"The Code of Conduct of the Medical Council of Barbados is published on the Arnott Cato Foundation's website as a public service. The Foundation is dedicated to enhancing the human resources in health and feels that this important document should be available to the medical and health professions as well as the public. By providing this Code, the Foundation affirms the philosophy that all rules governing conduct in our society must be made available to all those whom they affect."

CODE OF **CONDUCT**

BARBADOS MEDICAL COUNCIL

2015

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Introduction

The Code of Conduct contained in this document provides a guide for conduct acceptable to the Barbados Medical Council for medical practitioners and specialists registered in Barbados. It is also a guide to the conduct that is expected of medical practitioners, the public, patients, other professionals, and administrative, financial and other staff employed in institutions involved in medical and healthcare delivery in Barbados. In seeking comprehensiveness, the document draws on existing codes of conduct for the medical professions, on the principles laid down in the Constitution of Barbados, and is consistent with the Medical Profession Act 2011-1, and other relevant laws of Barbados.

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

The principles of ethical conduct by the medical professional are usually summarised as being guided by beneficence, non-malfeasance, autonomy, and justice. It is therefore appropriate that this document be introduced with a Charter of Patients' Rights adopted by the Medical Council of Barbados.

Professor Sir Errol Walrond
Chairman, Barbados Medical Council
2015

The Rights of Patients

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

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

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

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

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

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

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

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

Refusal of Treatment
Any legally competent patient can refuse to be treated and must be

informed of the medical consequences of their refusal.

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

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

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

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

Ethical Conduct of Medical Practitioners and Specialists

The Hippocratic Oath is often referred to as the guideline for conduct of the medical profession. The broad principles enunciated in that oath can be applied to all medical practitioners or specialists, their staff in offices or healthcare facilities where they work. They are summarised in the terms of ethical conduct towards patients, namely:

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

These principles are expressed through:

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

With these principles in mind, the following expands on these principles and guides the practitioner into safe ethical conduct, in keeping with the law laid out in the Medical Profession Act 2011-1, hereinafter called the Act.

1. Registration of Medical Practitioners and Specialists

The rights of patients and those of medical practitioners and specialists cannot be realised without assessment of the training, qualifications and continuing professional development of practitioners. The Council registers practitioners following *Sections 9* to *21* and schedules 6 and 7 of the Act; accreditation of medical education programmes by CAAM-HP and other accreditation agencies such as the GMC (UK), LCME (USA and Canada), MCI (India) of qualifications in their own countries. CAMC examinations are applied where appropriate.

1.1. Fitness to Practise

Sections 9, 12, 13, and *21* of the Act give the Council the authority to determine a practitioner's fitness to practise in Barbados. The Council relies on certificates of good standing and police certificates of good character. A certificate of good standing, valid for the last six months of the applicant's registration in another jurisdiction, must be sent directly to the Council by the last registering body. It should contain the dates of registration of the practitioner and any disciplinary actions taken or pending.

1.2. Annual Registration and Continuing Professional Education

The Act requires the annual renewal of registration. Renewal requires satisfactory participation in continuing professional education (CPE) and payment of the annual registration fee. The requirements for CPE are conveyed to each practitioner on registration. Practitioners require at least two CPE awards a year.

Practitioners, who do not re-register by January 31 each year, are required to pay double the registration fee. Any practitioner, who does not re-register by March 31 in the year, is removed from the register, and their names published in the Official Gazette as no longer being registered. Any practitioner who is removed from the register and wishes to be restored to the register must reapply to do so.

1.3. Specialists Listing

The register consists of separate lists of medical practitioners and specialists published by April 30 each year. Specialists may appear on both lists. Those specialists whose names appear on the specialist register only, may see patients on referral only. This designation reflects the fact that these doctors have only been in specialist training and practice after their basic qualification. Such specialists are not experienced in the diagnosis of the generality of patients.

1.4. Limits of Council's Jurisdiction

A person who purports to practise medicine without registration has committed a criminal offence, *Section 46 (2)*, and it becomes a police matter.It can be brought to Council's attention.

1.5. Temporary and Special Registration

Any practitioner practising temporarily or is specially registered, in accordance with *Section 15*, is instructed that the standards in this code of conduct must be observed.

2. The Responsibilities of Medical Practitioners and Specialists to Patients

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

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

2.1. Access to and Provision of Care

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

2.1.1. Advertising and Solicitation of Patients

Section 23 (2) (c) of the Act states "any form of advertising, canvassing or promotion, either directly or indirectly, for the purpose of obtaining patients or promoting his own professional advantage that is contrary to the provisions of this Act or rules" is professional misconduct.

Sections 24 to *31* of the Act and the guidelines published by Council provide a guide to medical practitioners and specialists as to what is permissible in advertising.

2.1.2. Patients' Right to Service

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

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

of their personal beliefs, unless and until they have made adequate arrangements for the continuation of that patient's care.

2.1.3. Prisoners and particularly Vulnerable Patients

Medical practitioners and specialists, looking after prisoners, detainees and other institutionalised or disadvantaged patients, have a duty to provide them with treatment and protection of the same quality and standard as is given to others.

