

**DRAFT**

## **MEDICAL REGULATIONS, 2014**

### **Arrangement of Regulations**

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#### **Regulation**

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#### **SCHEDULE**

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**MEDICAL ACT  
(NO. 29 OF 2014)**

**MEDICAL REGULATIONS, 2014**

The Minister, in exercise of the powers conferred by section 61 of the Medical Act, 2014, makes the following regulations —

**1. Citation.**

These regulations may be cited as the Medical Regulations, 2014.

**2. Interpretation.**

“**Act**” means the Medical Act, 2014;

“**Code of Professional Conduct**” means the Standards of Professional Conduct;

“**continuing medical education**” means the continuing education and training referred to under section 30(3) of the Act;

“**continuing education credits**” means the value attached to a learning activity for continuing medical education;

“**core standards**” means the Core General Standards of the American Telemedicine Operations;

“**physician**” means a medical practitioner.

**3. Code of Professional Conduct.**

- (1) Every medical practitioner shall comply with the Code of Professional Conduct as set out in the Schedule.
- (2) Where a registered medical practitioner fails to comply with the Code of Professional Conduct, the Council may by notice in writing served on him, require the medical practitioner to comply with the Code of Professional Conduct.
- (3) A medical practitioner who fails to comply with a notice issued under paragraph (2) may be liable to disciplinary proceedings under the Act.

**4. Core standards.**

The Council may register a person for special purposes including telemedicine, where the Council is satisfied that, that person is qualified to practice medicine and meets the core standards set out in Appendix H in the Schedule.

**5. Continuing medical education.**

- (1) Every medical practitioner applying for renewal of his licence shall provide proof of completion of continuing medical education as determined by the Council.
- (2) Where a medical practitioner's licence was suspended or cancelled, the medical practitioner shall provide proof of completion of continuing medical education for relicensure.

**6. Requirements for continuing medical education.**

- (1) A medical practitioner whose name, on 1 January 2015, appears on the registers kept pursuant to the Act shall comply with the requirements of continuing medical education referred to under paragraph (4) as a prerequisite for the medical practitioner to retain his registration and licence under the Act.
- (2) A person who, after 1 January 2015, registers for the first time under the Act as a medical practitioner in any category of independent practice or public service, shall comply with the requirements of continuing medical education referred to under paragraph (4), which shall be a prerequisite for the medical practitioner to retain his registration and licence under the Act.
- (3) Notwithstanding paragraph (2), a person who is registered for the first time after 1 January of any year, shall be required to comply with these requirements during the first year of his registration.
- (4) The requirements of continuing medical education shall be determined by the Council.
- (5) The deferment of compliance with the requirements of continuing medical education for any specific period may be granted to medical practitioners by the Council on application and submission of adequate reasons for such request and subject to such conditions as the Council may determine.

**SCHEDULE****(regulation 3)****CODE OF PROFESSIONAL CONDUCT FOR THE GUIDANCE OF  
REGISTERED MEDICAL PRACTITIONERS****PART I****A. INTRODUCTION**

Medicine as a profession is distinguished from other professions by a special moral duty of care to save lives and to relieve suffering. Medical ethics emphasizes the priority of this moral ideal over and above considerations of personal interests and private gains. The earliest code of medical ethics was the Hippocratic Oath (5<sup>th</sup> Century B.C.). While the Medical Act 2014 confers upon the medical profession considerable freedom of self regulation, the profession is obliged to abide by a strict code of conduct which embodies high ethical values, protects patients' interests, and upholds professional integrity.

Recognizing the need for medical ethics to evolve with changing social circumstances, The Bahamas Medical Council keeps the Code under continuous review. International practices, local peer opinion, legal requirements, public expectations and moral obligations have all played important roles in the development of the Code.

The Code embodies two cardinal values of the medical profession: maintaining high standards of proper conduct and good practice to fulfill medical practitioners' moral obligations of care. Importantly also, the Code upholds a well-defined professional culture to support self-governance and professional development through fulfilling specific obligations and virtues of the medical profession that shape the identity of the medical community in The Bahamas. The Code marks the profession's commitment to integrity, excellence, responsibility, and responsiveness to the changing needs of both patients and the public in The Bahamas.

This Code is a guide and will be updated every periodically, and subsequent amendments will be made and published.

Contravention of this Code, as well as any written and unwritten rules of the profession, may render a registered medical practitioner liable to disciplinary proceedings.

All medical practitioners shall familiarize themselves with The Bahamas Medical Act 2014.

A medical practitioner must comply with the law governing the practice of medicine. Section 15 of the Medical Act, 2014 provides that “no person shall practice medicine or surgery unless he is registered by the Council”.

## **B. ROLE OF THE BAHAMAS MEDICAL COUNCIL**

The Bahamas Medical Council is established under the Medical Act, 2014. It is responsible for registration, licensing and professional discipline of medical practitioners, in order to maintain professional standards for protection of the public.

In the exercise of its disciplinary powers, the Council not only provides a form of redress for the aggrieved public, but also seeks to protect the public from professional misconduct. The maintenance of a high standard of professional conduct is necessary to uphold public trust in the competence and integrity of the profession.

If a medical practitioner is found guilty of professional misconduct, The Bahamas Medical Council may, in writing, censure the medical practitioner; reprimand the medical practitioner and may enter the facts of the reprimand in the register or specialist register in which his name is entered; or by order, suspend the registration of a medical practitioner for such fixed period as The Bahamas Medical Council considers necessary; suspend the registration of the medical practitioner for an indefinite period until the occurrence of some specified future event; or terminate the registration of the medical practitioner, remove his name from the register or specialist register and revoke his certificate.

Where a medical practitioner or specialist whose name has been removed from the register or specialist register, has satisfied the Council that any conduct that had been the cause of the suspension or termination has ceased; any fee that was to be paid has been paid in full; any condition imposed by The Bahamas Medical Council to cause a restoration of the registration has been discharged; or the person has satisfied all of the requirements for registration under the Act, The Bahamas Medical Council shall immediately restore the name of that medical practitioner or specialist to the register except where The Bahamas Medical Council is engaged in conducting any other investigation, in relation to the medical practitioner.

In order to maintain impartiality in its quasi-judicial function in disciplinary proceedings, the Council will not advise individuals. A medical practitioner seeking advice on questions of professional conduct arising in particular

circumstances should consult an appropriate authority, a professional association or his own legal adviser.

The Ethics Committee of the Council advises and makes recommendations to the Council on matters about medical ethics and professional conduct.

**C. THE INTERNATIONAL CODE OF MEDICAL ETHICS**

The International Code of Medical Ethics (2006) has been adopted by the World Medical Association. It is endorsed by The Bahamas Medical Council, except where the contrary intention appears from the context of this Code of Professional Conduct. The Council will have regard to the International Code in the exercise of its disciplinary power.

The latest version of the International Code of Medical Ethics published by the World Medical Association in 2006 is reproduced below: Members of the profession are advised to check any subsequent amendments at the World Medical Association's website.

**DUTIES OF PHYSICIANS IN GENERAL**

- A PHYSICIAN SHALL always exercise his/her independent professional judgment and maintain the highest standards of professional conduct.
- A PHYSICIAN SHALL respect a competent patient's right to accept or refuse treatment.
- A PHYSICIAN SHALL not allow his/her judgment to be influenced by personal profit or unfair discrimination.
- A PHYSICIAN SHALL be dedicated to providing competent medical service in full professional and moral independence, with compassion and respect for human dignity.
- A PHYSICIAN SHALL deal honestly with patients and colleagues, and report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception.

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- A PHYSICIAN SHALL not receive any financial benefits or other incentives solely for referring patients or prescribing specific products.
- A PHYSICIAN SHALL respect the rights and preferences of patients, colleagues, and other health professionals.
- A PHYSICIAN SHALL recognize his/her important role in educating the public but should use due caution in divulging discoveries or new techniques or treatment through non-professional channels.
- A PHYSICIAN SHALL certify only that which he/she has personally verified.
- A PHYSICIAN SHALL strive to use health care resources in the best way to benefit patients and their community.
- A PHYSICIAN SHALL seek appropriate care and attention if he/she suffers from mental or physical illness.
- A PHYSICIAN SHALL respect the local and national codes of ethics.

### **DUTIES OF PHYSICIANS TO PATIENTS**

- A PHYSICIAN SHALL always bear in mind the obligation to respect human life.
- A PHYSICIAN SHALL act in the patient's best interest when providing medical care.
- A PHYSICIAN SHALL owe his/her patients complete loyalty and all the scientific resources available to him/her. Whenever an examination or treatment is beyond the physician's capacity, he/she should consult with or refer to another physician who has the necessary ability.
- A PHYSICIAN SHALL respect a patient's right to confidentiality. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality.

- A PHYSICIAN SHALL give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care.
- A PHYSICIAN SHALL in situations when he/she is acting for a third party, ensure that the patient has full knowledge of that situation.
- A PHYSICIAN SHALL not enter into a sexual relationship with his/her current patient or into any other abusive or exploitative relationship.

**DUTIES OF PHYSICIANS TO COLLEAGUES**

- A PHYSICIAN SHALL behave towards colleagues as he/she would have them behave towards him/her.
- A PHYSICIAN SHALL NOT undermine the patient-physician relationship of colleagues in order to attract patients.
- A PHYSICIAN SHALL when medically necessary, communicate with colleagues who are involved in the care of the same patient. This communication should respect patient confidentiality and be confined to necessary information.

**DECLARATION OF GENEVA**

Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948 and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968 and the 35th World Medical Assembly, Venice, Italy, October 1983 and the 46th WMA General Assembly, Stockholm, Sweden, September 1994 and editorially revised at the 170th Council Session, Divonne-les-Bains, France, May 2005 and the 173rd Council Session, Divonne-les-Bains, France, May 2006

AT THE TIME OF BEING ADMITTED AS A MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE to consecrate my life to the service of humanity;

I WILL GIVE to my teachers the respect and gratitude that is their due;

I WILL PRACTISE my profession with conscience and dignity;

THE HEALTH OF MY PATIENT will be my first consideration;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL MAINTAIN by all the means in my power, the honour and the noble traditions of the medical profession;

MY COLLEAGUES will be my sisters and brothers;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties;

I MAKE THESE PROMISES solemnly, freely and upon my honour.

## **PART II**

### **PROFESSIONAL RESPONSIBILITIES AND CONDUCT**

The Medical Act, 2014 provides that a medical practitioner shall provide such services as are medically necessary for the diagnosis and treatment of any physical or mental condition in human beings and where the diagnosis is cancer, report such diagnosis to the National Cancer Registry; prescribe medication, prosthetic appliances and therapeutic devices as are necessary for such diagnosis and treatment; where he is assisted by other persons in his practice, ensure that those persons are properly trained and certified as competent to render the required service; and in the discharge of his professional responsibilities, conduct himself in a manner that is in accordance with this Code.

While this Code provides guidance in certain areas of professional conduct, it is NOT a complete code of professional ethics. It is not possible to cover all areas of professional conduct, or to specify all forms of misconduct which may lead to disciplinary action.

#### **A. PROFESSIONAL RESPONSIBILITIES TO PATIENTS**

##### **ETHICAL GUIDELINES**

This Code shall be applied to clinical practice and all areas of professional activity conducted by medical practitioners.

The following section provides interpretation and guidance on how the Code shall be applied to various areas of professional activity. Obviously it is impossible to be exhaustive, but medical practitioners shall conscientiously study the guidelines, endeavour to follow them and extend their application to areas that may not be addressed specifically. Breaches of these guidelines could lead to medical practitioners being asked to defend their actions and ultimately to face disciplinary proceedings for professional misconduct.

