

Good Surgical Practice

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The Association of Surgeons of Great Britain and Ireland
The British Association of Paediatric Surgeons
The British Association of Plastic Surgeons
The British Association of Oral and Maxillofacial Surgeons
The British Association of Otorhinolaryngologists – Head and Neck Surgeons
The British Association of Urological Surgeons
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The duties of a doctor registered with the General Medical Council

Patients must be able to trust doctors with their lives and wellbeing. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care and to show respect for human life. In particular as a doctor you must:

- make the care of your patient your first concern;
- treat every patient politely and considerately;
- respect patients' dignity and privacy;
- listen to patients and respect their views;
- give patients information in a way they can understand;
- respect the rights of patients to be fully involved in decisions about their care;
- keep your professional knowledge and skills up to date;
- recognise the limits of your professional competence;
- be honest and trustworthy;
- respect and protect confidential information;
- make sure that your personal beliefs do not prejudice your patients' care;
- act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise;
- avoid abusing your position as a doctor; and
- work with colleagues in the ways that best serve patients' interests.

In all these matters you must never discriminate unfairly against your patients or colleagues. And you must always be prepared to justify your actions to them.

Good Medical Practice. GMC, 2001.

Introduction

Good Surgical Practice sets standards for surgeons. The standards are intended to be reasonable, assessable and achievable by all competent surgeons and they complement those required of all doctors by the General Medical Council as set out in *Good Medical Practice* (GMC, 2001). *Good Surgical Practice* uses the seven headings that appear in *Good Medical Practice* and is the surgical companion to the GMC document.

Good Surgical Practice is primarily written for all surgeons, both career grade and trainee, working within and outside NHS practice. However, it is also presented for the benefit of patients. It is anticipated that the standards set out in the document may be used by surgeons to confirm their good practice and also by those who may have to make judgements about surgeons' performance. *Good Surgical Practice* may be used as a framework for providing evidence for appraisal and revalidation based on the criteria and standards in *Good Medical Practice*.

It is recognised that good surgical practice depends not only on the personal attributes of the surgeon but also on effective teamworking and adequate resources and time. All surgeons are responsible for the standards of clinical care they offer to patients and should bring to the attention of their employing authority any deficiencies in resources that impact on the safety of their patients.

It is acknowledged that a document of this kind may be seen as being either too prescriptive or ambiguous. It is for surgeons to reflect on their practice and work to the standards set out in this document.

Good surgical practice: clinical governance, appraisal and revalidation

- Clinical governance: this can be defined as a framework through which the NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (*A First Class Service – Quality in the New NHS*. Department of Health, 1998). Clinically focused practice depends on the governance of clinicians by clinicians. The process is supported by the chief executive of the Trust who is required to confirm and facilitate the process and is individually legally accountable for the service provided in the Trust. Similar arrangements should exist in the independent sector.
- Appraisal: this process gives surgeons an opportunity to formally discuss their professional roles and clinical practice (*Supporting Doctors, Protecting Patients*. Department of Health, 1999). Its dual role is to improve on good performance and also to recognise poor performance at an early stage. A national appraisal scheme was introduced in 2001 and is now a contractual requirement for all consultants working in the NHS. Consultants who practice both in the NHS and the private sector have the opportunity to submit their private practice activity as part of their NHS appraisal. Consultants in independent practice who do not have an NHS contract will need to make independent arrangements for appraisal.

Appraisal is based on the seven core headings set out in *Good Medical Practice* (GMC, 2001) which sets out the standards required of all doctors:

- 1 Good clinical care.
- 2 Maintaining good medical practice.
- 3 Relationships with patients.
- 4 Working with colleagues.
- 5 Teaching and training.

6 Health.

7 Probity.

Each of these headings is addressed within this document.

- Revalidation: the General Medical Council will introduce revalidation. It will be based on evidence that the seven core headings of *Good Medical Practice* are being met by the surgeon. All doctors must be able to demonstrate that they continue to be fit to practise in their chosen field.

Further information on appraisal and revalidation

The General Medical Council and Departments of Health in England, Scotland and Wales have a website which is designed as a support tool to guide and assist doctors with the processes of appraisal and revalidation at www.revalidationuk.info/.

