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Regulating the medical profession in Ireland
Medical regulation, medical dilemmas and making decisions…

Medical regulation in Ireland

Around 12,000 doctors work in the Irish health service, including many nationals of other countries or doctors who have trained overseas. Their many specialities and complex responsibilities are just some of the challenges to be dealt with in ensuring that the care they provide is safe and competent. That responsibility is shared by a number of agencies and individuals, including the doctors themselves, but at a high level falls to the Medical Council.

The Medical Council was established by the 1978 Medical Practitioners Act (1978 MPA) with a core responsibility to protect the interests of the public when dealing with registered medical practitioners; in 2015 more than 20,000 doctors were registered with the Medical Council. Council's key role has been further addressed by the 2007 Medical Practitioners' Act (2007 MPA) which significantly expanded and modernised its mission. However, the fundamental tools available to Council remain the same:

1. Registration - Registration of suitably qualified and acceptable doctors.

2. Medical Education – Accreditation of agencies to provide undergraduate education in medicine and postgraduate training across the full spectrum of medical specialities.

3. Professional Standards - Publishing guidance on professional standards for doctors and establishing the ethical standards to which they must adhere.

4. Fitness to Practise - Investigating complaints against doctors and, if necessary, imposing sanctions on those who have breached their professional standards.

Medical regulators in many countries use the same tools; indeed, they reflect the strategies introduced by the first major medical regulator, Britain's General Medical Council, established in 1858. Internationally, however, many of these functions are now divided between separate agencies, which themselves may be tasked with quite distinct missions. By contrast, in Ireland each role continues to be driven by a distinct overarching responsibility – that of protecting the public interest.

The Medical Council has 25 members; the 2007 MPA significantly altered the balance from a predominantly medical membership to one which now has a majority of lay members. While Council is entirely self-funding and is an independent public body, the 2007 MPA also greatly increased the powers of the Minister for Health, in that he or she appoints its members and has decision making powers in relation to many of Council's operational activities.

Ethical principles and practice

The familiar principles upon which bodies such as the Medical Council or the General Medical Council offer guidance on professional standards include:

1. Respect for autonomy

2. Acting in the patient's best interests (Beneficence)

3. Avoiding or minimising harm (Non-maleficence)

4. Justice / equity

Council has a statutory duty to publish guidance on professional conduct and does so about every five years to address changes in society, healthcare and the standards expected of doctors; the 2016 Guide is the 8th Edition. Council invites submissions from the public and profession when writing a new Edition of the Guide.

The 2016 Guide to Professional Conduct and Ethics for Registered Medical Practitioners introduces what Council calls the 'Three Pillars of Professionalism - Partnership, Practice and Performance'.

It describes 'Partnership' as based on trust, patient-centred care, working together, good communication and advocacy. It describes 'Practice' as having elements such as caring, confidentiality, integrity and promoting patient safety. It describes 'Performance' as having elements such as competence and reflective practice.

Failure to meet the expected standards may result in a complaint (from any source) to the Fitness to Practise Committee. Complaints to the Medical Council are taken very seriously indeed by doctors. As well as the potential penalties from a finding of professional misconduct (ranging from advice to erasure from the register), an inquiry uses many of the forms of a trial and is now often heard in public. The courts have defined professional misconduct as:

1. Conduct which doctors of experience, competence and good repute consider disgraceful or dishonourable; and/or

2. Conduct connected with his or her profession in which the doctor concerned has seriously fallen short by omission or commission of the standards of conduct expected among doctors.

These definitions help to clarify the responsibilities of Council and its members. Firstly, the standards published by Council will become a benchmark against which the conduct of doctors may be judged. Secondly, a significant component of peer evaluation is involved in making a judgment about a doctor's performance. Thirdly, those standards implicitly require doctors to act in ways which might be described as 'honourable'. And finally, although an inquiry by Council's Fitness to Practise Committee may establish that professional misconduct has occurred and Council may impose a sanction, the High Court must then confirm the finding and almost all sanctions, before they take effect.

Dilemmas in medicine

Dilemma - perhaps simply described as a situation in which one must choose between difficult options and usually ones which are equally undesirable.

Dilemmas can occur in almost all branches of medicine and reflect the distressing problems for which patients seek help. Examples might include making choices between treatment options in serious illness, respecting patient's instructions not to share information with family members, trying to achieve a balance between the needs of individual patients and the needs of the healthcare system, allocating scare resources or dealing with difficult reproductive medicine or end-of-life situations.

