Family Medicine*, for example, are linked closely to CPD which are compulsory components of Maintenance of Certification (MOC). But doctors are not summatively assessed on this, and MOC is not presented as an assurance of fitness to practise in line with the code.

All 24 Member Boards of the ABIM have 'endorsed' *Physician Charter* and are developing maintenance of certification (MOC) systems. Elements of these are assessed formatively through self-assessment and summatively through examination. Robust methods are also being developed to assess communication skills using feedback from patients. However, they have not adopted *Physician Charter* as a set of standards underpinning their MOC, although there is some overlap between the content of the charter and the six general competencies of a physician of MOC.

Good Medical Practice currently serves as the framework which underpins much of undergraduate and postgraduate medical education in the UK, as well as the mandatory appraisal of all doctors working in the NHS. Some medical education is assessed summatively against the standards in *Good Medical Practice*, but the NHS appraisal system is explicitly formative, and not assessed in a summative way, thus cannot be said to guarantee a doctor's adherence to the code.

'Revalidation,' a system based firmly on the revised edition of *Good Medical Practice*, is expected to introduce more stringent assessment of a doctor's performance in relation to the code. If implemented in a rigorous way, the 'revalidation' of a doctor's license to practise will be contingent on regular summative assessment against the standards of *Good Medical Practice*.

In order for a code to form the basis for summative assessment of fitness to practise, it must be thoroughly operationalised into measurable and reliable standards against which a doctor can be assessed. The trade-off between measurability/reliability and generalisability (Walshe, 2003) remains a tension within all codes.

8 Discussion

We return now to the frameworks for examining the content and purpose of the codes and draw together the interesting and important issues which have emerged from the review of these codes in terms of their patient-centredness, their representation of medical professionalism, and their application.

8.1 Content: medical professionalism

Technical/scientific issues

Technical competence is a key element of professional practice, and this is reflected in the codes. The codes differ in the degree to which they specify what constitutes technical competence. The lowest common denominator is that doctors should keep their clinical skills up-to-date. Some codes expand this to include team-working skills, while others embrace record-keeping and undertaking audit activities in order to identify areas of technical competence in need of improvement. This is one example of the challenges to writers of codes in all areas to judge the trade-off between brevity, specificity and generalisability. Another approach is to acknowledge the breadth, ambiguity and complexity of the problems which present to doctors, without attempting to offer anything but the broadest guidance on how to respond to them.

Ethical issues

Guidance on ethical issues demands more or less pro-active action on the part of doctors, depending on the code. Some require only that they themselves do not, for example, discriminate unfairly against patients, while others insist that they must actively challenge discrimination. The stronger the responsibility a doctor has for the ethical behaviour of the profession or system as a whole, the greater the chance the code works in the interests of patients, but also the greater the risk that it makes demands on doctors for things they may not always have direct control over (such as allocation of resources).

Relationships: individual and collective

The individual doctor-patient relationship is the main focus of most of the codes. Variations in the extent to which they address the responsibilities of doctors to patients collectively reflect, to some extent, the different groups of doctors at which they are aimed. The codes for GPs or family doctors advocate their roles in the community and in preventing ill health, and the effect of the patient's family and community on their health.

Surprisingly few codes acknowledge the collaborative and multi-disciplinary context within which doctors increasingly work, although a minority do pay close attention to the importance of teamwork, and the effects of the dynamics of individuals in the team. There is a balance to be struck between the responsibilities of doctors to their colleagues

and to the profession as a whole both to support one another, and to act when they suspect colleagues are underperforming.

8.2 Content: patient-centredness

As we set out in the introduction, patient-centredness can be understood in four distinct ways.

Acting in patient's best interests

In general, exhorting doctors to act in patients' best interests - where those interests are defined by anyone other than the patient - may conflict with the requirement to respect patient autonomy. However, in several respects the requirement to act in patients' best interests is central to all medical codes.