1 Good clinical care

1.1 Providing a good standard of surgical practice and care

In meeting the standards set out in *Good Medical Practice* 2001, surgeons must provide good clinical care by:

- ensuring that patients are treated according to the priority of their clinical need
- communicating compassionately and clearly with patients and, with the patient's consent, with their supporters* and, in the case of children, with their parent(s)/responsible adult(s)
- carrying out surgical procedures in a timely, safe and competent manner
- providing elective care for patients with non-urgent conditions and carrying out procedures on them that lie within the range of the surgeons' routine practice
- ensuring patients are cared for in an appropriate and safe environment that takes into account any special needs they may have
- ensuring that adequate resources are available for safe patient care and postponing planned procedures if they are not. If patient safety may be compromised by a lack of resources, this must be recorded by the surgeon and communicated to the chief executive and medical director
- ensuring patients receive satisfactory postoperative care and that relevant information is promptly recorded and shared with the caring team, the patient and their supporter(s)

*The word supporter is used throughout this document to refer to the relative, carer or friend who has been identified by the patient as someone with whom they wish to share information about their treatment/operation. Information should only be shared with the supporter with the patient's consent (see section 4.1). The name of the supporter should be recorded clearly in the patient's notes.

- ensuring that, on the discharge of a patient from hospital care, appropriate information is shared with the patient and/or their carer(s)
- ensuring that any instruction to withhold or withdraw treatment (for example, resuscitation categorisation) is taken in consultation with the patient or family and authorised by the appropriate senior clinician (see *Withholding and Withdrawing Life Prolonging Treatments: Good Practice in Decision Making*. GMC Standards Committee draft guidance, 2001)
- accepting patients on referral from general practitioners, consultant colleagues or as an emergency through the accident and emergency department. If a surgeon agrees to see a patient directly without referral, the patient should be informed that the general practitioner will normally receive a report
- utilising the knowledge and skills of other clinicians and transferring the patient, when appropriate, to another colleague or unit where the required resources and skills are available
- being aware of current clinical guidelines in their field of practice and the advice they contain. Surgeons should explain to patients the reasons for not following such guidance if an alternative course of clinical management is undertaken; and
- discussing with patients and their supporters alternative forms of treatment, including non-operative care and recording the reasons for their decisions.

1.2 The treatment of emergencies

Emergency care is a major component of surgical practice.

When on-call, surgeons must:

- accept responsibility for the assessment and continuing care of every emergency patient admitted under their name unless, or until, they are formally transferred to the care of another doctor
- be available either within the hospital or within a reasonable distance of the hospital to give advice throughout the duty period
- ensure they are able to respond promptly to a call to attend an emergency patient
- be aware of protocols for the safe transfer to another unit of emergency patients when the complexity of the patient's condition is beyond the experience of the admitting surgeon or the resources available for their proper care
- delegate assessment or emergency surgical operations only when they are sure of the competence of those trainees and non-consultant career grades to whom the patient's operative care will be delegated
- ensure that on-call rotas are published in advance and that any alternative cover arrangements are specifically made and clearly understood; and
- ensure the formal handover of patients to an appropriate colleague following periods on duty.

In an emergency, unfamiliar operative procedures should be performed only if there is no clinical alternative, if there is no more experienced colleague available or if transfer to a specialist unit is considered a greater risk.

1.3 Working with children

Surgeons must:

- treat children only if they have the appropriate training and ongoing experience in the clinical care of children in their specialty, except in the case of an emergency
- communicate with parent(s)/responsible adult(s) and with the child to the level of their understanding; and
- protect the child's privacy.

1.4 Organ and tissue transplantation

Surgeons undertaking organ or tissue transplantation must:

- comply with current laws and ethics (see *The Surgeon's Duty of Care*. The Senate of Surgery of Great Britain and Ireland, 1997. pp. 23-25) and follow the guidance set out in *Towards Standards for Organ and Tissue Transplantation in the UK*. The British Transplantation Society, 1998
- choose recipients solely on the basis of medical suitability
- fully inform recipients of hazards and likely outcome when gaining informed consent
- fully inform living donors of risks and outcome to themselves and of the benefits and risks for the recipient. Living organ donation must never be acquired by coercion or for profit; and
- when using cadaver donors or other tissue, conform to current regulations regarding, for example, prior agreement, assent of relatives and certification of brain death.