How do doctors respond? Individual doctors must address the unique circumstances of the situation they face. Inevitably then, the outcomes of dilemmas which appear superficially similar may differ significantly – there is no guidebook which provides stock answers. However, it is possible to provide frameworks within which doctors can work through such a situation – the usual framework offered in medical education is to consider:

- The law in the area
- Relevant guidance from the professional/ethics body
- The scientific evidence relating to the topic
- The doctor's own attitude or values, guided by reflection and perhaps discussion with colleagues

Two items, professional guidance and personal attitudes, may be worth further reflection in the context of this paper.

The Medical Council's guidance on decision making does not specifically address dilemmas. However, it acknowledges the many situations in which difficult choices must be made. It advises that the guiding principle should be to act in the best interests of the patient – *'you must exercise your clinical skill and judgement in your patients' interests'*- and to use as wide a range of sources as possible in determining what those interests might be, especially the patient's own wishes and views. The best interests of the patient are usually understood to be served by a decision in which the balance of risk versus benefit is likely to fall on the side of benefit. Meeting the patient's best interests does not necessarily mean agreeing to the patient's request – Council guidance clearly indicates that a refusal to agree to a request may be acceptable in the right circumstances.

The exercise of personal judgement by doctors inevitably leads to situations in which differing attitudes or judgements will come to the fore. Council acknowledges the potential for differences in values and attitudes among healthcare professionals and between those carers and their patients or families. It also clearly says that a doctor may express a conscientious objection to a course of action and refuse to provide that service – however, that doctor retains a responsibility to provide care to the patient. That responsibility includes continuing care until the patient finds a new doctor or the original doctor helps them to do so, ensuring they understand their entitlement to seek a doctor who will provide the service and providing adequate information for the patient to arrange that care. If the situation is an urgent one, the doctor must make that patient's care a priority.

At all stages within medical education, the importance of the 'thinking practitioner' is emphasised. Rote learning, 'cookbook medicine', rigid adherence to protocols and avoidance behaviours are among the traps which lead to the practice of bad medicine. Among the worst of those traps are overconfidence, a lack of awareness of one's own limits or an inability to see the issues from the perspective of the patient. From entry to medical school students are encouraged not just to develop the consultation and communication skills needed

to interact effectively but also to reflect on their own values and attitudes and to consider how these will impact on their roles as doctors. That very process of reflection inevitably illustrates how we may differ in our handling of dilemmas. Discussion of those issues with colleagues is encouraged – seeking different opinions can be a clarifying process which may reinforce or change the perspective of the doctor involved. But the responsibility remains with the individual doctor – every dilemma will require some decision to be made.

The Medical Council and abortion

Council's position on abortion has evolved significantly over the years. While in the past, there may have been conflicts between the legal position and Council's guidance, that no longer appears to be the case.

Section 48 of the 2016 Guide sets out Council's current position on abortion. The guidance is in line with current Irish law and indicates that abortion is legally permissible 'where there is a real and substantial risk to the life of the mother which cannot be prevented by other means'. The Guide also notes that it is lawful to give information in relation to abortion abroad, but not to promote or advocate an abortion overseas.

The Guide does not say that doctors have a duty to provide abortions but does emphasise the duty of all doctors to provide 'care, support and follow-up for women who have had an abortion'. The section dealing with conscientious objection follows, indicating that doctors can refuse to provide certain services 'which conflict with your sincerely held ethical or moral values'. However, the responsibility for continuity of care is as described earlier.

Abortion remains as highly sensitive an issue for doctors as for other members of Irish society. Are disciplinary cases or conflicts between Council's guidance and the law likely to arise in the area of abortion? Doctors have a clear statement of their responsibilities in the Guide and also have the option of conscientious objection to involvement in potential abortion cases. At the same time, Council's guidance and the law appear to be well aligned. When these issues were less clearly addressed the potential for conflict may have been higher than is currently the case.

That situation may change in the future, with the potential to raise conflicts between Council's guidance and the law; such conflict has occurred in the past and may be possible in the near future.

Possible conflicts between the law and professional guidance

Ward of Court Case

In 1995, the 'Ward of Court Case' sharply illustrated both the dilemmas which may arise in an increasingly technological healthcare system and the potential for conflicts between the law and professional guidance.

The case centred on a woman who had been in what the Supreme Court described as a 'near-Persistent Vegetative State' for some years. She was a long-term resident of a healthcare institution and was being fed through a gastrostomy tube, inserted through her abdominal

wall. She was not known to have ever expressed any views on such a situation but her family concluded that she would wish to be allowed to die rather than continue in this state. They requested that the gastrostomy tube be removed. The institution and its senior doctors refused to comply with this request on ethical grounds. The issues ultimately came to the Supreme Court which ruled that the tube could be removed and that the patient's inherent rights included that of being allowed to die with dignity.