##### **STANDARD OF GOOD MEDICAL PRACTICE**

###### **Good clinical care**

The standard of care expected of the attending medical practitioner encompasses the following:

###### **Adequate clinical evaluation of patients**

A medical practitioner is expected to have a sense of responsibility for his patients and to provide medical care only after an adequate assessment of a patient's condition through good history taking and appropriate clinical examination.

If treatment is suggested or offered to a patient without such personal evaluation, the medical practitioner must satisfy himself that he has sufficient information available and that the patient's best interest is being served. Such information could be transmitted by voice, electronic or other means by a referring medical practitioner. Only in exceptional or emergency circumstances should a diagnosis or treatment be offered without personal contact and without the intermediation of a referring medical practitioner .

### **Remote initial consultations**

In a technological age with numerous means of communications including the Internet, there are situations in which a previously unknown patient could initiate a consultation over a web-based educational platform in which a medical practitioner is participating, or simply through his email. Such consultation is inappropriate. Only general information may be provided in such instances and the person shall be advised to seek a personal consultation. No medical practitioner patient relationship can be established through electronic means and consequently no consultation fee may be received.

However, in view of developments in telemedicine and remote-control surgery, it is acceptable for a medical practitioner to manage a patient remotely provided this is in the context of a system of care in which a patient has timely or concurrent access to another medical practitioner who manages him in person. A medical practitioner who provides remote management is responsible for any outcome related to his management.

### **Remote consultations in continuing care**

If a medical practitioner has already established a professional relationship through direct personal contact with a patient, previously made a diagnosis and has commenced treatment, adjusting treatment or providing continued treatment following remote contact with a patient or receipt of electronically transmitted medical data is allowable. If on the other hand it appears from the communication that the patient has developed a new problem or a significant complication, then the medical practitioner shall endeavour to see the patient personally for a further evaluation before offering further treatment.

### **Delegation of duties**

A medical practitioner may delegate another medical practitioner, nurse, medical student or other health care worker to provide treatment or care on his behalf, but this person must be competent to carry out the care or procedure required. A medical practitioner retains responsibility for the overall management of the patient when he delegates care. If the person delegated to is not duly registered as a practitioner, this must be in the

context of a legitimate training programme and the medical practitioner must exercise effective supervision over this person.

### **Duty of care**

A medical practitioner shall provide competent, compassionate and appropriate care to his patient. This includes making necessary and timely visits, arranging appropriate and timely investigations and ensuring that results of tests are communicated to the patient and the most appropriate management is expeditiously provided.

A comparable standard of practice is expected from medical practitioners whose contribution to a patient's care is indirect, for example, those in laboratory and radiological specialties.

A medical practitioner who avails his patient of any supporting medical service is responsible to be reasonably confident that this service is of an adequate standard and is reliable.

In addition, a medical practitioner who undertakes to manage, direct or perform clinical work for organizations offering medical services shall satisfy himself that these organizations provide adequate clinical and therapeutic facilities for the services offered.

### **Practise within competence and referral of patients**

A medical practitioner should practise within the limits of his own competence in managing a patient. Where he believes that this is exceeded, he shall offer to refer the patient to another medical practitioner with the necessary expertise. A medical practitioner shall not persist in unsupervised practice of a branch of medicine without having the appropriate knowledge and skill or having the required experience.

Where such a referral is transient, for example for a specialised investigation or specific treatment modality, the medical practitioner retains responsibility for the overall management of the patient. A medical practitioner shall continue to care for his patient until the patient is properly handed over to the referred medical practitioner. If a patient refuses to see a specialist, the medical practitioner shall counsel the patient adequately and if he still refuses, it is allowable for that medical practitioner to treat the patient in consultation with a specialist.

### **Medical records**

Medical records kept by medical practitioners shall be clear, accurate, legible and shall be made at the time that a consultation takes place, or not long afterwards.

Medical records shall be of sufficient detail so that any other medical practitioner reading them would be able to take over the management of a case. All clinical details, investigation results, discussion of treatment

options, informed consents and treatment by drugs or procedures should be documented.

### **Prescription of medicine**

A medical practitioner may only prescribe medicines that are legally available in The Bahamas and must comply with all the statutory requirements governing their use.

A medical practitioner shall prescribe, dispense or supply medicines only on clear medical grounds and in reasonable quantities as appropriate to the patient's needs. This includes prescription by a medical practitioner for his own use. Patients shall be appropriately informed about the purpose of the prescribed medicines, contraindications and possible side effects.

A medical practitioner shall prescribe medicines only following an adequate personal consultation and relevant investigations. A decision to prescribe solely based on information provided by telephone or any electronic means is allowable for continuing care, or for exceptional situations where a patient's best interests are being served by doing so.

### **Untested practices and clinical trials**

A medical practitioner shall treat patients according to generally accepted methods and use only licensed drugs for appropriate indications. A medical practitioner shall not offer to patients, management plans or remedies that are not generally accepted by the profession, except in the context of a formal and approved clinical trial.

A medical practitioner who participates in clinical research must put the care and safety of patients first. If a medical practitioner wishes to enter a patient into a clinical trial, he must ensure that the trial is approved by an ethics committee and conforms to the Good Clinical Practice Guidelines. In addition, informed consent must be obtained from the patient.

It is not acceptable to experiment or authorise experiments or research which are not part of a formal clinical trial and which are not primarily part of treatment or in the best interest of the patient, or which could cause undue suffering or threat to the life of a patient.

### **Association with complementary medicine practitioners**

The field of complementary medicine is very wide and the health authorities may from time to time licence and regulate complementary medicine practitioners. A medical practitioner may avail his patients to complementary medicine practices through licensed and registered practitioners, but he must first assure himself that this is in his patients' best interests. In addition, unless the patient discharges himself from the medical practitioner's care, the medical practitioner remains responsible for the patient's care.

A medical practitioner should only practise complementary medicine if he is adequately trained and registered by the proper authority to do so and only where the law allows joint practice. In addition, the patient must be informed and should consent to be treated by complementary medicine.

#### **Association with persons not qualified to provide medical or medical support services**

A medical practitioner shall not associate himself with anyone who is not qualified to provide medical care, or generally accepted support services such as that provided by dietitians, physiotherapists and occupational therapists or podiatrists. A medical practitioner shall not in his professional capacity support the services provided by persons or organizations that do not provide legitimate medical or medical support services, e.g. beauticians, beauty parlours, health spas, colonic cleansing services, etc.

#### **Decisions about providing services**

##### **Non discrimination of patients**

A medical practitioner is obliged to provide access to medical care and treat patients without prejudice of race, religion, creed, social standing, disability or socio-economic status. A medical practitioner shall not allow his personal beliefs to influence his management of his patients. Where a medical practitioner feels unable to continue his care for a patient due to such beliefs, the patient should be referred to another medical practitioner who is able and willing to care for the patient. An example of such a situation is a request for an abortion.

##### **Treatment in emergency situations**

A medical practitioner shall be prepared to treat patients on an emergency or humanitarian basis unless circumstances prevent him from doing so.

##### **Relationship with system of care**

Every medical practitioner practises within a national system of healthcare that is governed by legislation and rules. Every medical practitioner is expected to abide by these laws and rules while providing the most appropriate treatment for his patients.

Medical practitioners shall however base their counsel to patients on the interest of the individual patient, regardless of the constraints of the system of care. It is recognised that in third party payer systems, the medical practitioner is often constrained to give only cheaper treatment. This is acceptable provided the treatment is appropriate.

## **Medical certificates**

The issuance of a medical certificate by a medical practitioner carries with it the responsibility to ensure that the patient deserves it on proper medical grounds and that such grounds have been arrived at through good clinical assessment as detailed above. Medical certificates may neither be post-dated nor back-dated and shall start from the day of consultation or procedure, except where it is clear that a patient's absence from work prior to consultation is consistent with the patient's clinical presentation to the medical practitioner and there is medical justification to issue the certificate.

The certificate which is issued after the medical examination should specify the expected period of illness and if appropriate, whether the illness renders the person unfit to attend work or a specific function.

As a medical certificate carries with it a professional and legal responsibility, the medical practitioner must sign the certificate personally and if another person has filled in the details on his behalf, he must satisfy himself that the details are correct before signing.

## **1. Medical records and confidentiality**

### **1.1 Medical records**

- 1.1.1.1 The medical record is the formal documentation maintained by a medical practitioner on his patients' history, physical findings, investigations, treatment, and clinical progress. It may be handwritten, printed, or electronically generated. Special medical records include audio and visual recording.
- 1.1.1.2 A medical record documents the basis for the clinical management of a patient. It reflects on the quality of care and is necessary for continuity of care. It protects the legal interest of the patient and the healthcare provider.
- 1.1.1.3 All medical practitioners have the responsibility to maintain systematic, true, adequate, clear, and contemporaneous medical records. Material alterations to a medical record can only be made with justifiable reason which must be clearly documented.
- 1.1.1.4 All medical records should be kept secure. This includes ensuring that unauthorized persons do not have access to the information contained in the records and that there are adequate procedures to prevent improper disclosure or amendment. Medical records should be kept for such duration as required by the circumstances of the case and other relevant requirements.

1.1.1.5 Medical practitioners should have due regard to their responsibilities and liabilities under the Data Protection (Privacy of Personal Information) Act (*Ch. 324A*) in particular, patient's rights of access to and correction of information in the medical record and the circumstances under which medical practitioners may refuse to entertain such requests.

## **1.2 Medical examination and subsequent reporting**

1.2.1 Whenever a medical practitioner conducts a health check-up on a person there exists a medical practitioner patient relationship which should be respected at all times. The medical information should not be disclosed to a third party without the prior consent of the patient. If consent is withheld or withdrawn, the medical practitioner must respect this except in the circumstances set out in section 1.4.2.

1.2.2 A medical practitioner is advised to ensure that the patient fully understands what may be involved in furnishing a medical report and his contractual liabilities with the third party. A medical practitioner should ensure that the patient understands his right of not giving consent to disclose certain parts of his medical information.

1.2.3 If a patient being examined under the arrangement of a prospective employer or insurance company wishes to obtain medical service beyond the scope of the prescribed examination, the medical practitioner should always define his role as an examiner and explain to the patient the cost for which the patient will be personally responsible before providing such additional services.

1.2.3.4 An intimate examination of a patient is recommended to be conducted in the presence of a chaperone to the knowledge of the patient. If the patient requests to be examined without a chaperone, it is also recommended to record the request in the medical records.

## **1.3 Handling of medical records upon transfer or cessation of practice**

1.3.1 It is the responsibility of the medical practitioner who intends to stop practising medicine, either generally or in a particular area, to ensure that his patients' medical records are properly handled and preserved. This could be achieved either by giving the medical record or a copy of it to the relevant patient, if appropriate, or by transferring the record to another medical practitioner who is, in his opinion, competent to look after the patient.

1.3.2 The patients should be informed of the change of circumstances and the arrangements that have been made in respect of their medical records by reasonable means including:

- (a) notifying each patient individually, either verbally or in writing;
- (b) publishing a public announcement in the newspapers; or
- (c) displaying prominent notices in the practice premises.

1.3.1.1.3 The medical practitioner who assumes custody of the medical records has a responsibility to inform the patient of the transfer of the record to him either upon enquiry or upon the patient attending his practice. He must seek the patient's consent to his taking over the patient's medical care and his custody of the medical record. Before such consent is obtained, the succeeding medical practitioner should not make reference to the patient's medical record under his custody unless it is in the best interest of the patient to do so.

1.3.1.1.4 A medical practitioner who employs a locum medical practitioner in his stead should display a notice to this effect inside the practice premises and ensure that patients are informed about the change of medical practitioner prior to any consultation.