Draft guidance and a series of consent forms produced by the NHS Executive covering the removal, retention and use of human organs can be found at www.doh.gov.uk/organretention/.

1.5 Record keeping

Surgeons must:

- Ensure all medical records are legible, complete and contemporaneous and have the patient's identification details on them.
- Ensure that when members of the surgical team make case-note entries they are dated and legibly signed, and timed where the clinical condition is changing.
- Record the name of the most senior surgeon seeing the patient at each postoperative visit.
- Ensure that a record is made by a member of the surgical team of important events and communications with the patient or supporter (for example, prognosis or potential complication). Any change in the treatment plan should be recorded.
- Ensure that there are legible operative notes (typed if possible) for every operative procedure. The notes should accompany the patient into recovery and to the ward and should be in sufficient detail to enable continuity of care by another doctor. The notes should include:
 - date and time
 - elective/emergency procedure
 - the names of the operating surgeon and assistant
 - the operative procedure carried out
 - the incision
 - the operative diagnosis
 - the operative findings
 - any problems/complications
 - any extra procedure performed and the reason why it was performed
 - details of tissue removed, added or altered
 - identification of any prosthesis used, including the serial numbers of prostheses and other implanted materials
 - details of closure technique
 - postoperative care instructions; and
 - a signature.

- Ensure that follow-up notes are sufficiently detailed to allow another doctor to assess the care of the patient at any time.

2 Maintaining good surgical practice

All surgeons must maintain their knowledge base and performance by:

- keeping up to date with the relevant literature
- attending and contributing to regular meetings with colleagues in the same and related specialties
- attending multidisciplinary meetings with, for example, pathologists, radiologists, oncologists and other physicians
- fulfilling the continuing professional development (CPD) requirements of the Senate of Surgery and registering this with their college; and
- establishing and maintaining an up-to-date and valid portfolio.

2.1 Maintaining your performance

All surgeons must:

- take part in annual appraisal
- take part in national enquiries and audits, for example, the National Confidential Enquiry into Perioperative Deaths (NCEPOD) and the Scottish Audit of Surgical Mortality (SASM); and
- take part in regular morbidity/mortality and audit meetings.

All surgeons should:

- be aware of their immediate results and participate in the audit of the long-term outcomes of operations
- be aware of the results obtained by peer groups and seek advice from colleagues if there is a major discrepancy
- share their results through the audit process
- keep an accessible record of their surgical activity complying with the Data Protection Act 1998; and
- recognise when they are unfit to work through fatigue, illness or the influence of alcohol or drugs.

2.2 Adverse events*

Surgeons should inform patients of any adverse events that occur during their care, report the event to the responsible officer of the Trust and, if considered necessary, to:

- a local audit meeting, then;
- the National Patient Safety Agency.

All surgeons must be aware of the 'alert' and 'hazard' notices issued by the Medical Devices Agency (MDA). Adverse incidents arising from the failure of medical devices must be reported to the MDA (www.medical-devices.gov.uk/).

*In the context of NHS patients, National Patient Safety Agency draft guidance defines the term 'adverse patient incidents' as 'any event or circumstance arising during NHS care that could have or did lead to unintended or unexpected harm, loss or damage'.

2.3 New techniques

New techniques include:

- a new or personally developed operation
- any major modifications to an established procedure; and
- the introduction of a procedure not previously performed in the Trust.