First, professionals work in a field in which the public needs protection against incompetence. It is in the patient's best interests that doctors are technically competent and practise safely, and this is something that is usually best judged by doctors' peers. Most codes emphasise the importance of technical competence and the duty to keep up to date, and some strongly urge doctors to act if they think they or other doctors are not practising within the limits of their own competence, but very few offer detailed criteria against which competence should be measured. This largely reflects the difficulties of generalising about the situation-specific demands of technical performance, which may be more sensitively defined at a local or specialty level than by a general professional code. However, a code should underline the importance of competence, and may acknowledge the complexity and ambiguity of the problems without attempting to specify criteria of acceptable behaviour. The emphasis of codes on doctors' responsibility for their technical competence undoubtedly supports patients' best interests.

A second area in which several of the codes suggest that doctors should define patients' best interests rather than respect their autonomy is where patients 'lack capacity' to identify or express their best interests. This judgement of capacity is more straightforward in some situations than others: for example, in an emergency where a patient is unconscious, a doctor has to judge the best course of action without that patient's involvement or consent. Where a patient is mentally ill, however, their capacity to know what is in their best interests is more difficult to judge, and this presents a challenge for patient-centredness and patient autonomy. A code may lean more or less towards respect for patient autonomy, depending on the stringency of the justification a doctor must provide for overriding a patient's preferences. None of the codes fully addresses this tension. Guidance to respect a patient's autonomy unless the doctor believes it is not in the patient's interests may be well meant, but is open to interpretation in ways which allow abuse of power and does not necessarily protect patients' best interests.

Some codes advocate compassion and integrity, while others are based strongly and explicitly on altruism as a defining feature of medical professionalism. The suggestion that doctors have a special right to call themselves altruistic is contentious as it implies a moral differential between doctors and other members of society which may be uncondusive to equality and mutual respect within the doctor-patient relationship. The Royal College of Physicians' Working Party which produced *Doctors in Society* ultimately decided to retain altruism as a core value of medical professionalism since it was valued by a considerable proportion of doctors, trainees and the Department of Health. But it

was the issue at the root of the most dissent among working party members, and they note that one of its working party's witnesses warned of the risks associated with its inclusion:

"It is the claim of altruism that allows the medical profession to claim moral superiority... Certainty of goodness leads to complacency and worse."(RCP, 2005 para 2.20)

It may be helpful to draw on Glannon & Ross's (2002) subtle distinction between altruism and beneficence, both of which denote the interests of others as an action-guiding principle. Whereas beneficence prescribes a moral obligation to act for the benefit of others, altruism is optional and beyond the call of duty, and is directed toward individuals to whom one has no special ties and therefore no special obligations (Nagel, 1970; Blum, 1980). The nature of the professional relationship between doctor and patient entails obligations to the patient such that doctors cannot be altruistic in their daily encounters with patients (Glannon & Ross, 2002). Applebaum says of professionals in general,

"the fact that a person occupies a professional role affects what he is morally required, permitted or forbidden to do, and affects how his character and actions are to be morally evaluated." (Applebaum, 1998, p51).

Glannon & Ross suggest the most fundamental feature of medical professionalism may be beneficence,

"a fiduciary responsibility to patients, which implies a duty or obligation to act in the patient's best medical interests." (Glannon & Ross, 2002, p68).

Some codes reflect more than others that doctors' actions may be beneficent, compassionate and deserving of praise, without invoking altruism with its connotations of moral superiority and going beyond the call of duty.

In accordance with patients' preferences

The degree to which patients' preferences vary between patients and between situations makes it unfeasible to write a code which sets out specific criteria of good practice which meet all patients' preferences. However, tensions may arise where patients' wishes are not considered by the doctor to be appropriate, for clinical or resource reasons, and some codes do address this. Where patient preferences conflict with the principle of social justice (for example when he or she requests expensive and unnecessary tests which would use limited resources for which others have greater need), doctors' wisdom and fairness are called on by many codes. However, very few spell out the principles (such as equal access to care, or reducing health inequalities) which should underpin the judgements a doctor makes in such situations.