#### **1.4 Disclosure of medical information to third parties**

1.4.4.1.1 A medical practitioner should obtain consent from a patient before disclosure of medical information to a third party not involved in the medical referral.

1.4.4.1.2 In exceptional circumstances medical information about a patient may be disclosed to a third party without the patient's consent. Examples are: (i) where disclosure is necessary to prevent serious harm to the patient or other persons; (ii) when disclosure is required by law.

1.4.4.1.3 However, before making disclosure without the patient's consent a medical practitioner must weigh carefully the arguments for and against disclosure and be prepared to justify the decision. If in doubt, it would be prudent to seek advice from an experienced colleague, a medical defence society, a professional association or an ethics committee.

## **2. Consent to medical treatment**

2.1 Consent to medical treatment is part of quality care and also a legal requirement. Consent has to be given voluntarily by the patient after

having been informed of the relevant aspects of the medical procedure including the general nature, effect and risks involved.

- 2.2 Consent is normally given by the patient himself or by a designated person under specific circumstances. When it is not possible for an otherwise competent patient to give consent, the views of the family members should be considered provided that such views are compatible with (i) the patient's best interests; and (ii) the patient's right of self-determination.
- 2.3 Consent should preferably be recorded in writing, although in law consent in written form is not always required. In certain circumstances, written consent is required under specific statutory provisions.
- 2.4 A patient has the right to refuse to give consent to treatment, provided that the patient is able to exercise his judgement clearly and freely. The refusal should be respected and preferably documented.

### **3. Termination of medical practitioner -patient relationship**

- 3.1 A medical practitioner has the primary responsibility to provide proper medical care to his patients. However, there may be situations where it is in the best interest of the patient for such medical care to be provided by another medical practitioner. Examples of such situations include loss of trust between the medical practitioner and the patient (e.g. where the medical practitioner does not wish to comply with the patient's request for an intimate examination to be conducted in the absence of a chaperone), and where the treatment requested is beyond the medical practitioner's competence. In such situations the medical practitioner may terminate the medical practitioner -patient relationship, provided that the patient's health interest is not jeopardized. medical practitioners should exercise their professional judgment before terminating the medical practitioner -patient relationship.
- 3.2 When it is decided to terminate the medical practitioner -patient relationship, the medical practitioner should inform the patient of his decision at the earliest opportunity. He should explain the reasons for terminating the relationship and offer to refer the patient to another medical practitioner who has the ability to provide the necessary services.

### **4. Fitness to practise**

- 4.1 Section 54 of the Medical Act, 2014 gives powers to The Bahamas Medical Council to take disciplinary action in relation to a medical

practitioner who, by reason of health, is physically or mentally unfit to practise medicine or surgery.

The Council may take such disciplinary action both in response to information from concerned colleagues and also where, during disciplinary proceedings, it appears that an illness may be the underlying cause.

- 4.2 A medical practitioner whose mental or physical health are such that patients would be put at risk if he continues with his normal practice should either wholly or partially alter or withhold his practice and undergo treatment and rehabilitation where appropriate.

### **4.3 Serious infectious diseases**

#### 4.3.1 Responsibilities

A medical practitioner who has reason to suspect that he may be a carrier of a serious infectious disease should seek appropriate investigation and treatment. If confirmed, he must take the necessary steps to prevent the spread of infection to his patients and others. Where appropriate a medical practitioner seek counselling and act accordingly. It is unethical if he/she fails to do so as patients are put at risk.

The medical practitioner who has counselled an infected colleague on general management and job modification and who is aware that the advice is not being followed and patients are put at risk has a duty to inform The Bahamas Medical Council for appropriate action.

#### 4.3.2 Expert advice and counselling

Information and counselling should be made easily available for medical practitioners who may have been exposed to serious contagious diseases through risky behaviour, exposure to contaminated blood/blood products or occupational accidents. The importance of voluntary, confidential and anonymous counselling and testing should be underlined.

#### 4.3.3 Confidentiality

In general, a medical practitioner is not required to disclose his/her infectious disease to patients. However he/she has to inform the Department of Public Health if it is a notifiable disease. A medical practitioner who treats or counsels another medical practitioner should maintain confidentiality. In exceptional circumstances, breach of confidentiality may be warranted, as for instance, when an infected medical

practitioner fails to observe certain restrictions putting patients and other healthcare workers at risk.

Maintaining confidentiality is essential in encouraging the medical practitioner to receive proper counselling and management.

#### 4.3.4 Right to work

The status and rights of an infected medical practitioner as an employee should be safeguarded. If work restriction is required, employers should make arrangement for alternative work, with provision for retraining and redeployment.

Restriction or modification, if any, should be determined on a case-by-case basis.

## **B. COMMUNICATION IN PROFESSIONAL PRACTICE**

### **5. Professional communication and information dissemination**

#### **5.1 The need for good communication and accessible information**

5.1.1.1 Good communication between medical practitioners and patients, and between medical practitioners, is fundamental to the provision of good patient care.

5.1.1.2 A key aspect of good communication in professional practice is to provide appropriate information to users of a medical practitioner's service and to enable those who need such information to have ready access to it. Patients need such information in order to make an informed choice of medical practitioners and to make the best use of the services the medical practitioner offers. Medical practitioners, for their part, need information about the services of their professional colleagues. Medical practitioners in particular need information about specialist services so that they may advise patients and refer them, where appropriate, for further investigations and/or treatment.

5.1.1.3 Persons seeking medical service for themselves or their families can nevertheless be particularly vulnerable to persuasive influence, and patients are entitled to protection from misleading advertisements. Practice promotion of medical practitioners' medical services as a commercial activity is likely to undermine public trust in the medical profession and, over time, to diminish the standard of medical care.

## **5.2 Principles and rules of good communication and information dissemination**

5.2.1. A medical practitioner providing information to the public or his patients must comply with the principles set out below:

5.2.1.1 Any information provided by a medical practitioner to the public or his patients must be:

- (a) accurate,
- (b) factual,
- (c) objectively verifiable,
- (d) presented in a balanced manner (when referring to the efficacy of particular treatment, both the advantages and disadvantages should be set out).

5.2.1.2 Such information must not:

- (a) be exaggerated or misleading,
- (b) be comparative with or claim superiority over other medical practitioners,
- (c) claim uniqueness without proper justifications for such claim,
- (d) aim to solicit or canvass for patients,
- (e) be used for commercial promotion of medical and health related products and services (for the avoidance of doubt, recommendations in clinical consultations are not regarded as commercial promotion of products and services),
- (f) be sensational or unduly persuasive,
- (g) arouse unjustified public concern or distress,
- (h) generate unrealistic expectations,
- (i) disparage other medical practitioners (fair comments excepted).

5.2.1.3 Where a medical practitioner has a conflict of interest of any nature in a product or service, he must declare such interest before making comments on the product or service.

5.2.2 Practice promotion

5.2.2.1.1 Practice promotion means publicity for promoting the professional services of a medical practitioner, his practice or his group, excluding communication with podiatrists; chiropractors; nurses; midwife; psychologists., medical laboratory technologists, radiographers, physiotherapists, occupational therapists and optometrists.

Practice promotion in this context will be interpreted by The Bahamas Medical Council in its broadest sense, and includes any means by which a medical practitioner or his practice is publicized, in The Bahamas or elsewhere, by himself or anybody acting on his behalf or with his forbearance (including the failure to take adequate steps to prevent such publicity in circumstances which would call for caution), which objectively speaking constitutes promotion of his professional services, irrespective of whether he actually benefits from such publicity.

5.2.2.1.2 Practice promotion by individual medical practitioners, or by anybody acting on their behalf or with their forbearance, to people who are not their patients is not permitted except to the extent allowed under section 5.2.3.

5.2.3 Dissemination of service information to the public

A medical practitioner, whether in private or public service, may provide information about his professional services to the public (i.e. persons other than his patients as defined in section 5.2.4.1) only in the ways set out below. Where the provision refers to medical practice groups, it means a group in which all medical practitioners in the group practise in the same premises and are governed by a genuine management structure.

5.2.3.1 Signboards

Signboards include any signs and notices exhibited by a medical practitioner to identify his practice to the public.

Medical practitioners in group practice may exhibit either their own individual signboards or a shared signboard. Both individual and shared signboards must comply with the requirements set out in Appendix A.

Signboards should not be ornate. Illumination is allowed only to the extent required to enable the contents to be read. Blinking lights are not allowed.

A signboard may carry only the following information:

- (a) name of the medical practitioner the prefix Dr.;
- (b) name of the practice;
- (c) quotable qualifications approved by The Bahamas Medical Council in the approved abbreviated forms;
- (d) specialist title approved by The Bahamas Medical Council;

- (e) name and logo of the medical establishment with which the medical practitioner is associated. (Only bona fide logos which are graphic symbols designed for ready recognition of the medical establishment may be displayed.);
- (f) consultation hours.
- (g) Indication of the location of the practice in the building.

A medical practitioner should not allow his name to appear on any signboard which carries merchandise or service promotion. He should not allow the placement of his signboard in a way which gives the appearance that he is associated with other signboards which do not comply with section 5.2.

#### 5.2.3.2 Stationery

Stationery (visiting cards, letterheads, envelopes, prescription slips, notices etc.) may only carry the following information:

- (a) name of the medical practitioner with the prefix Dr.;
- (b) name of the practice;
- (c) names of partners, assistants or associates in the practice;
- (d) quotable qualifications and appointments and other titles approved by The Bahamas Medical Council;
- (e) specialist title approved by The Bahamas Medical Council;
- (f) name and logo of the medical establishment with which the medical practitioner is associated. (Only bona fide logos which are graphic symbols designed for ready recognition of the medical establishment may be displayed.);
- (g) consultation hours;
- (h) telephone, fax, pager numbers and e-mail address;
- (i) address(es) and location map of the practice.

#### 5.2.3.3 Announcements in mass media

##### Commencement and Altered Conditions of Practice

Announcements of commencement of practice or altered conditions of practice (e.g. change of address, partnership etc.) are permissible in the media provided that all announcements are completed within two weeks of the commencement/change taking place AND comply with

section 5.2.1 of this Code. The size of the announcement must not exceed 300cm<sup>2</sup> and the announcement may contain only the information specified in section 5.2.3.2 together with the date of the commencement or alteration of the conditions of practice. Photographs are not allowed. Examples of permitted announcements are given in Appendix B.

#### Other announcements

Letters of gratitude or announcements of appreciation from grateful patients or related persons identifying the medical practitioner concerned should not be published in the media or made available to members of the public. A medical practitioner should take all practical steps to discourage any such publications.

#### 5.2.3.4 Telephone directories published by telephone companies

Entries in telephone directories published by telephone companies in respect of subscribers to their telephone services may be listed under the appropriate descriptive heading e.g. medical practitioners, medical practitoners and surgeons. Medical practitioners included in the specialist register may have their names listed under the appropriate specialty.

Telephone directory entries may only carry the following information:

- (a) name of the medical practitioner;
- (b) gender of the medical practitioner;
- (c) language(s)/ spoken;
- (d) name of the practice;
- (e) names of partners, assistants or associates in the practice;
- (f) affiliated hospitals;
- (g) availability of emergency service and emergency contact telephone number;
- (h) quotable qualifications and appointments approved by the Council;
- (i) specialist title approved by The Bahamas Medical Council;
- (j) consultation hours;
- (k) telephone, fax, pager numbers and e-mail address;
- (l) address(es) of the practice.

The characters of all the entries should be uniform, i.e. of the same size, not bold-type, and not in italic etc.