When a new technique is to be used, the patient's interests should be considered paramount. Therefore, surgeons must:

- first discuss the technique with colleagues who have relevant specialist experience and the medical/clinical director
- follow local protocols with regard to local ethics committee approval
- contact the Safety and Efficacy Register of New Interventional Procedures (SERNIP) at the National Institute for Clinical Excellence (NICE) to learn the status of the procedure and/or to register it
- liaise with the relevant specialist association if appropriate
- ensure that patients and their supporters know when a technique is new before seeking consent and that all the established alternatives are fully explained prior to recording their agreement to proceed
- be open and transparent regarding the sources of funding for the development of any new technique
- audit outcomes and review progress with a peer group
- where possible, obtain necessary training in the new technique
- enable the training of other surgeons in this new technique; and
- ensure that any new device complies with European standards and is certified by the competent body.

3 Teaching, training and supervising

Surgeons have responsibilities for creating a learning environment suitable for teaching, training and supervising students, trainees and others. Individuals with whom trainees can legitimately share concerns should be identified.

3.1 Medical students

Surgeons should:

- explain to patients that they have the right to refuse to participate in student teaching and reassure patients that such a refusal will not prejudice their treatment in any way
- ensure that students are introduced to patients
- ensure that privacy and confidentiality are maintained and that students understand and respect this requirement; and
- ensure that when a student is involved in specific examinations or procedures on patients under general anaesthesia, consent has been obtained giving the full extent of the student's involvement.

Further reading

The Doctor as a Teacher. GMC, 1999.

3.2 Surgical trainees

Consultant surgeons must accept overall responsibility for any duties that are delegated to a trainee or other doctor.

Surgeons should:

- delegate duties and responsibilities only to those registrars, house officers or other doctors whom they know to be competent in the relevant area of practice
- indicate to trainees when more senior advice and assistance should be sought
- be present throughout an operation until they are satisfied that the trainee is competent to carry out the procedure without immediate supervision
- when on duty, be available to advise/assist the trainee at all times unless specific arrangements have been made for someone else to deputise
- ensure that the trainee maintains an up-to-date portfolio that complies with the Data Protection Act 1998 that is accurate, legible and frequently updated
- attend a *Training the Trainers* course, or equivalent, and an approved course in appraisal skills if undertaking the role of supervisor or trainer of any junior doctor
- take reasonable steps to ensure that the trainee is fit to undertake their responsibilities particularly with reference to fatigue, ill health or the influence of alcohol or drugs; and
- ensure that assessment and appraisal of trainees is carried out regularly, thoroughly, honestly, openly and with courtesy.

3.3 Non-consultant career grade surgeons

Surgeons should:

- ensure that non-consultant career grade surgeons are only appointed to standard, recognised grades.

Non-consultant career grade surgeons must:

- perform to the standards detailed in this document
- be accountable for their activities to a named consultant
- identify and agree the extent of their delegated responsibilities with a named consultant including the level of independent activity expected; and
- undertake continuing professional development.

3.4 Locum surgeons

Consultant surgeons practising in the same specialty, or the specialty nearest to that of the locum concerned, must ensure that the locum is:

- fully conversant with the routines and practices of the surgical team
- familiar with, and takes part in, the audit processes of the unit
- not isolated and knows from whom to seek advice on clinical or managerial matters; and
- not required or expected to work outside their field of expertise.

A locum consultant, not on the GMC Specialist Register, must be under the supervision of a substantive consultant in the same specialty

Locum surgeons must perform to the standards detailed in this document.

3.5 Responsibilities of surgical trainees (specialist registrars, senior house officers and pre-registration house officers)

In addition to the requirements of all surgeons set out in this document, trainees must:

- ensure continuity of care for patients for whom they are responsible by formally handing over the patient's care to a responsible colleague at the end of their period of duty
- know which consultant is on-call and seek advice or assistance when appropriate
- understand the importance of seeking advice from someone with more experience
- recognise the circumstances in which they are expected to seek advice and assistance from a more senior member of the team
- be available according to a rota published in advance
- maintain all records relating to their training
- maintain legible and up-to-date clinical records
- support and assist their colleagues, in particular those junior to them
- be prepared to share concerns about possible shortcomings in patient care that they perceive in those with whom they work, whether senior or junior to them
- inform the responsible consultant before a patient is taken to theatre for a major surgical procedure; and
- recognise when they are unfit to work through fatigue, illness or the influence of alcohol or drugs.