The Medical Council of the day took a contrary view. It issued a statement indicating that it believed that access to fluids and nutrition were basic human rights and could not be discontinued – essentially that these were 'ordinary' forms of care. Following the Supreme Court's finding, the patient was brought home from the institution and died some weeks later.

No complaint or further legal challenge occurred in this case – therefore no clear conclusions can be reached about the potential impact of the differences between the views of the Supreme Court and Council.

Since that case, the Medical Council has included a continuing commitment to provision of fluids and nutrition in its guidelines. However, the guidance has evolved significantly and now more closely matches the 1995 Supreme Court judgement, in that it emphasises that hydration and nutrition by routes which are burdensome to the patient may be discontinued, within Council's ethical framework.

Assisted Decision-Making (Capacity) Act 2015

This legislation aims to assist those who have reduced capacity, to exercise their decision-making rights in relation to their own health care. It also provides for advance healthcare directives which will guide future healthcare, should the individual lose the capacity to make such decisions at a later stage. The overall purpose is to enhance the ability of individuals to determine their care, in advanced and serious illness. The Act clarifies the definition of 'capacity' and introduces a legal presumption that all of us have the capacity to make our own decisions, unless we fail to meet the tests which it sets out (those tests relate to understanding the consequences of the illness and the consequences of the options available).

While those purposes are welcome, the legislation raises serious questions which may soon become the source of professional dilemmas not previously encountered in this country, particularly in relation to emergency situations. Essentially the Act contrasts the 'best interests' approach used by doctors with the patient's 'expressed intentions' and clearly indicates that the latter has precedence.

In relation to 'Advance Healthcare Directives' the Act sets out its overall purpose in clear terms:

'**Purpose of this Part**

83. (1) The purpose of this Part is to –

(a) enable persons to be treated according to their will and preferences, and
(b) provide healthcare professionals with information about persons in relation to their treatment choices.

(2) A relevant person who has attained the age of 18 years and who has capacity is entitled to refuse treatment for any reason (including a reason based on his or her religious beliefs) notwithstanding that the refusal –

(a) appears to be an unwise decision,
(b) appears not to be based on sound medical principles, or
(c) may result in his or her death.'

While unwise or unsound decisions may be troubling ones for healthcare professionals to deal with, it is very difficult to see a situation in which the avoidable death of a patient would be accepted by doctors or nurses, without taking any action. Sadly our society has a great deal of experience of suicide and self-harm; should the emergency services stand by at a hanging or overdose, because a note meeting the criteria for an 'Advance Healthcare Directive' is found nearby?

Only part of the 2015 Assisted Decision-Making (Capacity) Act has so far been enacted. However, in the section of its 2016 Guide to Professional Conduct and Ethics dealing with consent and capacity, the Medical Council appears to have advised Registered Medical Practitioners on how to deal with such emergencies:

'14 Emergency situations

14.1 In an emergency, where consent cannot be obtained, you should provide medical treatment to anyone who needs it, provided the treatment is limited to what is immediately necessary to save a life or to avoid significant deterioration in the patient's health.'

Although the 2015 legislation is not cited above, much of the language used by the Medical Council is drawn directly from the Act; one must therefore assume that the requirement to provide life-saving treatment is understood to be at odds with Section 88(2)(c). Doctors may therefore feel that they have professional guidance to take action where the 2015 legislation might be interpreted as requiring them not to intervene.

The distinction between Council guidance and this legislation may result in doctors pursuing one route or the other and their actions may generate complaints from patients or family members. Ultimately, the divergence between the two may therefore end up being addressed in the courts, as has happened in the past.

The Medical Council is not above the law and the decisions of the courts apply fully to its work; however, its fundamental mission and independent status require it to offer its best interpretation of how the delivery of care in the circumstances of the day should strive to meet the highest ethical standards.

In summary

Doctors in Ireland have the privilege of regulating much of their own work, through a powerful legislative framework. The guidance and standards established by that regulation have the potential to conflict with the law - and the personal values of individual doctors may be at odds with either or both. Doctors have always been encouraged to reflect on and

strengthen their personal values to help guide them in resolving such dilemmas; doctors have also depended on their judgements about what is in the patient's best interests.

The evolving healthcare environment, whether framed by legislative change, new science or technology or by the values of doctors, patients or the communities we serve will continue to demand the highest standards of medical regulation.

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