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

2.1.4. Referrals for Care

Medical practitioners and specialists should recognise when their own knowledge, skill, competencies and experience are inadequate for the care of a particular condition or patient. In this eventuality, the practitioner or specialist has a duty to refer patients to suitably qualified and experienced colleagues where available, locally or elsewhere.

2.1.5. Effective Communication with Patients

Medical practitioners and specialists and first contact staff working with practitioners (that is receptionists, clerks and nurses) must have communication skills that allow them to successfully relate to patients, regardless of their education or socio-economic level. Sensitive, compassionate and temperate language avoids offence, and should not heighten the anxiety that affects patients and others about their illness.

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

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

2.1.6. Intimate Contacts, Examinations and Sexual Misconduct

Doctors, nurses and other health professionals are required to have "intimate" contacts with their patients, during taking a history, examination, investigation, treatment and nursing care. To avoid any perception of improper sexual conduct, all intimate contacts such as vaginal, rectal, or breast examinations should be

chaperoned. This applies whether the contacts are male/female or same-sex contacts. Another health professional, a parent/guardian or a relative approved by the patient may act as the chaperone.

When a chaperone is not available, the health professional should either defer the procedure or ask the patient in the presence of a witness whether they wish the procedure to go on without a chaperone. If during the procedure the patient expresses any anxiety, disquiet or sign of sexual stimulation, the health professional should cease the procedure immediately and resume only when a chaperone is available.

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

Any sexual act, sexual advance or indecent exposure committed by a medical practitioner or specialist that involves patients may be considered a criminal act, as well as serious professional misconduct and is treated as such by the Council (*Section 23 (2) (b)*).

2.1.7. Quality of Service

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

- the conscientious recording of patient data such as name, address, insurance status
- an accurate assessment and recording of a patient's clinical condition
- competent and considerate professional management
- recognition and appropriate responses to patients requiring urgent intervention
- seeking advice and consultation with colleagues when necessary
- promptly acceding to a patient's right of access to information from their

records

- being considerate and understanding of the anxiety of patients and their families
- providing care that allows life to end with dignity, respect and in comfort.

2.1.8. Adherence to the Law

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

2.1.9. Refusing to Treat

The Council considers it professional misconduct for a practitioner or their staff to refuse treatment, or investigation to a patient. Medical practitioners and other healthcare professionals have the right to conscientious objection and may refuse to participate in procedures such as termination of pregnancy. However, such refusal must not place the patient in danger, and arrangements must be made for the patient to be treated by a competent practitioner or health professional who has no such conscientious objection.

A practitioner has no right to refuse to care for patients on the basis of a fear of contagion or possible injury. Practitioners would have received sufficient training to allow them to protect themselves from the transmission of commonly feared diseases. It is the practitioner's responsibility to undergo further training where necessary.

It is unprofessional to withhold treatment from any patient on the basis of a moral judgement that the patient's behaviour or lifestyle contributed to their medical condition.

2.1.10. Safe Equipment, Supplies and Medications

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

Except in a life-threatening emergency, a practitioner should defer treatment where essential equipment is either unavailable or is known to be unsafe. Practitioners should make a patient aware of any known malfunction of any equipment in use and only agree to its use in urgent unavoidable situations.

2.1.11. Risks to Patients from Health Staff

Medical practitioners, and other health workers, should not expose patients to risks from their personal health. This includes dependence on alcohol, drugs or medications, and transmissible diseases such as hepatitis. Such conduct is considered professional misconduct under *Section 23 (2) (h)* of the Act.

Risks to patients from acquired infections must be minimised through the proper maintenance of buildings and equipment, handwashing and the use of sterilised instruments.

2.1.12. Up-to-date Care

Medical practitioners and specialists have a responsibility to keep up to date with relevant developments in their fields. In particular, patients should not be subjected to risks from unnecessary or outdated procedures or equipment. Evidence of continued professional education before re-registration to practise is required, *Section 18 (2)*. Practitioners should ensure that their CPE is most appropriate to their practice.

2.1.13. Costs of Services

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

2.1.14. Appropriate Use of Resources

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

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

2.2. Religion and Culture

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

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

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

2.3. Identification of Practitioners

Medical practitioners and specialists must be identifiable to patients and other members of staff in institutional settings. Such identification may be in the form of a name tag or identification badge, and by displaying their registration certificate in private offices. Except in dire emergencies, all medical practitioners and specialists must dress in a manner befitting their professional status.

Practitioners are entitled to privacy of their personal matters, including contractual conditions within an institution or business. The involvement of particular practitioners in the proceedings of meetings, case conferences, et cetera, are confidential.

2.4. Confidentiality

The obligation of practitioners to patient's confidentiality is found in *Section 23 (2) (d)* of the Act. All information about patients in the course of medical care is confidential and cannot be divulged without the explicit consent of the patient or their legal guardian, or as a result of a court order. Medical practitioners and specialists are obligated to ensure that other members of their staff have an obligation to the patient's confidentiality.

2.4.1. Patient Records

All patient information, including financial information, is confidential. Patient notes must only be handled by relevant staff and the health professionals taking care of the patient. Staff should not allow access to a patient's notes by any staff or other health professional without the permission of the patient and the physician in charge of the patient's care. Patient notes should not be removed without the

knowledge of the patient's physician and/or the supervisor of the patient care area. Patient records being used for report writing, et cetera, must be kept secure and confidential at all times and should be returned to their secure location as soon as possible.