#### 5.2.3.5 Practice websites

A medical practitioner may publish his professional service information in either his practice website or the website of a bona fide medical practice group. If a medical practitioner is a member of more than one medical practice group, he may publish his service information in the website of only one of the groups.

The website may carry only the service information which is permitted on medical practitioners directories under section 5.2.3.7. The same rules on medical practitioners directories in electronic format also apply to practice websites. Hyperlinkage may be established between the website and specialist medical practitioners directories in which the medical practitioner's name is listed.

#### 5.2.3.6 Service information notices

A medical practitioner may display at the exterior of his office a service information notice bearing the fee schedules and the medical services provided by him. The service information notice must comply with the guidelines set out in Appendix C.

#### 5.2.3.7 Medical practitioners directories

#### 5.2.3.8 Newspapers, magazines, journals and periodicals

A medical practitioner may publish his service information in bona fide newspapers, magazines, journals and periodicals for the purpose of enabling the public to make an informed choice of medical practitioners.

A publication published for the predominant purpose of promotion of the products or services of a medical practitioner or other persons is not regarded as an acceptable newspaper, magazine, journal or periodical for this purpose.

A medical practitioner who publishes his service information in these publications must ensure that:

- (a) the published information includes only the information which is permitted in Service Information Notices and Medical practitioners Directories;
- (b) the same rules as to terminology of procedure and operations for Service Information Notices and Medical practitioners Directories are complied with, and no questionable terminology is adopted;

- (c) a written undertaking is secured from the publisher that his service information will not be published in a manner which may reasonably be regarded as suggesting his endorsement of other medical or health related products/services, such as publication in close proximity to advertisements for those products/services;
- (d) the published information does not exceed the size limit of 300 cm<sup>2</sup>, and not more than one notice is published in the same issue of a publication; and
- (e) a proper record of the published information and the arrangements for its publication is kept for two years.

#### 5.2.4 Dissemination of service information to patients

No attempt should be made to put pressure on patients and there should be no abuse of the trust of patients in the dissemination of information.

5.2.4.1A patient in this context refers to someone who has, at any time, consulted that medical practitioner, a partner in his practice, or a medical practitioner in a practice which that medical practitioner has taken over, and whose name appears in the records of the practice.

5.2.4.2 A medical practitioner may provide information about his service to his patients provided that such information:

- (a) is not disseminated in such a way as to constitute practice promotion to non-patients;
- (b) conforms with section 5.2.1;
- (c) does not involve intrusive visits, telephone calls, fax or e-mails by himself or by people acting on his behalf;
- (d) does not abuse the patient's trust or exploit his lack of knowledge;
- (e) does not put the patient under undue pressure; and
- (f) does not offer guarantees to cure particular conditions.

5.2.4.3 Medical practitioners in private practice as well as those in public organizations are bound by the same rules.

5.2.4.4 A medical practitioner may provide information about the acceptance of credit facilities inside his office.

5.2.4.5 A medical practitioner may provide information about medical or ancillary services inside his office.

5.2.4.6 A medical practitioner should not take advantage of his professional capacity in the promotion and sale of medical products or health claim substances.

### 5.2.5 Unsolicited visits or telephone calls

Medical practitioners' services may not be promoted by means of unsolicited visits, telephone calls, fax, e-mails or leaflets by medical practitioners or persons acting on their behalf or with their forbearance.

## 6. Health education activities

- 6.1 It is appropriate for a medical practitioner to take part in bona fide health education activities, such as lectures and publications. However, he must not exploit such activities for promotion of his practice or to canvass for patients. Any information provided should be objectively verifiable and presented in a balanced manner, without exaggeration of the positive aspects or omission of the significant negative aspects.
- 6.2 A medical practitioner should take reasonable steps to ensure that the published or broadcasted materials, either by their contents or the manner they are referred to, do not give the impression that the audience is encouraged to seek consultation or treatment from him or organizations with which he is associated. He should also take reasonable steps to ensure that the materials are not used directly or indirectly for the commercial promotion of any medical and health related products or services.
- 6.3 Information given to the public should be authoritative, appropriate and in accordance with general experience. It should be factual, lucid and expressed in simple terms. It should not arouse unnecessary public concern or personal distress, or generate unrealistic expectations. Medical practitioners must not give the impression that they, or the institutions with which they are associated, have unique or special skills or solutions to health problems. Information should not be presented in such a way that it furthers the professional interests of the medical practitioners concerned, or attracts patients to their care.

## 7. Specialist title

- 7.1 Only medical practitioners on the specialist register are recognized as specialists, and can use the title of "specialist in a specialty". A specialist can claim himself as a specialist only in the specialty under which he is included in the specialist register but not other specialties.
- 7.2 Medical practitioners who are not on the specialist register cannot claim to be or hold themselves out as specialists. A non-specialist is not allowed to use any misleading description or title implying specialization in a particular area (irrespective of whether it is a

recognized specialty), such as “medical practitioner in dermatology”.

## **8. Information about medical innovations**

8.1 medical practitioners who directly or indirectly release information to the public on new discoveries, inventions, procedures, or improvements should ensure beforehand that:

- (a) the relevant medical innovation has been adequately tested;
- (b) the value of the innovation is evidence-based;
- (c) the evidence-based research has been properly documented and completed with peer approval. It is the duty of the author to seek peer approval from the relevant professional or academic bodies;
- (d) the ethical guidelines under sections 5.2.1 and 22 are observed; and
- (e) it is not implied that the medical practitioner may be consulted by individual patients.

## **9. Electronic Communication with Patients**

Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve, maintain, or assist patients’ health status. Closely associated with telemedicine is the term “telehealth,” which is often used to encompass a broader definition of remote health care that does not always involve clinical services. Videoconferencing, transmission of still imaging, e-health including patient portals, remote monitoring of vital signs, continuing medical education, and nursing call centers, are all considered part of telemedicine and telehealth and is acceptable practice in accordance with Appendix H.

## **C. DRUGS**

### **10. Prescription and labelling of dispensed medicines**

10.1 A medical practitioner may prescribe medicine to a patient only after proper consultation and only if drug treatment is appropriate.

10.2 A medical practitioner who dispenses medicine to patients has the personal responsibility to ensure that the drugs are dispensed strictly in accordance with the prescription and are properly labelled before they are handed over to the patients. The medical

practitioner should establish suitable procedures for ensuring that drugs are properly labelled and dispensed.

- 10.3 Patients should be given the choice of either receiving medicine directly from the medical practitioner or taking a prescription from him. In either case, the medical practitioner has the responsibility to decide the proper dosage.
- 10.4 All medications dispensed to patients directly or indirectly by a medical practitioner should be properly and separately labelled with all the following information:
  - (a) name of prescribing medical practitioner or proper means of identifying him;
  - (b) full name of the patient, except where the full name is unusually long (in which case the family name and such part of the given name or initials sufficient to identify the patient should be written);
  - (c) date of dispensing;
  - (d) name of medicine, which can be either the generic, chemical or pharmacological name of the medicine;
  - (e) method of administration;
  - (f) dosage to be administered; and
  - (g) precautions where applicable.
- 10.5 The only exemptions from the labelling requirement are:
  - (a) medicines for clinical trials with informed consent of the patient; and
  - (b) situations in which it may not be in the interest of the patient to label and describe the medicine, such as medicines supplied solely for psychological effect on the patient.
- 10.6 Where a drug is commonly known to have serious side effects, the medical practitioner has the responsibility to properly explain the side effects to the patient before prescribing the drug.

## **11. Supply of dangerous or scheduled drugs**

- 11.1 Medical practitioners are advised to acquaint themselves with the Dangerous Drug Act (*Ch 228*) and adhere to the Guidelines on Proper Prescription and Dispensing of Dangerous Drugs (Appendix E).
- 11.2 A medical practitioner should not prescribe or supply drugs of addiction or dependence otherwise than in the course of bona fide and proper treatment.

- 11.3 A medical practitioner should not permit unqualified assistants to be in charge of any place in which scheduled poisons and dangerous drugs or preparations containing such substances are supplied to the public.
- 11.4 A medical practitioner is required to keep a register of every quantity of dangerous drug obtained or supplied by him. Failure to comply with these requirements will result in disciplinary action.
- 11.5 The specified form of dangerous drugs register set out in Appendix F. All entries with the specified particulars must be entered in chronological sequence, on the date of receipt or supply of the dangerous drug. Every entry must be made in ink or other indelible form. No cancellation, obliteration or alteration is allowed. Any correction can only be made by a marginal note or footnote specifying the date of correction.

## **12. Abuse of alcohol or drugs**

- 12.1 Convictions for offences arising from drunkenness or abuse of alcohol or drugs (such as driving under the influence of alcohol or drugs) may be regarded as professional misconduct.
- 12.2 It is professional misconduct for a medical practitioner to treat patients or perform other professional duties while being rendered unfit to perform such duties by the influence of alcohol or drugs.
- 12.3 Disciplinary proceedings will be taken against a medical practitioner convicted of drugs related offences committed in order to gratify his own addiction.

## **D. FINANCIAL ARRANGEMENTS**

### **13. Fees**

- 13.1 Consultation fees should be made known to patients on request. In the course of investigation and treatment, all charges, to the medical practitioners' best knowledge, should be made known to patients on request before the provision of services. A medical practitioner who fails to make the charges known when properly requested may be guilty of professional misconduct.
- 13.2 Although there is no obligation to give advance quotation of fees, medical practitioners are strongly advised to give quotation to patients before providing services if substantial fees will be incurred, in order to avoid subsequent complaints and disputes.
- 13.3 A medical practitioner should not charge or collect an excessive fee. The Bahamas Medical Council will consider the following factors in determining whether a fee is excessive:

- (a) the difficulty, costs and special circumstances of the services performed and the time, skill and experience required;
- (b) the average fee customarily charged for similar services; and
- (c) the experience and ability of the doctor in performing the kind of services involved.

#### **14. Financial relationship with health care organizations**

14.1 A medical practitioner may refer a patient to any hospital, nursing home, health centre or similar institution, for treatment by himself or other persons only if it is, and is seen to be, in the best interest of the patient. Medical practitioners should therefore avoid accepting any financial or other inducement from such an institution which may compromise, or may be regarded by others as likely to compromise, the independent exercise of their professional judgment.

#### **14.2 Contract medicine and managed care**

A medical practitioner who is an owner, a director or an employee of, or is in a contractual relationship with, an organization which, either directly or indirectly, provides medical services or administers medical schemes, may continue such association with the organization only if the following principles are complied with:

14.2.1.1 The principles on provision of information to the public and patients in section 5.2.1 must be observed.

14.2.1.2 A medical practitioner should exercise careful scrutiny and judgment of medical contracts and schemes of the organization to ensure that they are ethical and in the best interest of the patients. He should dissociate himself from an organization which provides substandard medical services, imposes restrictions on the independent professional judgment of doctors, infringes patients' rights or otherwise contravenes this Code.

14.2.3 Where administrators, agents, brokers, middlemen etc. are involved in a medical contract, information pertaining to the financial arrangements should be made readily available to all parties on request.

14.2.4 Medical schemes and contracts often involve administrative costs. Medical practitioners should do their best to ensure that these administrative costs are reasonable. Medical practitioners should also ensure that administrative costs are not disguised as part of the professional fees they charge the

patients and are clearly set out separately in the invoices, payment vouchers and receipts.

14.2.5 Arrangements under which the remuneration for a medical practitioner's medical services, if averaged out among the services provided, diminishes with or is inversely proportional to the quantity of services provided are incompatible with proper medical standards. They encourage lowering of the standard of service to match the diminishing remuneration and will compromise the interests of the patients. Such arrangements include commercial capitation schemes and similar medical schemes. Medical practitioners must not enter into such arrangements. Medical practitioners are also prohibited from administering or operating such schemes.