Involving or in partnership with patients

The active promotion of patient autonomy through involvement in decision-making about their care is increasingly included in professional codes, a positive development in line with the rise in various social forces (for example, the rise in 'consumer' expectations in health, the increasing availability of information to lay people, and the decline of deference to authority). It is expressed in terms of involving patients in decisions about their care, or sometimes more pro-active efforts to empower them to make informed decisions. The exceptions to a duty to promote patient autonomy arise when the patient 'lacks capacity' or when it leads to unethical practice and demands for inappropriate care. The codes which make the most forceful case for empowering patients do not explicitly

account for the possibility that a patient may prefer not to 'take charge' of their own health care. A good code should promote patient autonomy and emphasise that this includes patients' freedom to choose dependency autonomously.

Working with the 'whole person.'

Codes which advocate the involvement of patients in decisions about their care imply acknowledging their values, emotions and social circumstances, and working with more than simply disease or symptoms. However, beyond this, working with the 'whole person' is overlooked by most codes other than those written for primary care/ family doctors.

Four Principles of Family Medicine goes beyond the whole person to the whole community. They acknowledge the role of the doctor in promoting the health of the community, and working with the determinants of the health of not only those who consult them but also those who do not. Some underline the importance of sensitivity to the effect of the community on patients' health, and of the trusting doctor-patient relationship as an ongoing entity to patients, the family and the doctor.

8.3 Purpose

Realistic/aspirational

A code may either set out the lowest acceptable standards, set realistic targets, or provide a wish list of the qualities of a "fantasy" ideal doctor. In Irvine & Irvine's terms, these are minimum, optimal or ideal standards. Clearly, requiring that doctors adhere to optimal standards is in patients' better interests than adherence to minimum standards: no-one would knowingly choose a 'suboptimal' doctor in preference to a 'good' one. It is important that a code is explicit about which level of standards it represents, so doctors can understand its implications for their practice. If the code contains principles which doctors are expected to adhere to as minimum standards, it is important that they are compatible with one another and not contradictory. Where there are tensions between them, for example, between respecting individual and population interests in access and allocation of resources, these must be acknowledged.

This is the point of view of one doctor on the extent to which a code can provide answers to the complex and ambiguous aspects of practice:

"It tells you the two sides of the dilemma but it doesn't give you the answer which I don't know if it could do really, but I think that it needs to go alongside a lot of guidance and a lot of help. I don't think it would be right for guidance on Good Medical Practice to tell you what you should do in specific terms and I don't think it could really tell you ... where to put the line on the balance." (General Practitioner research participant).

Criteria and thresholds

How specifically a code sets out the criteria which constitute good practice partly determines how effective it can be in influencing the standards of care. There is some trade-off between generalisability and specificity: a code written for doctors within a single specialty can specify criteria more closely than a general code, but has less

relevance to doctors beyond that specialty and will be less suited to representing the values of the profession as a whole.

In the UK, *Good Medical Practice* applies to doctors of all specialties, setting out an overarching framework to unify medical standards and referring to other documents which offer detailed advice on, for example, consent. It also serves as a template for each Medical Royal College to interpret with greater specificity in ways that have relevance to its specialty.

Some codes set out thresholds of acceptable and unacceptable practice, and this means their implementation may be standardised across populations of doctors and over time. The stringency of the standards varies: those which set the bar the highest mean best protection for patients.

Specificity and generalisability

General codes can be quite specific in certain areas common to all medical specialties, but some are full of grand rhetoric which is difficult to operationalise. Interestingly, the guidance documents written for general use are, in some cases, more specific than those for specialties.

While some codes specify their guidance in positive terms, others use negative terms. *Good Medical Practice for GPs* does both. Walshe sets out the following arguments for regulatory standards that are highly specified: that without them, regulatory assessment is likely to be inconsistent and subjective, driven by assessors' biases and interests, open to manipulation and deal-making, and lacking in due process. The regulatory investment made in developing and defining standards is recouped through savings in regulatory detection and enforcement. Explicit standards provide a framework for patients to exert pressure for regulatory compliance and they mean regulated organisations are more likely to comply. Further, devising or developing standards may require the organisations or individuals being regulated to consult with, or otherwise empower, patients (Walshe, 2003).