Patient clinical records/information kept in electronic form must have a unique identification number, and must be password protected.

2.4.2. Exceptions to Non-disclosure

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

Other healthcare professionals who are participating in, or are assuming responsibility for the management of a patient, should receive confidential information about patients from the practitioner of record. It is the practitioner's responsibility to ensure that those professionals appreciate that the information imparted is in professional confidence.

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

Third parties at risk. When a person is diagnosed with a sexually transmitted disease such as HIV, the practitioner must discuss with the patient the question of informing a spouse or sexual partner(s). Where a patient refuses to inform their sexual partner(s) or refuses consent for the healthcare team to do so, the practitioner should carefully consider the risks to those parties and others who may be affected, and seek to ensure that any known sexual partner is informed of the risks to which they might be exposed.

If there is any doubt about whether information should be disclosed, advice should be sought from the practitioner's legal advisor or the appropriate institutional ethical committee.

2.4.3. Disclosure for Legal Purposes

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

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

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

2.4.4. Issues in Maintaining Confidentiality

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

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

2.4.5. Withholding Information from a Patient

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

2.4.6. Mature Minors

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

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

Before offering advice or treatment to the minor, a medical practitioner or specialist must satisfy themself that the minor has sufficient maturity and understanding of their condition to appreciate what is involved. If after every effort has been made to have the minor agree to have the parents or guardian informed, and the practitioner is satisfied that it is in the minor's best interests to offer advice or treatment and preserve the minor's confidentiality, they may do so without the parent or guardian's consent. The practitioner's decision is supported by judicial precedent, provided the course of action can be justified on the medical record.

2.4.7. Confidentiality after Death

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

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

2.5. Access of Patients to their Records

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

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

2.5.1. Relatives and Patient Information

The involvement of family is highly desirable in managing a patient's illness. However, information can only be given to relatives (including spouses and close relatives) with the clear consent of the patient when they are, or were, competent to do so. Practitioners should ascertain if a patient wishes to have their relatives present during, or to be briefed on the results of, any consultation.

2.5.2. Medical Certificates

Medical certificates are given to patients at their request for presentation to employers, school authorities, examination boards, et cetera. Improper certification is subject to disciplinary action for professional misconduct under the Act *(Section 23 (2) (f)*).

Certificates may state fitness or unfitness on medical grounds, but must not indicate the nature of the medical condition, unless specifically requested by the patient. Requests from the patient to include their diagnosis should be in a written consent form, which is usually contained in insurance claim forms or other similar documents.

Physicians should ensure that patients understand the nature of the consent that the patient may unwittingly sign, for example using carbon copies of NIS certificates as certification for employers.

2.5.3. Medical Reports

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

Medical reports can be vital to the health and well-being of patients and should be provided expeditiously. The Act at *Section 23 (2) (n)* requires that such reports should be furnished "within [three] months of a request being made for the report".

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

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

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

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

2.6. Other Opinions

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

If the patient requests a second opinion from a person who is not a medical practitioner, the practitioner or specialist should make clear to the patient if they have any objection to taking part in the consultation and why. Practitioners are reminded that it is improper to associate 'with unqualified or unregistered medical persons to enable such persons to practise medicine, dentistry or optometry, *Section 23 (2) (j)*.

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

A medical practitioner or specialist should record the request for an opinion by a record in the patient notes, in addition to any other form of communication. Where the consultation is external to an institutional setting, a medical report containing all the relevant information should accompany the patient. The physician of record should receive the second opinion and discuss it with the patient, wherever possible, jointly with the second physician.

2.7. Consenting to Investigation and Treatment

Patients have a right to receive all relevant information about their condition, including the examination, investigations, the treatment proposed and the risks involved. Except in a life-threatening emergency treatment should not be undertaken without the free and informed consent of any patient who has the legal and mental capacity to do so.

2.7.1. Right of the Patient to Question

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

2.7.2. Minors and Consent

Unless under the conditions exempted by law and precedent, all people under the age of 18 years should have their consent given by a parent or a legally appointed guardian. Minors like any other patient must be treated in a life-threatening emergency with or without the consent of their parents or guardian.

The Termination of Pregnancy Act 1983 allows for a 16-year-old female to consult with a medical practitioner or obstetrician-gynaecologist and to consent, without parental approval, to a termination of a pregnancy of 12 weeks or less gestation.

Refusal by a minor of parental consent. A specialist who has assessed, and can demonstrate, that it is in the best interest of a minor to be treated without the parents' consent or knowledge, may do so if the minor can be demonstrated to be sufficiently mature to understand their medical condition and its consequences, and to give informed consent to treatment. In carrying out such action, it is the responsibility of the specialist to demonstrate that the parents or legal guardian are not acting in the best interest of the minor, either by neglect or the decisions they wish to make. These conditions also apply when the minor insists on confidentiality of their illness from their parents.

Specialists in embarking on such a course of action should be mindful that such action is based on legal precedent rather than statute law (Gillick 1985). Furthermore, that they have recourse to the courts, directly or through the Child Care Board, to remove parental responsibility by petitioning to make the minor a ward of the court.

2.7.3. Mental Incompetence

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

If there is no known next of kin or legal guardian, consent may be sought from the

chief executive officer of the institution treating the patient, or through the court appointing a legal guardian.