## **15. Improper financial transactions**

- 15.1 A medical practitioner shall not offer to, or accept from, any person or organization (including diagnostic laboratories, hospitals, nursing homes, health centres, beauty centres or similar institutions) any financial or other inducement (including free or subsidized consulting premises or secretarial support) for referral of patients for consultation, investigation or treatment.
- 15.2 A medical practitioner shall not share his professional fees with any person other than the bona fide partners of his practice. However, it is not a form of fee-sharing for a doctor to make payment to other doctors and healthcare professionals collaborating in the provision of bona fide medical services to the patient, provided that the patient is informed of their involvement and services as soon as reasonably practicable.
- 15.3 If a medical practitioner has any interest in commercial organizations (including but not limited to organizations providing health care or pharmaceutical or biomedical companies) or products, he must not allow such interest to affect the way he prescribes for, treats or refers patients.
- 15.4 A medical practitioner, before taking part in discussion with patients or their relatives about buying goods or services, must declare any relevant financial interest or commercial interest which he or his family may have in the purchase.
- 15.5 Sponsorship from commercial organizations for participation in scientific meetings or for educational and charitable services is acceptable, provided that the amount sponsored is reasonable.

## **16. Pharmaceutical and allied industries**

- 16.1 Advertising and other forms of products promotion by individual firms within the pharmaceutical and allied industries can provide information which is useful to the profession. Nevertheless, a medical practitioner when prescribing should not only choose but should also be seen to be choosing the drug or appliance which, in his independent professional judgment and having due regard to cost effectiveness, will best serve the medical interests of his patients. Medical practitioners should therefore avoid accepting any inducement which may compromise, or may be regarded by others as likely to compromise, the independent exercise of their professional judgment in matters pertaining to patients' management.
- 16.2 The medical profession and the pharmaceutical industry have common interests in the research and development of new drugs or appliances of diagnostic or therapeutic value. Advances achieved by the pharmaceutical industry contribute to the improvement of medical practice. The industry also provides financial support for medical research and postgraduate medical education.
- 16.3 While reasonable sums may be charged by a medical practitioner for services properly rendered such as collection of clinical data, it is improper for medical practitioners to solicit or accept unreasonable sums of money or gifts from commercial firms which manufacture or market drugs or medical products. It is improper for medical practitioners to accept from such firms monetary gifts or loans or equipment or other expensive items for their personal use.
- 16.4 Some exceptions can however be made for donations and grants of money or equipment to institutions such as hospitals, health care centres and universities specifically for the purposes of patient services, education or approved research.
- 16.5 Clinical trials of drugs and appliances  
It is improper for a medical practitioner to accept directly or indirectly any form of payments or benefits from a pharmaceutical firm:
  - (a) in relation to a research project such as the clinical trial of drugs and appliances, unless the payments have been specified in a protocol for the project which has been approved by the relevant local ethics committee (other than the ethics committee of the sponsoring pharmaceutical firm);
  - (b) under arrangements for recording clinical assessments of a licensed medicinal product, whereby he is asked to report reactions which he has observed in patients for whom he has prescribed the drug, unless the

payments have been specified in a protocol for the project which has been approved by the relevant ethics committee (other than the ethics committee of the sponsoring pharmaceutical firm); or

- (c) which could influence his professional assessment of the clinical value of drugs or appliances.

Payment by pharmaceutical companies for costs properly incurred in conducting approved clinical studies is acceptable.

## **17. Professional indemnity insurance**

- 17.1 Professional indemnity insurance provides protection to the patient as well as the medical practitioner against whom medical negligence claims are made. Some areas of medical practice involve statistically higher risks of claim than others. Although it is not a mandatory requirement, a medical practitioner should seriously assess the risks of his practice, his personal ability to pay the potential compensation awards and the legal costs of defending the claims, and obtain proper insurance coverage where appropriate.

## **E. RELATIONSHIP WITH OTHER PRACTITIONERS AND ORGANIZATIONS**

### **18. Referral of patients**

- 18.1 A medical practitioner may refer a patient for diagnostic or therapeutic services to another medical practitioner, a practitioner with limited registration, or any other provider of health care services permitted by law to furnish such services, if in his clinical judgment this may benefit the patient. Referrals to medical specialists should be based on their individual competence and ability to perform the services needed by the patient. A medical practitioner should not so refer a patient unless he is confident that the services provided on referral will be performed competently and in accordance with accepted scientific standards and legal requirements.

### **19. Relationship with health care and health products organizations**

- 19.1 Medical and health products and services are offered by a variety of organizations. The Bahamas Medical Council does not have jurisdiction over such organizations. However, subject to section 19.2, disciplinary action will be taken against a medical practitioner where an advertisement in the name of the organization is in effect promotion of the medical practitioner's practice. In this respect, The

Bahamas Medical Council will look at the actual effect of the advertisement.

19.2 A medical practitioner who has any kind of financial or professional relationship with, uses the facilities of, or accepts patients referred by, such an organization, must exercise due diligence (but not merely nominal efforts) to ensure that the organization does not advertise in contravention of the principles and rules applicable to individual medical practitioner. Due diligence shall include acquainting himself with the nature and content of the organization's advertising, and discontinuation of the relationship with an organization which is found to be advertising in contravention of the principles and rules.

19.2.1 Under no circumstances should a medical practitioner permit his professional fees or contact information to be published in an organization's promotional materials.

## **20. Disparagement of other medical practitioners**

20.1 Medical practitioners are frequently called upon to express a view about a colleague's professional practice. This may, for example, happen in the course of a medical audit or peer review procedure, or when a medical practitioner is asked to give a reference about a colleague. It may also occur in a less direct and explicit way 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 and can be justified, offered in good faith and intended to promote the best interests of the patient.

20.2 A medical practitioner should, where the circumstances so warrant, inform an appropriate person or body about a colleague whose professional conduct, competence or fitness to practise may be called into question. The Bahamas Medical Council has procedures for rehabilitating medical practitioners whose fitness to practise is impaired by a physical or mental condition (See section 4).

20.3 It is unethical for a medical practitioner to make unjustifiable comments which, whether directly or by implication, undermines trust in the professional competence or integrity of another medical practitioner.

## **21. Practice in association with non-qualified persons**

21.1 A medical practitioner should not associate himself with a non-qualified person in providing any form of healing or treatment for his patients.

21.2 In respect of a profession with a registration system, a person not registered in The Bahamas is regarded as a non-qualified person. In

respect of a profession with no registration system, the professional training and criteria required for a person to qualify for practice of such profession are relevant in determining whether a person is a non-qualified person.

**22. Covering or improper delegation of medical duties to non-qualified persons**

22.1 A medical practitioner who improperly delegates to a person who is not a registered medical practitioner duties or functions in connection with the medical treatment of a patient for whom the medical practitioner or is responsible or who assists such a person to treat patients as though that person were a registered medical practitioner, is liable to disciplinary proceedings. The proper training of medical and other bona fide students or the proper employment of nurses, midwives and other persons trained to perform specialized functions relevant to medicine is entirely acceptable provided that the medical practitioner concerned exercises effective personal supervision over any person so employed and retains personal responsibility for the treatment of the patients.

22.2 A medical practitioner who employs or otherwise engages a person to carry out the functions of an associated Medical Professional (i.e. medical laboratory technologists, radiographers, physiotherapists, occupational therapists and optometrists) may only do so if that person is registered in accordance with the provisions of their respective Act. A medical practitioner who employs any person to practise any of such professions also commits an offence if that person is not registered in respect of that profession.

**F. NEW MEDICAL PROCEDURES, CLINICAL RESEARCH AND ALTERNATIVE MEDICINE**

**23. New medical procedures**

23.1 Medical practitioners in public institutions or in the private sector may apply new methods of treatment for appropriate patients under appropriate circumstances. In this respect, innovative ideas, new appliances and medications are expected and are encouraged. Nevertheless, the medical practitioner must be reminded that the human rights of the patient must be protected and his dignity respected.

23.2 New medical procedures should be conducted in accordance with the ethical principles that have their origin in the Declaration of

Helsinki, and that are consistent with good clinical practice and the applicable regulatory requirements.

- 23.3 Medical practitioners when using NEW surgical procedures, grafts, implants or medications on patients should give due consideration to the following:
- (a) such new surgical procedures, grafts, implants or medications should be primarily for the benefit of the patient;
  - (b) the medical practitioner should have good grounds, supported where necessary by experimental or trial results, to expect that such surgical procedures, grafts, implants or medications would yield equal or better results than alternative methods of available treatment;
  - (c) the medical practitioner should make adequate preparations and acquire the necessary facilities to meet the undertaking, as well as any expected complications arising from such an undertaking;
  - (d) the medical practitioner should clearly explain to the patient the nature of the surgical procedure, graft, implant or medication, as well as alternative methods of available treatment. Informed consent from the patient is required for invasive procedures;
  - (e) the medical practitioner should consult and obtain approval from the relevant ethics committee for the use of such surgical procedures, grafts, implants or medications.
- 23.4 Medical practitioners should familiarize themselves with the guidelines issued by The Bahamas Medical Council from time to time.
- 23.5 Medical practitioners are reminded that they may be asked to justify their action. Failure to adhere to the above principles may result in disciplinary action.

## **24. Clinical research**

- 24.1 The practice of good clinical research should follow the principles of good clinical practice set out in the following sections. These principles are adopted from the International Conference on Harmonization (ICH), Harmonized Tripartite Guideline and ICH Guidelines.
- 24.2 Clinical trials should be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki (2013) and that are consistent with good clinical practice and the applicable regulatory requirements.

- 24.3 Before a trial is initiated, foreseeable risks and inconveniences should be weighed against the anticipated benefit for the individual trial subject and society. A trial should be initiated and continued only if the anticipated benefits justify the risks.
- 24.4 The rights, safety, and well being of the trial subjects are the most important considerations and should prevail over interests of science and society.
- 24.5 The available non-clinical and clinical information on an investigation product should be adequate to support the proposed clinical trial.
- 24.6 Clinical trials should be scientifically sound, and described in a clear, detailed protocol.
- 24.7 A clinical trial should be conducted in compliance with the protocol that has received prior approval from an appropriate ethics committee or mechanism of similar standing.
- 24.8 The formation of an ethics committee in all institutions in addition to the National Ethics Committee where researches on humans are undertaken should be encouraged.
- 24.9 The medical care given to, and medical decisions made on behalf of, subjects should always be the responsibility of a qualified medical practitioner.
- 24.10 Each individual involved in conducting a trial should be qualified by education, training, and experience to perform his respective tasks.
- 24.11 Freely given informed consent should be obtained from every subject prior to clinical trial participation.
- 24.12 All clinical trial information should be recorded, handled and stored in a way that allows its accurate reporting, interpretation and verification.
- 24.13 The confidentiality of records that could identify subjects should be protected, respecting the privacy and confidentiality rules in accordance with the applicable regulatory requirements.
- 24.14 Investigation products should be manufactured, handled, and stored in accordance with applicable good manufacturing practice. They should be used in accordance with the approval protocol.
- 24.15 Systems with procedures that assure the quality of every aspect of the trial should be implemented.
- 24.16 Fraudulent practice of clinical research constitutes professional misconduct.