Relationship with regulation

Establishing links between the principles, criteria, thresholds and assessment is often highly political. Codes may exhort doctors to aspire to the highest standards of care and competence, but if they are applied only reactively in response to flagrant examples of abuse, negligence, misconduct or incompetence, they may be of limited value to patients.

Irvine (2005) and Pringle (2005) argue that to assure the highest standards of conduct and protection for patients, and to instil confidence in the public, the principles embodied within a code must be enforced through a proactive system of regulation. The only way to ensure public trust in the medical profession, some other reformers say, is for doctors to be assessed routinely against well defined standards. On the other hand, some within the medical profession such as Horton (2006) see this sort of regulatory system as an overly-bureaucratic and unjustified intrusion into doctors' practice. There is resistance to it from many who feel that doctors will respond better to compliance regulation and feel resentful and offended at the idea of being subjected to a system they perceive as unnecessary, aggressive and adversarial.

8.4 Similarities, differences, tensions and strengths

What is common to most of the codes?

Certain themes are common to almost all the codes: for example, the notion that doctors must be technically competent and up-to-date. However, the extent to which this is underpinned by assessment and regulation varies from country to country. In none of the three countries is there currently a system for routinely assessing doctors summatively against standards of competence, but moves in this direction are under development in all three countries.

Most codes focus predominantly on the individual doctor-patient relationship. Certain ethical issues, such as the duty not to discriminate unfairly against patients because of their lifestyle or behaviour, are common to the majority of the codes. Some codes go further and state that doctors should take an active role in stamping out discrimination where they see it. Maintaining confidentiality other than in exceptional circumstances is another common theme, although some codes spell out more thoroughly than others the circumstances in which breaking 'professional secrecy' is acceptable, and how it should be done.

Informed consent, most codes agree, means more than simply obtaining a patient's signature, and should be obtained before any treatment or investigation is carried out.

Where are the greatest differences?

Some of the most notable differences lie in the extent to which the doctor-patient relationship is portrayed as one in which the patient is empowered and autonomous. The Canadian codes entreat doctors to facilitate patients' learning and to enable them to take charge of their health care to the point that informed consent is implicit.

Trust and communication between doctors and patients are emphasised most heavily in codes written for doctors who practise in primary care: they are regarded by them as intrinsic to the ongoing relationship and the provision of good care. Trust is also given particular attention in the code for psychiatrists, a specialty in which care is often long-term and trust is sometimes hard to maintain.

The psychiatrists' code particularly illuminates a number of other issues, such as the complexities of respecting confidentiality, obtaining consent and promoting patient autonomy in situations where patients' 'capacity' is compromised by their health problems. Psychiatrists' responsibilities to those beyond the patient – their family, carers and the safety of the community are also highlighted more than in most other codes. In some respects, this code appears to make assumptions about psychiatrists' moral authority and to make fewer allowances for their fallibility than other codes, and to state principles and standards in ways which are open to interpretations which protect the psychiatrist rather than the patient.

Tensions and ambiguities

Good Medical Practice and *Good Medical Practice for GPs* are the strongest on doctors' duties to report underperforming colleagues, and offer relatively specific and detailed guidance on how this should be undertaken. However, the difficulties faced by doctors in gathering the evidence to support such challenges, and in dealing with the potential

damage to professional relationships which might arise as a result, are not very well addressed.

The most universal tension within the codes is between doctors' responsibilities to use resources wisely, and their responsibility to the individual patient, or between individual and collective access to resources. Again, few codes acknowledge the tension and only two make explicit the principles which should guide a doctor's judgement when faced with it.

Are some codes better than others as guides to practice?

The UK model, where there is one general and a number of specialty-specific codes which derive from it, and with references to further guidance, may be a good answer to the tension between specificity and generalisability.

Canadian codes are the most strongly patient-centred in the sense of involving patients and working with the whole person, although they could be criticised for not making explicit that patient autonomy includes the rights of patients to choose dependency, so as to accommodate the preferences of patients who prefer not to take charge of their care.

8.5 Conclusions

This paper raises a number of issues about the content of codes themselves, as well as about the operational issues around their use and implementation. We pose them here as questions for further consideration.