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

2.7.4. Consenting in Emergencies

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

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

2.7.5. Advance Directives (Living Will)

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

2.7.6. Disclosure of Risks and Alternatives

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

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

2.7.7. Implicit and Explicit Consent

A patient's consent may be given implicitly, for example by their agreement to provide a specimen of blood for multiple analyses. In other circumstances consent

needs to be given explicitly, for example before undergoing a specified operative procedure or providing a specimen to be tested for a specific condition such as a cancer or HIV.

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

2.8. Refusal of Treatment by Patients

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

2.8.1. Counselling re Refusal of Treatment

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

2.8.2. Refusal Form

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

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

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

2.9. Abandonment of Care

Section 23 (2) (e) of the Act states that it is professional misconduct for a medical practitioner or specialist for the "abandonment of a patient in danger without sufficient cause and without allowing the patient sufficient opportunity to retain the services of another medical practitioner or specialist".

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

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

2.9.1. End of life Care

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

2.9.2. Isolation or Quarantine

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

2.10. Basic Necessities in Offices and Institutions

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

If for any reason a patient or a relative requests that they supply their own basic items in an institutional setting, the request may be granted by the head of the unit concerned. The head should be satisfied that the reasons are good ones, and that it will not compromise the care or comfort of other patients.

2.11. Ethical Conduct and Organ Transplantation

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

Death is certified by a registered medical practitioner; however, there is no current provision in statute law for certification of brain death in Barbados. A medical practitioner or specialist certifying the death of a potential organ donor should not be directly involved in organ removal, subsequent transplant procedures, or the care of the patient receiving the transplant.

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

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

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

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

2.11.1. Prohibition on the Sale or Purchase of Organs

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

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

If a medical practitioner or specialist involved in the surgical or medical care of the patient or donor is suspicious that an illegal transaction is occurring, they should seek legal or ethical advice as to whether they should continue to participate in such care.

2.12. Security

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

2.12.1. Patient Identity Tags

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

2.12.2. Weapons and other Security Risks

Weapons and animals of any description should be discouraged from being brought onto the premises of healthcare facilities by patients, visitors or by staff not authorised to do so.

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

2.13. Biomedical Research

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

2.13.1. Approval of a Research Proposal

All medical research conducted should be approved in advance by the appropriate committee of the institution involved, or other appropriate authority. Only research proposals should be considered that are clearly formulated in a protocol that contains provisions for the informed consent and confidentiality of the subjects of the research.
In approving a research proposal, institutions and other authorities should be satisfied that the life and health of the individual patient/human subject is protected at all times. Where research involves the treatment of patients, they must remain under the supervision of the responsible medical practitioner or specialist.

2.13.2. Consenting to being a Subject of Research

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

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

2.13.3. Withdrawal from a Research Study

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

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

2.13.4. New versus Standard Treatment

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

2.13.5. Research Funds and Payments

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

2.13.6. Publication of Research

A medical practitioner or specialist may submit the publication of research findings for a continuing professional education award of the Council. Any submission of a publication involving multiple researchers for a CPE award should be accompanied by a statement on the relative contributions of the authors.

3. Professional Relations and Conduct

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

Internal mechanisms should be the first avenue for dealing with problems between healthcare professionals. However, when problems are unresolved and it is felt that some disciplinary action should be considered by the Council, a complaint can be made to the Council. The Complaints Committee of the Council deals in a confidential manner with matters brought to its attention. If after an investigation, the conduct of a medical practitioner or specialist is such that it requires disciplinary action, the matter is referred for disciplinary proceedings (part V of the Act).

3.1. Working and Consulting with Colleagues

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

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

3.1.1. Consultations and Second Opinions

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

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

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

After a second opinion, a joint decision should be communicated to the patient by the attending physician, supplemented if necessary by the practitioner giving the second opinion. If an agreement as to diagnosis and treatment is not possible, the points of disagreement should be conveyed to the patient with any suggestions for the resolution of the differences in opinion.

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

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

3.1.2. Comments about Professional Colleagues or Other Staff

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

3.1.3. Assessment of Colleagues

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

Health professionals are called upon to express a view about a colleague's professional practice, in the course of a medical audit, peer review procedures, or

during an investigation being carried out by Council or other authority. Comments made in the process of assessment, medical audits, or similar forums and to the Council, are confidential and should not be repeated outside of those forums.

3.1.4. Professional Conduct and Fitness to Work

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

The Act part V, gives the Council the right and the mechanisms to investigate "the conduct of a practitioner or specialist where it is believed that such an investigation is warranted in the public interest and in the interest of maintaining the standards and dignity of the profession", *Section 32 (1)*.

3.1.5. Nurses and other Health Professionals

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

3.1.6. Challenging an order of a Medical Practitioner or Specialist

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

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

3.1.7. Delegation of Patient Care

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

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

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

3.1.8 Delegation to Junior Doctors

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

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

3.2. On Call

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

Senior staff in an institution may be required to make themselves available at all times for mass emergencies or unexpected disaster situations which require their input.

3.2.1. Fitness for Duty

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

Medical practitioners are required to carry out their duties regardless of the time of day or night. Except in unusual situations, such as responding to a disaster, no practitioner should agree to or be required to work without adequate time for sleep or meal times. Unless otherwise agreed, the Council recommends that all practitioners should have the opportunity of several hours of uninterrupted sleep in a 24-hour period.