**25. Complementary/alternative treatment modalities**

- 25.1 A medical practitioner utilizing complementary/alternative treatment modalities should ensure that:
- (a) the modality of treatment concerned is ethical, beneficial and safe for the patient;
  - (b) the procedure is carried out in good faith and in the patient's best interest and would yield equal or better results than the conventional treatments available;
  - (c) informed consent has been obtained after the following have been properly explained to the patient:
    - (i) the benefits of the procedure;
    - (ii) the risks of the procedure;
    - (iii) the fact that the procedure is a form of complementary/alternative treatment; and
    - (iv) the prevailing conventional method available;
  - (d) the medical practitioner himself has received relevant and adequate training and is clinically competent in carrying out the treatment; if necessary, he should obtain professional support from qualified persons.
- 25.2 A medical practitioner who utilizes complementary/alternative treatment modalities may be subject to strict review and judgment with reference to the law governing the alternative practice.
- 25.3 A medical practitioner may undertake scientific research related to complementary/alternative treatment modality, provided that the guidelines on clinical research in section 23 are observed.
- 25.4 If a medical practitioner prescribes any health claim substance, which includes any proprietary health food product with or without herbal medicine contents, to his patient, he must make sure that:
- (a) he is not omitting the established conventional methods of treatment;
  - (b) the health claim substance concerned is beneficial and does not cause any harm to the patient;
  - (c) he is acting in good faith and in the patient's best interest;
  - (d) he has explained the efficacy, deficiency and uncertainty of the health claim substance fully to the patient, including but not limited to explaining that it may contain an element for which there is no/insufficient evidence of efficacy; and
  - (e) he does not take advantage of his professional relationship with patients to promote the sale of any health claim substance. In any

event where he or his family has a financial interest in any health claim substance, he should comply with section 15.

## **G. ABUSE OF PROFESSIONAL POSITION**

### **26. Improper personal relationship with patients**

26.1 Any form of sexual advance to a person with whom the medical practitioner has a professional relationship is professional misconduct. The Council takes a serious view of a medical practitioner who uses his professional position to pursue a personal relationship of a sexual nature with his patient or the patient's spouse.

26.2 The practice of medicine often involves a close personal relationship between medical practitioners and their patients, and patients sometimes become emotionally dependent. A medical practitioner must be aware of such a possibility and that to take any advantage of such dependency may be abuse of responsibility and trust. Medical practitioners should exercise special care and prudence in situations which could leave them open to such an allegation.

### **27. Untrue or misleading certificates and similar documents**

27.1 Medical practitioners are required to issue reports and certificates for a variety of purposes (e.g. insurance claim forms, payment receipts, medical reports, vaccination certificates, sick leave certificates) on the basis that the truth of the contents can be accepted without question. Medical practitioners are expected to exercise care in issuing certificates and similar documents, and should not include in them statements which they have not taken appropriate steps to verify.

27.2 A sick leave certificate can only be issued after proper medical consultation of the patient by the medical practitioner. The date of consultation and the date of issue must be truly stated in the certificate, including a certificate recommending retrospective sick leave.

27.3 Any medical practitioner who in his professional capacity gives any certificate or similar document containing statements which are untrue, misleading or otherwise improper renders himself liable to disciplinary proceedings. The signing of blank certificates is prohibited by The Bahamas Medical Council.

27.4 Medical practitioners must not issue more than one original receipt in respect of the same payment. Copy receipts must be clearly

stated to be copies or duplicates. If it is necessary to issue separate receipts for fractions of the payment for a single item of service, it should be clearly stated in each receipt the amount of the full payment and that the receipt is in respect of the part payment only.

## **H. CRIMINAL CONVICTION AND DISCIPLINARY PROCEEDINGS**

### **28. Criminal conviction**

28.2 A medical practitioner convicted of any offence punishable on indictment is liable to disciplinary measures by The Bahamas Medical Council, whether he is sentenced to imprisonment or not. A conviction in itself will invoke the The Bahamas Medical Council's disciplinary measures even if the offence does not involve professional misconduct. However, The Bahamas Medical Council may decide not to hold an inquiry where the conviction has no bearing on the medical practitioner's practice as a registered medical practitioner.

28.3 Of particular concern to The Bahamas Medical Council is offences involving dishonesty (e.g. obtaining money or goods by deception, forgery, fraud, theft), indecent behaviour or violence. Offences which may affect a medical practitioner's fitness to practise (e.g. alcohol or drug related offences) will also be of particular concern to the The Bahamas Medical Council.

### **29. Adverse disciplinary findings by other professional bodies**

Adverse findings on a registered medical practitioner in disciplinary proceedings by other professional regulatory bodies in or outside The Bahamas may likewise invoke the Council's disciplinary procedure.

### **30. Duty to report**

A medical practitioner who has been convicted in or outside The Bahamas in respect of an indictable offence must immediately report such conviction to The Bahamas Medical Council.

## **I. SERIOUS INFECTIOUS DISEASE**

### **31. Prevention**

31.1 Medical practitioners should take adequate precautions when in contact with patients and medical specimens to ensure that the risk of spreading infection to themselves and to others is minimized.

### **32. Patient entitlement**

All patients, including those with serious infectious disease, are entitled to timely and appropriate care, including those whose own lifestyles have caused the infection.

### **33. Confidentiality**

- 33.1 In any given case when it appears that others, i.e. spouses, those close to the patient, other medical practitioners and health care workers, may be at risk if not informed that a patient has a serious infection, the medical practitioner should discuss the situation fully and completely with the patient laying particular stress, in the case of other medical or allied health staff, on the need for them to know the situation so that they may, if required, be able to treat and support the patient. In the case of spouses, or other partners, similar considerations will apply, and the medical practitioner should endeavour also to obtain the patient's permission for the disclosure of the facts to those at risk.
- 33.2 Difficulties may clearly arise if the patient, after full discussion and consideration, refuses to consent to disclosure. If mutual trust between medical practitioner and patient has been established such a case will, hopefully, be rare. In this case, it is covered by the general ethical standards of the profession and the refusal should be respected. Should permission be refused, however, the medical practitioner will have to decide how to proceed, in the knowledge that the decision reached, may have to be justified subsequently. If the welfare of other health workers may be properly considered to be endangered, the Council would not consider it to be unethical if those who might be at risk of infection whilst treating the patient were to be informed of the risk. They in their turn would, of course, be bound by the general rules of confidentiality.
- 33.3 In the exceptional circumstances of spouses or other partners being at risk, the need to disclose the position to them might be more pressing, but here again the medical practitioner should urgently seek the patient's consent to disclosure. If this is refused, the medical practitioner may, given the circumstances of the case, consider it a duty to inform the spouse or other partner.
- 33.4 Medical practitioners involved in the diagnosis and treatment of HIV infection or AIDS must endeavour to ensure that all allied health and ancillary staff, e.g. in laboratories, fully understand their obligations to maintain confidentiality at all times.

## **J. SPECIAL AREAS**

### **34. Religion**

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- 34.1 All religions should be respected in all respects.
- 34.2 The patient's clinical benefit is of the utmost importance. If a medical practitioner, because of his own religious belief, has any objection to a procedure which is beneficial to the patient, he should give a full explanation to the patient and ask the patient to seek advice from another qualified medical practitioner.
- 34.3 Special demands from religious groups concerning medical treatment should be seriously considered.

**35. Care for the terminally ill**

- 35.1 Where death is imminent, it is the medical practitioner's responsibility to take care that a patient dies with dignity and with as little suffering as possible. A terminally ill patient's right to adequate symptom control should be respected. This includes problems arising from physical, emotional, social and spiritual aspects.
- 35.2 Euthanasia is defined as "direct intentional killing of a person as part of the medical care being offered". It is illegal and unethical.
- 35.3 The withholding or withdrawing of artificial life support procedures for a terminally ill patient is not euthanasia. Withholding/withdrawing life sustaining treatment for a terminally ill patient after taking into account the patient's benefits, wishes of the patient and family, and the principle of futility of treatment, is acceptable.
- 35.4 It is important that the right of the terminally ill patient be respected. The views of his relatives should be solicited where it is impossible to ascertain the views of the patient. The decision of withholding or withdrawing life support should have sufficient participation of the terminally ill patient himself, if possible, and his immediate family, who should be provided with full information relating to the circumstances and the medical practitioner's recommendation. In case of conflict, a patient's right of self-determination, once he is in the right state of mind, should prevail over the wishes of his relatives. A medical practitioner's decision should always be guided by the best interest of the patient.
- 35.5 Medical practitioners should exercise careful clinical judgment and whenever there is disagreement between medical practitioner and patient or between medical practitioner and relatives, the matter should be referred to the ethics committee of the hospital concerned or relevant authority for advice. In case of further doubt, direction from the court may be sought, as necessary.

35.6 Medical practitioners may seek further reference from the Public Hospitals Authority, The Bahamas Medical Association and the relevant colleges in the practice of Medicine in The Bahamas.

**36. Organ transplant and organ donation**

36.1 Medical practitioners should observe the WHO Principles on Human Organ Transplantation. The Bahamas endorses these principles which, in part, prohibit the trafficking of human organs into and outside of territories, including The Bahamas.

36.2 The welfare of the donor in any organ transplant, irrespective of whether he is genetically related to the recipient, should be respected and protected.

36.3 Consent must be given freely and voluntarily by any donor. If there is doubt as to whether the consent is given freely or voluntarily by the donor, the medical practitioner should reject the proposed donation.

36.4 In the case of referral of the recipient to a place outside The Bahamas for an organ transplant from any donor, it is unethical for a medical practitioner to make the referral without ascertaining the status of the donor or following these principles.

**37. Pre-natal diagnosis and intervention; scientifically assisted reproduction and related technology**

37.1 All human reproductive technology procedures are governed by the Medical Act, 2014 and the National Ethics Committee's requirements. Medical practitioners who perform any human reproductive technology procedure or conduct research on human embryos should ensure that they comply with the Medical Act, 2014 and this Code.

37.2 Medical practitioners performing termination of pregnancy must observe the principles laid down in the laws of The Bahamas. A pregnancy may be terminated only if Consultants who are registered medical practitioners and specialists in obstetrics and gynaecology are of the opinion, formed in good faith, that (a) the continuance of the pregnancy would involve risk to the life of the pregnant woman or of injury to the physical or mental health of the pregnant woman, greater than if the pregnancy were terminated; or (b) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormality as to be seriously handicapped.

37.3 Prenatal screening for common congenital, genetic and chromosomal disorders can be offered as part of antenatal care. The pregnant woman has the right to decline prenatal screening.

- 37.4 Prenatal diagnostic procedures are for the detection and confirmation of foetal diseases. The medical practitioner should ensure that the recommended procedure is reasonably safe and will lead to reliable results. He/she should also balance the risks and benefits of the procedure, and advise the pregnant woman accordingly. The procedure should be performed by appropriately trained specialists following informed consent of the pregnant woman.
- 37.5 The interest of both the pregnant woman and her foetus should be taken into consideration before undertaking any prenatal intervention.
- 37.6 Sex selection for social, cultural or other non-medical reasons should not be performed.
- 37.7 Hence, prenatal diagnosis and subsequent intervention can be justified if the following factors are thoroughly examined:
- (a) indications;
  - (b) nature of the disease;
  - (c) reliability of the diagnosis;
  - (d) risk of the procedure;
  - (e) informed consent.
- 37.8 Termination of pregnancy on ground (b) set out in section 37.2 should be offered only after appropriate counselling to the pregnant woman and, with her consent, her spouse or partner. However, there is no obligation to suggest termination of pregnancy when the diagnosed conditions are amenable to prenatal or postnatal treatment.
- 37.9 Counselling is necessary and the following points should be noted:
- (a) pre-test and post-test counselling by trained personnel of the relevant disciplines should be an integral part of the procedure;
  - (b) proper counselling should be offered to the pregnant woman and, with her consent, her spouse or partner to prepare them for possible physical and psychological sequelae following the disclosure of abnormal results;
  - (c) full information should be disclosed at all stages of counselling. Such information should include facts about the foetal condition and the risks, limitations and reliability of the proposed procedure;
  - (d) parents should be fully respected in their perception and opinion of the severity of the foetal disorders, and a decision on further management of pregnancy should

be made by the parents. The final decision should be that of the pregnant woman.