1. What kinds of evidence should underpin a code?

The degree of professional and public involvement in the development of codes has been limited but appears to be increasing. The original development of *CanMEDS*, and the current revisions of *Good Medical Practice*, involved patients thoroughly through engaging them in research processes to identify their expectations of doctors.

Other evidence which could be used to underpin professional codes for doctors may include assessments of cultural and organisational change and the systems through which healthcare is delivered. Consultations could usefully include other health care workers such as nurses and professions allied to medicine. If codes are to address such issues as the tension between individual and collective allocation of resources, there may be an argument for including health care managers in the consultation process.

There are a number of potential benefits to such strengthening of the evidential underpinnings of codes on a regular basis. Codes which accurately reflect patients' and the public's evolving expectations of doctors may better align the cultures of society and the medical profession, and support good relationships between individual patients and doctors. The more guidance is based on a thorough exploration of the tensions and ambiguities inherent in the codes, the more legitimate it will be as a basis to inform practice. Further, regulators and educators are better equipped to support the implementation of codes which are demonstrably based on the expectations of patients and the public, as well as those of the medical profession.

2. How closely should codes be linked to regulation?

Codes, however closely they reflect the expectations of patients, members of the public and doctors, may in themselves influence doctors' practice. Some argue that deterrence-based regulatory systems are an unjustified intrusion into doctors' practice which leaves them feeling resentful and offended. However others argue codes most powerfully protect patients' interests only when rigorous mechanisms for compliance are in place. From the latter point of view, there is some way to go on this count in all three countries: although regulatory bodies appear to be moving towards implementing more effective systems of revalidation or relicensure to hold doctors to account for maintaining the standards, there remains a significant gap between the content of these codes and how doctors practise. What patients actually experience, although it may generally meet minimum standards, often does not meet the optimal or ideal standards expressed in the codes. When the gap between optimal and the minimum is too wide, as the fifth report of the Shipman Inquiry suggests it still is in the UK (Smith, 2004), that poses a real problem for patients.

There is a great deal of evidence which demonstrates that a significant proportion of patients want to be more involved in decisions about their health care than they are, that they would like more information about their condition and its treatment, and that they are not treated with respect and dignity (Picker Institute, 2005). There is little evidence that regulators collect and use feedback of this kind. There is scope for further research to bring together extant evidence about patient experiences and measure them against the content of the codes, as well as into the factors which ease or impede working to the standards within the codes.

3. How can codes be used to foster patient empowerment, wider understanding of and debate about doctors' role in society?

Codes can be, and are, used in ways other than regulation. Evidence suggests (Chisholm, Cairncross & Askham, 2006) that there is scope for doctors themselves to be much more *au fait* with their content. There would be value in their use with medical students to discuss and explore the application of the principles of the codes to complex real life situations, and the tensions these may raise. Debate should be encouraged about the practical implications of some of the standards, such as resource allocation and promoting patient autonomy.

Finally, we think there is potential for codes more strongly to promote patient-centredness if they were effectively disseminated and made available to patients and the public. Patients in possession of a professional code are much more empowered to hold doctors to account against it.

4. What is the scope for further international collaboration in the development of the codes?

There is clearly significant overlap between the content of the codes in the UK, the USA and Canada and therefore opportunity for further collaboration and synthesis across international borders. Although they have different emphases, several common principles underpin them. These include the provision of technically good clinical care and keeping up-to-date; involvement of patients in their care and respect for patient autonomy; confidentiality and consent. A distillation of these principles may allow regulatory bodies

to move forward in their development of codes and to adapt them to their own cultural and organisational contexts.

Equally, some codes have particular strengths, and there is scope for sharing 'good practice' in areas such as the degree to which they advocate the empowerment of patients and reject paternalistic conceptualisations of the 'moral' basis of the doctor-patient relationship; the extent to which they address the relationships not only between individual doctor and patient, but between society, the medical profession and the wider healthcare system; whether they acknowledge the tensions and ambiguities inherent in the codes; and whether they are explicit about the principles which underlie judgements which doctors and patients must make when they are faced with the dilemmas which arise from them.

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