3.2.2. 'Second' Calls

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

3.2.3. Emergencies and Telephone Consultations/Advice

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

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

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

3.2.4. Responding to Disasters

All members of the profession have a responsibility to respond to emergency and disaster situations, and to contribute within the limits of a disaster plan of an institution or relevant authority responsible. Professionals who work in institutions or organisations dealing with disasters have a duty to familiarise and train staff about their responsibilities in emergency/disaster situations.

3.3. Dress Code

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

Working dress, such as used in operating theatres and other areas such as intensive care units, is designed to reduce the transfer of infections from outside those units; as well as avoiding soiling of the health workers' clothes with blood or other body fluids. Such garb is not suitable in community settings.

3.4. Personal Business versus Professional Work

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

3.4.1. Personal Visitors

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

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

3.5. Confidential Matters and Correspondence

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

3.5.1. Confidential Correspondence

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

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

Files and working papers should not be made available to third parties without the permission of the responsible person or organisation.

3.5.2. Patient Records

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

Patient records should be kept after the patient's death for reference purposes, and in case the estate of the deceased makes a claim. The minimum period for the statute of limitation on claims varies from three to six years.

3.5.3. Computers and Mobile Information Devices

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

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

Most importantly, patient records should have a unique identifier other than

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

3.6. Personal Relationships and Harassment

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

3.6.1. Improper Personal Relationships and Harassment

Improper conduct is that which leaves the other party uncomfortable, offended, disrupts work or the person's family life, and damages the contract of trust between the patient and a practitioner, other practitioners or staff. Such conduct consists of unwelcome, abusive or offensive conduct, whether verbal, physical or visual and based on a person's race, colour, creed, national origin, ancestry, sex, religion, age or disability.

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

3.6.2. Sexual Harassment

Unwelcome sexual advances, requests for sexual favours, and other verbal or physical conduct of a sexual nature can constitute sexual harassment, and constitutes professional misconduct under *Section 23 (2) (b)* and *(o)* of the Act. It may include:

- jokes, and the display of posters, cartoons, and magazines with sexual content;
- sexually derogatory, physically descriptive or suggestive comments about or towards another individual, including inappropriate use of communications such as email, telephone, and social media;

- unwelcome touching or physical contact; and
- punishment or favouritism on the basis of an individual's sex.

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

Such harassment directed at a patient is subject to severe penalty by the Council. Sexual acts involving practitioners and patients may be subject to criminal prosecution, as well as professional misconduct charges by the Council, *Section 23 (2) (b)*.

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

3.6.3. Violence in the Workplace

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

Complaints of acts of violence between practitioners, practitioners and other staff, and between practitioners, patients, and visitors will be investigated and treated with the utmost seriousness by the Council under *Section 23 (2) (o)* as professional misconduct or under *Sections 32 to 36* of the Act as a matter "warranted in the public interest".

3.6.4. Prohibition on Weapons

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

If a practitioner or staff member becomes aware of an individual carrying a weapon at their workplace, or if there is threatening behaviour taking place, that person should call the security personnel to deal with the matter. If the situation warrants immediate attention, dial 211.

3.6.5. The Violent Patient

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

3.7. Alcohol, Drugs, and Smoking

A practitioner's use of alcohol, illegal drugs as well as some prescription and over-the-counter medicines can pose a significant risk to the safety of patients, the practitioner themself and others. *Section 23 (2) (h)* of the Act states that it is professional misconduct for "the excessive ingestion of intoxicating liquor or drugs". This prohibition relates not only to the health of the practitioner, but its possible adverse consequences on patients who are being treated by that physician. Similarly, a practitioner should not smoke during the course of work for it may have a direct effect on the patient being treated. It also sets the poor example of a health practitioner who is not mindful of the generally acknowledged risks of smoking.

Medical practitioners and specialists have privileged access to controlled substances such as opiates for the treatment of appropriate patients. Practitioners

should not use that privilege for the illegal use of these drugs by themselves, patients, friends or others. Such misuse is criminal and is subject to disciplinary action by the Council.

A medical practitioner or specialist suspected of unauthorised drug use may be asked, as part of an investigation by Council, to submit themselves for testing. Any practitioner who refuses to consent to drug testing, tampers with a sample, or tests positive may be deemed to have committed an act of professional misconduct under *Section 23 (2) (o)*. The Council may in its own discretion recommend rehabilitation therapy for any practitioner found to be habituated or addicted to any illegal drug or controlled substance, *Section 36 (1)* of the Act.

Prescription Drugs – A medical practitioner or specialist taking prescribed medication while working has a responsibility to find out from their physician whether or not the prescribed drug they are taking would impair their job performance. If Council is asked to investigate a complaint of a practitioner's impaired job performance, the prescribing physician may be asked to provide written authorisation as to the practitioner's fitness to work while using the medication.

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

Voluntary Treatment – If a medical practitioner or specialist voluntarily informs the Council that they have a drug problem, and makes a written commitment to undergo adequate rehabilitation treatment, Council may defer any disciplinary action until it has had credible and satisfactory reports on the practitioner's condition. People undergoing voluntary treatment are required to agree to take drug detection tests without prior notice.