- 37.10 A medical practitioner is under no obligation to perform termination of pregnancy against his own beliefs or if his views on the severity of the foetal disorder differ from those of the parents. In such situation, he may refer the patient to another medical practitioner for independent consultation as he considers appropriate.

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**APPENDIX A****Guidelines on Signboards and Notices***I. Signboard**Permitted number:*

A medical practitioner is permitted to display:

- (i) up to 2 signboards on or next to the door for immediate access to his clinic; and
- (ii)(a) for a ground floor clinic: one signboard on building exterior below first floor level; or
- (b) for a clinic on other levels: one signboard on building exterior at the floor level of the clinic, and one signboard each at up to 2 building entrances.

*Permitted size:*

The aggregate area of all surfaces (including borders) of a signboard on which information is displayed must not exceed the following size:

- (i) for a signboard on or next to clinic door: 10 square feet;
- (ii) for a signboard below first floor level: 10 square feet;
- (iii) for a signboard at first floor level: 13 square feet;
- (iv) for a signboard above first floor level: 20 square feet.

*Shared signboards:*

The aggregate area of all surfaces (including borders) of a shared signboard on which information is displayed must not exceed the following size, irrespective of its location:

- (i) for a group practice with 2 medical practitioners: 20 square feet;
- (ii) for a group practice with more than 2 medical practitioners: 30 square feet.

Other health care professionals in the same practice may be included in the shared signboards, but they do not count for calculation of the permitted size of the shared signboard.

### *II. Building Directory Boards*

A medical practitioner's entry in common directory boards at building entrances and lobbies must be of the same standard size as all other entries. An entry may be included in each directory board. Only the same information permitted on signboards may be included.

### *III. Directional Notices*

A medical practitioner may display within the building a reasonable number of directional notices to direct patients to his clinic. Each notice (including borders) should not exceed one square foot, and may contain only his name and room number of his clinic. The spirit of section 5.2.3.1 of the Code must be followed.

### *IV. Notice of Clinic Hours*

A medical practitioner may display one notice containing his name and his clinic hours, if the same information is not already included in other signs. The notice (including borders) should not exceed 2 square feet.

**APPENDIX B**

**Sample Commencement/Removal Notice**

Dr. ....

.....

wishes to announce the commencement/relocation of his practice as from

..... (date) .....

\*\*at/to

..... (address) .....

Tel.: ..... Fax:..... Pager: .....

Mobile Phone : ..... E-mail: .....

Consultation Hours: .....

\*\*\*A tea reception will be held at ..... (time) .....

- \* specialist title, qualifications and appointments approved by the Medical Council may be shown
- \*\* delete as appropriate
- \* optional

*\*specialist title, qualifications and appointments approved by The Bahamas Medical Council may be shown*

*delete as appropriate*

*optional*

**APPENDIX C****Guidelines on Service Information Notices**

A medical practitioner may display a Service Information Notice bearing the fee schedules and the medical services provided by him at the exterior of his office. He must ensure that the displayed consultation fees truly reflect his normal charges. He must also ensure compliance with the provisions of section 5.2.1 of the Code governing “Principles and rules of good communication and information dissemination”.

The Service Information Notice must comply with the following guidelines:

*Location of Notices*

At the exterior of the office on or immediately next to the entrance for patients

*Number of Notices*

Maximum number of notices allowed is 2

*Size of Notice**Legal letter size**Format of Notice*

Single colour print

Uniform font size

Plain text only without graphic illustrations

The notice should not be ornate

*Permitted Contents of Notice*

All information presently permitted on signboards and stationery under sections 5.2.3.1 and 5.2.3.2 of the Code

Gender of the medical practitioner

Language(s) spoken

Medical services, procedures and operations provided by the medical practitioner and range of fees

Only those procedures in which the medical practitioner has received adequate training and which are within his area of competency may be quoted

The nomenclatures of procedures and operations should follow those promulgated by The Bahamas Medical Council, whenever such a list is available

Range of consultation fees, or composite fees including consultation and basic medicine for a certain number of days

Affiliated hospitals

Availability of emergency service and emergency contact telephone number

## APPENDIX D

### Guidelines on Medical Practitioner's Directories

A medical practitioner may disseminate his professional service through medical practitioners Directories published by professional medical organizations approved by The Bahamas Medical Council for that purpose.

He must ensure that the published consultation fees truly reflect his normal charges. He must also ensure compliance with the provisions of section 5.2.1 of the Code governing “Principles and rules of good communication and information dissemination”.

A medical practitioners Directory must comply with the following guidelines:-

#### *Parameters of Directory*

- (a) a Directory should be open to all registered medical practitioners;
- (b) medical practitioners may be categorized as specialist practitioners according to their specialties (i.e. practitioners included under the various specialties in the specialist register) and general practitioners;
- (c) each registered medical practitioner should be given the same choice of information for inclusion in the same Directory;
- (d) professional medical organizations fulfilling the following criteria may apply to The Bahamas Medical Council for approval to set up their Directories:
  - (i) an established body which is legally recognized;
  - (ii) non-profit sharing in nature; and
  - (iii) having the objectives of promoting health care and safeguarding the health interests of the community;
- (e) approved organizations are responsible for verifying the accuracy of the information before publication. They should establish a mechanism for regular updating of the published information;
- (f) a medical practitioner providing information for publication in a Directory should ensure compliance with the relevant provisions in the Code.

*Format of Directory*

Directory may be in electronic or printed format.

For printed format, the following rules should apply:

Single colour print

Uniform font size

Plain text only without graphic illustrations

Accentuation of particular entries by bordering, highlighting or otherwise is prohibited

For electronic format, the following rules should apply:

Single and uniform colour font for particulars of individual medical practitioner

Graphic illustrations limited to logos of organizations and those used to access different categories or locations of medical practitioner

Accentuation of particular entries by blinking, bordering, highlighting or otherwise is prohibited

If possible, random listing of same category or location of medical practitioners in each search is advisable

*Permitted Contents of Directory*

All information presently permitted on signboards and stationery under sections 5.2.3.1 and 5.2.3.2 of the Code

District where the office of the medical practitioner is located

Passport-type photograph of the medical practitioner

Gender of the medical practitioner

Language(s) spoken

Medical services, procedures and operations provided by the medical practitioner and range of fees

Only those procedures in which the medical practitioner has received adequate training and which are within his area of competency may be quoted

The nomenclatures of procedures and operations should follow those promulgated by The Bahamas Medical Council, whenever such a list is available

Range of consultation fees, or composite fees including consultation and basic medicine for a certain number of days

Affiliated hospitals

Availability of emergency service and emergency contact telephone number

*Distribution of Directory*

Publishing organizations should distribute their directories widely in order to facilitate public access to the directories. Individual medical practitioners may also make the directory available to the public provided that no particular entries are highlighted, extracted, or drawn to the special attention of readers.

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## APPENDIX E

### Guidelines on Proper Prescription and Dispensing of Dangerous Drugs

#### A. Application of Guidelines

1. This set of guidelines applies to the use of psychotropic drugs, such as methadone (Physeptone), dipipanone (Wellconal), fentanyl (Durogesic, Fentanyl) and benzodiazepines, such as diazepam (Diazemuls, Valium), triazolam (Halcion), flunitrazepam (Rohypnol), midazolam (Dormicum), and other psychoactive agents, such as phentermine (Duromine), ketamine (Ketalar), with known potential for abuse.

(Note: Medical practitioners should be alert to the updating of classification of drugs which will then come within the application of these guidelines.)

2. These guidelines reflect currently accepted professional standards on the use of such agents in the local context, and are intended to provide general guidance to medical practitioners for the promotion of good clinical practice.
3. The Practice Directions under Section (E) should be followed. Breach of these directions may be construed as improper use of dangerous drugs.

#### B. General Principles

1. The medical practitioner should be familiar with updated knowledge and guidelines on the use of dangerous drugs.
2. The medical practitioner should abstain from prescribing at the sole request of the patient any psychoactive drug that is not medically justified by his/her condition.
3. Psychoactive drugs with potential for abuse should be prescribed with due caution in order to avoid abuse and/or iatrogenic dependence.
4. Such drugs should only be prescribed after proper clinical assessment and diagnosis.
5. These drugs should be prescribed only in the dose and for the duration as necessary for the clinical condition being treated.
6. Simultaneous use of multiple psychoactive agents should be properly assessed and justified. Justification should be clearly documented.
7. The prescription, dispensing and/or administration of such drugs should be carefully organized so as to avoid stock piling, resale or other inappropriate use by the patient.
8. An adequate and proper medical record should always be kept concerning the treatment provided to the patient.

9. Special clinical problems deserve expert advice. Appropriate referral to specialists or programmes should always be considered.
10. All medical practitioners should comply with all the provisions in the Dangerous Drugs Ordinance and Regulations.

C. Use in Drug Dependence

Medical practitioners who use opioids or other psychoactive agents for the management of patients dependent on such drugs should ensure the following:

1. They should have relevant training or experience in the management of drug dependence.
2. They should keep themselves updated with relevant guidelines/information published by appropriate professional bodies
3. Adequate resources and support are made available to provide a comprehensive care, including physical, psychological, and social aspects, for their patients.
4. Patients dependent on psychoactive agents should be ensured attentive and conscientious care by the attending medical practitioner. Medical practitioners must know their limitations.
5. In every case, the attending medical practitioner should assess the patient thoroughly, formulate a suitable management plan, keep an adequate medical record concerning the treatment provided to the patient and monitor the outcome.

D. **High-Volume Consumption**

Significant social harm can be caused by abuse of psychoactive drugs supplied by medical practitioners or the inadvertent flow of such drugs into the “black market”. These are especially prone to occur, when such drugs are used in large quantities on out-patient basis in non-programme settings. To fulfil our social obligation and to avoid disrepute to our profession, the following measures are considered essential for all medical practitioners regularly prescribing large quantities of psychoactive agents:

1. The use of psychoactive agents should be reviewed regularly to ensure that their use meets the standards as stipulated in sections B and C. In every case, the use or continued use of such drugs should be adequately accounted for. These drugs should be withdrawn appropriately wherever their use is considered ineffective, inappropriate, or unnecessary.
2. Careful measures should be taken to guard against abuse of psychoactive drugs so supplied. Examples of such measures may include:

- (i) regular follow-up assessment, preferably monthly. Exceptions with appropriate justification could be allowed;
  - (ii) minimize the quantity of drugs dispensed per visit, bearing in mind that the practitioner has the responsibility to decide the proper medication with appropriate duration. The duration should not exceed one month although exceptions with appropriate justification could be allowed;
  - (iii) detail record of justification and prescription;
  - (iv) direct supervision of drug-taking where possible;
  - (v) random urine checking (for opioid dependence);
  - (vi) other measures as appropriate, e.g. referral to appropriate specialists (e.g. to pain clinic for patients in chronic pain), regular checking of unfinished drugs.
3. If a medical practitioner is not satisfied with the measures he has taken in relation to D.1 and D.2, he should seek advice and assistance from The Bahamas Medical Council. Continued use of large quantities of psychoactive agents cannot be accepted as proper medical practice, unless reasonable measures have been taken against possible abuse.

#### **E. Practice Directions for Selected Agents**

The following Practice Directions for selected agents should be followed:

1. Practice Directions for use of benzodiazepines
  - (a) initial assessment of the patient should include:
    - (i) proper history and examination;
    - (ii) appropriate investigation;
    - (iii) proper diagnosis and/or diagnostic formulation;
    - (iv) education and counselling;
  - (b) patients on benzodiazepines should be informed of the following:
    - (i) drugs are only part of the management plan;
    - (ii) drug dependence is likely to occur with improper use;
    - (iii) various adverse effects, which include impairment of the performance of skilled tasks and driving;
    - (iv) interactions with drugs and alcohol are potentially dangerous;
  - (c) the lowest effective dose which can control the symptoms should be used;
  - (d) in general, initial prescription and/or dispensing of benzodiazepines should be kept to the minimum appropriate dosage and duration;

- (e) for repeated and/or prolonged prescription, there should be a clearly documented management plan;
  - (f) if the duration of initial treatment is likely to be prolonged, the patient should be properly reassessed periodically. Alternative methods of therapy, if any, may be offered. In case of clinical problems which cannot be adequately dealt with, expert advice should be sought, or patients be referred to appropriate specialists or programmes;
  - (g) benzodiazepines should be prescribed with caution especially to patients under 18 and the elderly in which cases the prescribing medical practitioner should fully justify the use. Such justification should be documented;
  - (h) caution should be exercised in the use of benzodiazepines in the treatment of major depression;
  - (i) caution should be exercised in prescribing benzodiazepines for patients where there is a history or evidence of substance abuse (particularly alcohol or sedative-hypnotic drugs);
  - (j) caution should be exercised in the use of benzodiazepines for bereavement-related problems. A tapering-off regime should be used to minimize benzodiazepine withdrawal symptoms;
  - (k) simultaneous use of multiple benzodiazepines should be prescribed with caution and its justification should be documented;
  - (l) an adequate and proper medical record should be kept concerning the treatment provided to the patient;
  - (m) in addition the medical practitioner shall comply with all the provisions in the Dangerous Drugs Act.
2. Practice Directions on the use of substitute drugs for drug dependence
- (a) initial assessment of the patient should include:
    - (i) proper history and examination;
    - (ii) appropriate investigation;
    - (iii) proper diagnosis and/or diagnostic formulation;
    - (iv) education and counseling;
    - (v) promotion of detoxification programmes;
  - (b) the medical practitioner should inform patients of other treatment modalities available in the community before putting them on long-term maintenance therapy;
  - (c) treatment of opioid dependence should be prescribed only after accurate diagnosis. There should be a proper documented management plan given to the patient and accordingly recorded. In

the management plan for the use of substitute drugs for opioid dependence, holistic care is important and success of therapy is highly dependent on the trust between the medical practitioner and the patient;

- (d) the attending medical practitioner should ensure that he/she is fully competent to provide proper care of patients under his/her care. Specific training in the management of drug dependence is strongly encouraged for all medical practitioners involved in such work;
- (e) the patient should be informed that drugs are only part of the management plan, and should be put in touch with available support for proper social and psychological management;
- (f) the patient should be warned of risks of concurrent heroin/drug use. He should be informed of the need for random urine checking;
- (g) the prescription, dispensing and/or administration of substitute drugs should be organized in such a way as to avoid stock piling by the patient, resale or other illicit usage. The minimum amount of such substitute drugs as necessary should be supplied;
- (h) the patient should be regularly monitored, and an adequate and proper medical record should be kept concerning the treatment given to the patient;
- (i) simultaneous use of other psychoactive agents should be justified and used with caution. Clear documentation is required;
- (j) in addition the medical practitioner shall comply with all the provisions in the Dangerous Drugs Act.

## APPENDIX F

## Dangerous Drugs Register

Date of receipt/ supply	Name and address of person* or firm from whom received/to whom supplied	Patient's identity card number* *	Amount		Invoice No.	Balance
			received	supplied		

\*The name and address of a patient to whom dangerous drug is supplied may be replaced by the reference number of the patient's treatment record, provided that the patient's name and address are entered in the treatment record.

**Note:**

1. A separate register or a separate part of the register is required for each dangerous drug at each set of premises. A register cannot be used for recording any other matter.
2. A register shall at all times be kept at the premises to which it relates. The register, the stock and the documents related to any dealings in dangerous drug shall be available for inspection by authorized officers.
3. Only one register is allowed to be kept in respect of the same dangerous drug at the same premises, except with the approval of the Chief Medical Officer for different departments of the business.

4. The dangerous drug must be specified at the top of each page.
5. Each entry shall be made in chronological sequence, on the day of receipt by the medical practitioner or supply to a patient of the dangerous drug (unless it is not reasonably practicable to do so, in which case the entry must be made on the following day at the latest).
6. All 6 columns in the register must be filled in for each entry.
7. Each entry shall be made in ink or other indelible form. Therefore, a register stored electronically in a computer will not fulfill the requirement.
8. No cancellation, obliteration or alteration is allowed. Any correction can only be made by a marginal note or footnote specifying the date of the correction.

**APPENDIX G****WHO Principles on Human Organ Transplantation****Prohibition from dealings in human organs**

- (1) A person is guilty of serious professional misconduct where that person:
  - (a) makes or receives any payment for the supply of, or for an offer to supply;
  - (b) seeks to find a person willing to supply for payment, or offers to supply for payment; or
  - (c) initiates or negotiates any arrangement involving the making of a payment for the supply of, or for an offer to supply,  
an organ which has been or is to be removed from a dead or living person, whether in The Bahamas or elsewhere, and is intended to be transplanted into another person, whether in The Bahamas or elsewhere.
- (2) A person is guilty of serious professional misconduct where that person takes part in the management or control of a body of persons corporate or unincorporated whose activities consist of or include the initiation or negotiation of any arrangements referred to in subsection (1)(c).
- (3) Without prejudice to subsection (1)(b), a person is guilty of serious professional misconduct where that person causes to be published or distributed, or knowingly publishes or distributes an advertisement:
  - (a) inviting persons to supply for payment an organ which has been or is to be removed from a dead or living person, whether in The Bahamas or elsewhere, and is intended to be transplanted into another person, whether in The Bahamas or elsewhere, or offering to supply any such organ for payment; or
  - (b) indicating that the advertiser is willing to initiate or negotiate an arrangement referred to in subsection (1)(c).
- (4) In this section “advertisement” includes any form of advertising whether to the public generally, to any section of the public or individually to selected persons.
- (5) A person is guilty of serious professional misconduct where, in The Bahamas, that person transplants an organ into a person and he knew or ought, after reasonable inquiry, to have known that a payment was or was to be made for supplying the organ, regardless of where the payment was made and, where the payment was not made in The Bahamas, regardless of whether or not such payment was prohibited under the laws of the country where the payment was made.

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- (6) A person is guilty of serious professional misconduct where that person imports an organ for the purpose of:
- (a) having it transplanted into a person in The Bahamas; or
  - (b) exporting it to a country where it is intended that it be transplanted into a person,
- and he knew or ought, after reasonable inquiry, to have known that a payment was or was to be made for supplying the organ, regardless of whether or not such payment was prohibited under the laws of the country where the payment was made.
- (7) A person is guilty of serious professional misconduct where, in The Bahamas, that person removes from a dead or living person an organ intended for transplant into another person, whether in The Bahamas or elsewhere, and he knew or ought, after reasonable inquiry, to have known that a payment was or was to be made for that organ.

## APPENDIX H

### Core General Standards of the American Telemedicine Operations<sup>1</sup>

#### Administrative Standards

##### Organizations

1. Organizations providing services via telehealth shall follow the standard operating policies and procedures of the governing institution. If the telehealth operation is a sole entity or part of a solo practice, that entity or solo practice shall have policies and procedures in place to govern all administrative functions that responsibly include and address aspects of telehealth with regards to:
  - (a) human resource management;
  - (b) privacy and confidentiality
  - (c) government and other credentialing and regulatory agency requirements;
  - (d) fiscal management;
  - (e) ownership of patient records;
  - (f) documentation;
  - (g) patient rights and responsibilities;
  - (h) network security;
  - (i) telehealth equipment use;
  - (j) research protocols.
  
1. Organizations providing telehealth programs shall have in place a systematic quality improvement and performance management process that complies with any organizational, regulatory, or accrediting, requirements for outcomes management.
2. Organizations and health professionals providing telehealth services shall ensure compliance with relevant legislation, regulations, and accreditation requirements for supporting patient/client decision-making and consent, including protection of patient health information.
3. Organizations shall have a mechanism in place for assuring that patients are aware of their rights and responsibilities with respect to accessing health care via telehealth technologies, including the process for communicating complaints.

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<sup>1</sup>These Core General Standards of the American Telemedicine Operations has been adopted by The Bahamas Medical Council with modifications.

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4. Organizations shall integrate telehealth into the existing operational procedures for obtaining consent for treatment from patients; and organizations shall provide a mechanism for additional informed consent when required for invasive procedures.
5. Organizations providing telehealth services that establish collaborative partnerships shall be aware of applicable legal and regulatory requirements for appropriate written agreements, memorandum of understanding, or contracts. Those contracts, agreements, etc., shall be based on the scope and application of the telehealth services offered, and, shall address all applicable administrative, clinical, and technical requirements.

### **Health Professionals**

1. Health professionals providing telehealth services shall be fully licensed and registered with their respective regulatory/licensing bodies and with respect to the site where the patient is located, administrative, legislative, and regulatory requirements.
2. Professionals providing telehealth services shall be aware of credentialing requirements at the site where the consultant is located and the site where the patient is located, in compliance with and when required by regulatory and accrediting agencies.
3. Health professionals shall be aware of their locus of accountability and any/all requirements (including those for liability insurance) that apply when practicing telehealth in another jurisdiction.
4. Health professionals using telehealth shall be cognizant of when a provider-patient relationship has been established within the context of a telemedicine encounter between the health care provider and the patient, whether interactive or store-and-forward, and proceed accordingly with an evidence-based, best possible standard of care.
5. Health professionals providing telehealth services shall have the necessary education, training/orientation, and ongoing continuing education/professional development to ensure they possess the necessary competencies for the safe provision of quality health services in their specialty area.

### **Clinical Standards**

1. The organization and health professionals shall be satisfied that health professionals providing care via telehealth are aware of their own professional discipline standards and those standards shall be upheld in the telehealth encounter, considering the specific context, location and timing, and services delivered to the patient.
2. Health professionals shall be guided by professional discipline and national existing clinical practice guidelines when practising via

telehealth, and any modifications to specialty specific clinical practice standards for the telehealth setting shall ensure that clinical requirements specific to the discipline are maintained.

### **Technical Standards**

1. Organizations shall ensure that equipment sufficient to support diagnostic needs is available and functioning properly at the time of clinical encounters.
2. Organizations shall have strategies in place to address the environmental elements of care necessary for the safe use of telehealth equipment.
3. Organizations shall comply with all relevant safety laws, regulations, and codes for technology and technical safety.
4. Organizations shall have infection control policies and procedures in place for the use of telehealth equipment and patient peripherals that comply with organizational, legal, and regulatory requirements.
5. Organizations providing telehealth services shall have policies and procedures in place to comply with local legislated and regulatory rules for protection of patient health information and to ensure the physical security of telehealth equipment and the electronic security of data.
6. Organizations shall have appropriate redundant systems in place that ensure availability of the network for critical connectivity.
7. Organizations shall have appropriate redundant clinical video and exam equipment for critical clinical encounters and clinical functions.
8. Organizations shall meet required published technical standards for safety and efficacy for devices that interact with patients or are integral to the diagnostic capabilities of the practitioner when and where applicable.
9. Organizations providing telehealth services shall have processes in place to ensure the safety and effectiveness of equipment through on-going maintenance.

**Made this                      day of                      , 2014.**

**Minister responsible for Health**