3.8. Advertising, Solicitation, and Promotion of Services

The Act in *Section 23 (2) (c)* prohibits "any form of advertising, canvassing or promotion, for the purpose of obtaining patients", and at *Section 23 (2) (g)* "the division with any person who is not a partner or assistant, of any fees or profits resulting from consultations or other medical or surgical procedures without the patient's knowledge or consent".

The forms of notice, restrictions, and permitted forms of advertising or promotion

are contained in the Act in *Sections 24* to *31* and in the advertising guidelines approved by Council.

3.8.1. Advertising

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

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

Practitioners and the public who are seeking information about who are registered practitioners and specialists may check the list of registered medical practitioners and specialists available at the Council. Medical practitioners and specialists can make available to patients their qualifications and the services they provide. Any publication of false qualifications or claims of specialist status is subject to disciplinary action by the Council.

3.8.2. Press Interviews and Broadcasting

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

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

3.8.3. Pamphlets and Circulars

Section 27 of the Act states that it is permitted for practitioners to distribute

pamphlets, circulars or other written material to patients or in patient care areas to announce leave arrangements and any additions to their practice.

3.8.4. Sale of Medicines, Products, and Services

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

Medical practitioners and specialists should consider with great care the ordering of tests and investigations as to their appropriateness to the patient's management. When such tests are ordered to be done by or in a business in which the practitioner has a financial interest, they are at risk of being in contravention of *Section 23 (2) (o)* of the Act for conduct that "is in the opinion of Council unprofessional or discreditable".

3.9. Professional Integrity and Conflicts of Interest

The confidence of the public in the integrity of medical practitioners and specialists is vital to the proper functioning of the profession itself. The Act in *Section 23 (2)* outlines the ways practitioners can avoid damaging the integrity of the profession. These involve:

a. evidence of unethical or criminal behaviour

b. avoidance of sexual or other improper conduct or association with a patient

c. advertising, canvassing or promotion

d. wilful or reckless betrayal of a professional confidence

e. abandonment of a patient in danger, either physically or mentally

f. knowingly providing false certification

g. the splitting of fees without the knowledge of the patient

h.&m. practising when intoxicated or when mentally or physically unfit to do so

i.&k impersonation of another practitioner or representing themselves

to be a specialist when not qualified to do so

j.&l. association with unqualified persons to promote unproven medicines or procedures, and secret remedies

n. failure to provide a medical report in a timely manner

o. solicitation of public patients to attend the practitioner's private practice.

3.9.1. Private Interests and Public Practice

Practitioners employed in the public service must be clear that their private interests do not conflict with their responsibilities in the public service. A conflict of interest can arise when a practitioner has an economic interest which conflicts with their public service obligations. In particular, staff should not use their position within the public service or the service's property for their personal, that is private, business.

A medical practitioner or specialist is expected to provide the same standard of treatment to private or public patients.

3.9.2. Association with Commercial Enterprises

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

3.9.3. Alternative Medicine

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

Caution should be taken by a medical practitioner or specialist in recommending such practice to patients or other practitioners. Practitioners should also be cautious when associating with any non-physician in a system or method of treatment which is not under medical control and which is advertised in the public Press.

3.10. Medical Professionals and the Pharmaceutical and Allied Industries

The health professions, the pharmaceutical industry, and medical equipment

manufacturers have common interests in the research, development, and sale of new drugs and devices of therapeutic value. Healthcare practice owes much to the important advances achieved by the health-related industries.

3.10.1. Research Funds

Medical practitioners and specialists must only conduct research on drugs or equipment, and receive any associated remuneration, under research protocols approved by an appropriate ethical committee or institutional research board.

3.10.2. Continuing Professional Education

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

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

3.11. Gifts, Donations

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

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

3.12. Safety in the Workplace

Medical practitioners and specialists have a duty to provide safe treatment for their patients. This not only means safe medicines and procedures, it means ensuring the safety of the patient, themselves, and others. Practitioners who provide or tolerate unhygienic facilities, unsterilised equipment, malfunctioning equipment, et cetera, are liable for a charge of professional misconduct before the Council. This is separate and apart from any civil tort of negligence, should a patient become harmed as a result.

3.12.1. Buildings and Equipment

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

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

3.12.2. Unauthorised Visitors

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

3.13. Practitioner's Health

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

3.13.1. Physical Disabilities

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

3.13.2. Contagious Disease

A contagious disease can be transmitted by casual contacts or close association such as touching, coughing, sneezing, and handling food. A medical practitioner or specialist comes into contact with ill patients directly or indirectly, and any practitioner diagnosed with a dangerous contagious disease should not work while they are contagious.

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

3.13.3. Specified Diseases

The Council has no specific list of diseases which carry specific risks to or from a practitioner. Such conditions are part of the training of a practitioner and are the subject of alerts from the Ministry of Health from time to time.

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

- Tuberculosis – Practitioners with active tuberculosis should not work in direct patient care until certified to do so by a physician qualified to do so.

- Hepatitis B – Medical practitioners and specialists and other staff who come into frequent contact with blood, such as in operating theatre, renal dialysis, obstetrics, accident and emergency and laboratory staff, have a particular responsibility to themselves and to patients to avoid the transmission of blood-borne diseases in the settings in which they work. All such people should be screened and immunised against hepatitis B.

- HIV – Practitioners who work in direct patient care are encouraged to undergo testing for HIV, and if positive to seek advice about any continued role in the performance of procedures which may cause injury to themselves. Practitioners and other healthcare staff who are involved in injuries, such as needle sticks, are encouraged to seek immediate advice on prophylaxis for HIV.

3.13.4. Universal Prevention Precautions

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

3.13.5. Known Illness and Workers in Health

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

A practitioner who becomes infected with a dangerous transmissible pathogen, or who is ill in other ways, is entitled to the confidentiality and support afforded to other patients. Only in the most exceptional circumstances, such as the staff member refusing to follow advice, should such confidentiality be broken.

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

3.13.6. Care of Colleagues

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

Practitioners are under no obligation to provide private medical services, or reduced fees to their colleagues or their dependents. Any professional courtesy extended as regards private fees is a privilege, not a right, and is extended entirely at the discretion of the treating practitioner.

3.13.7. Inappropriate Certification/Prescribing

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

3.13.8. Alcohol Use and Drug Abuse

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

When all appropriate avenues have been exhausted in stopping a practitioner from treating patients while under the influence of alcohol or drugs, it is the duty of a practitioner to report the offending practitioner to the Council to be investigated for professional misconduct (*Section 23 (2) (h)*), and/or their fitness to practise under *Section 32* of the Act.

3.14. Practitioners engaged by Third Parties

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

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

When engaged to do an examination or assessment for insurance or any other third-party purpose, the consent of the patient must be obtained in writing. A patient has the right to know of the findings of the examination and/or assessment before it is sent on to the third party. Any false representation to the patient or the third party is serious professional misconduct, *Section 23 (2) (f)*.

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

3.14.1. Expressing an Opinion on Liability

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

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

3.14.2. Limitation of Examination

A practitioner examining a patient for a specific purpose should confine themselves to such investigation and examination as are necessary for the purpose indicated and agreed to by the patient. Any proposal or suggestion, which an examining

practitioner may wish to put forward regarding treatment, should be discussed with the practitioner designated by the patient.

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

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

3.14.3. Prohibition of Solicitation of Patients

An examining practitioner shall not utilise his/her position to influence the patient examined to choose him/her as their medical attendant. Such an act would be in contravention of *Section 23 (2) (c)* of the Act.

3.15. Professional Fees

Professional fees are chargeable for consultations, laboratory tests, investigations, special examinations, special procedures, surgery, and for medical reports. The Council does not regulate professional fees.

3.15.1. Public/Exempted Patients

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

Medical practitioners or specialists working in the public service have no role in collecting fees from patients, whether they fall into the exempted category or not. The Council views as serious professional misconduct any practitioner working in the public service who

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

3.15.2. Medical Certificates and Reports

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

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

Such reports should be provided expeditiously. Practitioners who do not supply such reports within three months are subject to disciplinary action, *Section 23 (2) (n)*.

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

3.16. Continuing Professional Education

The Act *Section 3 (4) (c)* requires Council to provide "a system to enable the continual assessment of the adequacy of training of practitioners". In accordance with *Section 18 (2)* of the Act, Council has established continuing professional education as a condition for the annual re-registration of practitioners and specialists.

Council administers the CPE system, which requires at least two awards of CPE activity for annual re-registration. Awards can be obtained through a broad range of activities chosen by the practitioner and approved by the Council. Council encourages the preparation and presentation of education and research papers for CPE awards.

Details of the CPE award scheme are available at the Council secretariat. Practitioners who apply for CPE awards are kept abreast of the awards gained for up to the three coming years.

4. Disciplinary Functions of the Council

The disciplinary process of the Council is intended to ensure that proper standards of professional conduct are maintained in patient care, professional relationships, and in any matter that betrays the trust of the community in a medical practitioner or specialist or the medical profession in general. The Council seeks to ensure a fair hearing for both the complainant and the professional who is the subject of a complaint. The process is intended to correct improper conduct rather than being a substitute for the courts. To this end, the Council makes it clear to complainants that it has no power to order financial restitution or compensation.

Council receives, assesses, and adjudicates on complaints from the public, organisations, businesses, and practitioners about the professional conduct of individual practitioners. Council is aware that when it receives a complaint, the complainant expects prompt disciplinary action, commensurate with what they consider the gravity of the misconduct that they have experienced. On the other hand, the practitioner complained about may have practised in the manner complained about for some time before the complaint was made, and may view the complainant and Council's enquiry into the matter as a personal witch-hunt. Council sees such views as inevitable and strives to maintain fairness to all.

The regulatory and disciplinary procedures and measures carried out by Council are contained in part IV of the Act, in respect of professional responsibilities and conduct; and in part V and schedules three and four in respect of investigations and disciplinary proceedings.

4.1. Breaches of Conduct requiring Disciplinary Action

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

- actions which endanger patients or others in the process of health care
- professional misconduct as set out in *Section 23* of the Act (see also 3.9 above)
- actions that are demonstrated to be negligent or dishonest
- behaviour that brings the medical profession into disrepute

- undertaking practices for which the person is not trained for or experienced in
- supplying, dispensing, or the administration of medicines, particularly controlled drugs and drugs of dependence, without the necessary statutory controls
- falsification of any document in the course of work, or in any matter related to registration or enquiry by the Council
- fraud or acceptance of fees/bribes for actions of professional misconduct
- Indecent or violent behaviour
- Sexual conduct, or sexually explicit exposure with or in the presence of patients.

Some of these offences may also be referred to the police for investigation.

4.2. Complaint and Disciplinary Procedures

A medical practitioner or specialist is subject to an enquiry and possible disciplinary procedure/hearing as the result of a complaint arising from outside or within the Council (*Section 32* of the Act) and on a charge brought by the Disciplinary Committee.

4.2.1. Making a Complaint

A complaint should be made in writing to the secretary of the Council. The Complaints Committee receives and forwards the complaint to the practitioner and asks for any representation they wish to make on the complaint. A complainant may be asked for further information, or to respond to any representation the practitioner makes. Should there be a disciplinary hearing, complainants are asked to testify under oath and are subject to cross-examination by the practitioner and any legal representative they have.

4.2.2. Complaints Committee

The Complaints Committee conducts such enquiries as it deems appropriate and decides:

- whether the complaint is without merit
- what action it is recommending in relation to the complaint, and
- in the case of a recommendation for disciplinary action, formulates the complaint in the form of a charge, and with the supporting documents /reports, et cetera, forwards the matter to the Disciplinary Committee.

4.2.3. Disciplinary Hearings

A disciplinary hearing is held after a charge is formulated by the disciplinary committee. The charge, along with any supporting documents, is conveyed by hand or registered mail to the medical practitioner or specialist who is the object of the hearing.

The charge shall be accompanied by a notice of the date and time of the hearing, which shall not be less than four weeks from the date at which the charge is served. The notice of the hearing shall state that the practitioner is entitled to be represented at the hearing by an attorney at law, and is entitled to bring witnesses and to cross-examine any witness or the author of any report used in evidence at the hearing.

4.2.4. Recommendations for Disciplinary Action

After a hearing, the Disciplinary Committee may recommend to the Council the following:

- that no action is necessary
- that the practitioner or specialist be censured or reprimanded
- that the practitioner's or specialist's registration be suspended or revoked.

When Council has made its decision, this is conveyed to the practitioner, along with a transcript of the hearings. All disciplinary actions are published in the Official Gazette, after the three-month period allowed in which the practitioner may appeal to the High Court, *Section 40* of the Act.

Glossary

In this code of conduct, the following words and phrases shall have the meaning ascribed to them unless the context otherwise requires:

Abandonment means the premature termination of the professional treatment relationship by the healthcare provider without adequate notice or the patient's consent.

Act refers to the Medical Profession Act 2011-1.

Advanced directives refers to a legal document such as a living will that is signed by a competent person to provide guidance for medical and healthcare decisions, such as the initiation or termination of life support or organ donation, in the event the person becomes incompetent to make such decisions.

Alcohol means ethyl alcohol (ethanol). References to use or possession of alcohol include use or possession of any beverage, mixture, or preparation containing alcohol.

CAAM-HP means Caribbean Accreditation Authority for Education in Medicine and other Health Professions.

CAMC means Caribbean Association of Medical Councils.

Conduct means the actual actions and behaviour of a person.

Consent means permission by a patient to undergo a medical or surgical treatment, or to participate in an approved experiment.

Controlled substance (other than alcohol but including prescription medicine) means any substance proscribed in law that has known mind or function altering effects.

Council refers to the Medical Council of Barbados as set out in the Medical Profession Act 2011-1.

CPE means continuing professional education, updating knowledge and practice.

Department refers to a specialised division within an institution.

Doctor means a person licensed to practice medicine as a medical practitioner or specialist.

Drug abuse means the use of illegal drugs or inappropriate use of legal drugs.

Ethics means the rules of conduct that translate characteristic ideals or the sum of ideals into everyday practice.

GMC (UK) means General Medical Council (United Kingdom).

Healthcare professional means a person who provides a service in identifying, preventing, or treating illness or disability.

Illegal drug refers to any form of drug, narcotic, hallucinogen, depressant, stimulant, cannabis, or other substance; the sale, purchase, transfer, or use of which is unlawful.

LCME means Liaison Committee for Medical Education (United States and Canada).

Negligent refers to a performance or conduct that falls below the standards of behaviour established for the protection of others against harm.

Nurse means a person formally educated and trained in nursing.

Mature minor means a minor who by virtue of being a parent or legal precedent may be allowed to consent on his or her own behalf outside the authority of their parents.

MCI means Medical Council of India.

Medical practitioner means a doctor whose name appears in the medical register.

Minor means a young person who is under the age of legal competence, that is 18 years.

NIS means National Insurance Scheme.

Patient means any individual who obtains or receives healthcare services.

Personal information about an individual includes identification features, physical and social characteristics, medical information, including financing and confidences given.

Practitioner means a medical practitioner or specialist.

Record means any document relating to a patient in a written, magnetic, optical, or other electronic medium.

Specialist means a medical practitioner who appears on the specialist register.

Under the influence means a noticeable or perceptible impairment of a person's mental or physical faculties due to alcohol, illegal drugs, or controlled substances.

Visitor means any person that is not a patient or a staff member of a health facility.

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