4 Relationships with patients

The following principles are laid out in *Good Medical Practice* (GMC, 2001) but are of particular relevance to surgeons.

4.1 Consent

The Department of Health has published a *Reference Guide to Consent for Examination or Treatment* (Department of Health, 2001); available at www.doh.gov.uk/consent. All surgeons must be familiar with the processes and details in this document before seeking agreement to proceed with any intervention. Obtaining consent involves a dialogue between surgeon and patient which leads to the signing of the consent form.

In addition, surgeons should:

- establish whether a patient has a close supporter as early as possible in the relationship and mark this clearly on their notes
- ensure that patients, including children, are given information about the treatment proposed, any alternatives and the main risks, side effects and complications when the decision to operate is made. The consequences of non-operative alternatives should also be explained
- provide time for patients and their supporter(s) to discuss the proposed procedure and provide an opportunity for the patient to make a fully informed and unharassed decision to agree to the treatment suggested and to indicate by signature their willingness to proceed
- carefully consider any 'advance statement' (living will) that the patient may have written
- give the patient the opportunity to indicate any procedure they do not wish to be carried out
- make sure that the patient understands, and is agreeable to, the

participation of students and other professionals in their operation

- gain agreement from the patient if video, photographic or audio records are to be made for purposes other than the patient's records (for example, teaching, research or public transmission)
- follow appropriate guidance for the retention of tissue
- clearly mark the site to be operated on with the patient's agreement while they are awake and prior to pre-medication
- verify the operation to be undertaken by checking the records, consent form and, where possible, with the patient rather than relying solely on the printed operating list for the procedure being performed
- ensure that written consent and the notes include, when appropriate, the side to be operated on using the words 'left' or 'right' in full
- ensure that digits on the hand are named and on the foot numbered and similarly marked with the patient's agreement while they are awake and prior to pre-medication; and
- record all discussions about consent in the patient's records.

Further reading

- 1 *Seeking Patients' Consent: The Ethical Considerations*. GMC, 1999.
- 2 *The Surgeon's Duty of Care*. The Senate of Surgery of Great Britain and Ireland, 1997.
- 3 *Confidentiality: Protecting and Providing Information*. GMC, 2000.

4.2 Consent for transfusion

Surgeons must establish the views held by individual patients regarding their position in relation to transfusion as certain forms of transfusion may be unacceptable.

Further reading

Code of Practice for the Surgical Management of Jehovah's Witnesses. The Royal College of Surgeons of England, 1996. (Only available online at www.rcseng.ac.uk/services/publications).

4.3 Maintaining trust

In addition to abiding by the recommendations of *Good Medical Practice*, surgeons should:

- ensure their working arrangements allow adequate time to listen and properly communicate with patients and their supporter(s). The chief executive and medical director must be informed if there are inadequacies
- fully inform patients and their supporters of the plans and procedures for their treatment, the risks and anticipated outcomes and any untoward developments as they occur, or as soon as possible afterwards
- support any request for a second opinion and give assistance in making the appropriate arrangements
- obtain the patient's verbal consent before carrying out any clinical examination
- support a request by a patient for a third person to be present while they are undergoing a clinical examination
- explain the purpose and nature of any examination of the breast, genitalia or rectum and observe GMC guidance on intimate examinations (www.gmc-uk.org)

- be aware of cultural differences and sensitivities and respect them;
and
- contribute to patient surveys and respond to their findings.

4.4 Communication

All surgeons should:

- listen to and respect the views of patients and their supporters
- listen to and respect the views of other members of the team involved in the patient's care
- recognise and respect the varying needs of patients for information and explanation
- insist that time is available for a detailed explanation of the clinical problem and the treatment options
- encourage patients to discuss the proposed treatment with their supporter(s)
- fully inform the patient and their supporter of progress during treatment
- explain any complications of treatment as they occur and explain the possible solutions; and
- act immediately when patients have suffered harm and apologise when appropriate.

5 Working with colleagues

Apart from exceptional circumstances, surgeons must always make formal arrangements for cover. However, in such exceptional circumstances, surgeons must take responsibility for patients under the care of an absent colleague even if formal arrangements have not been made.

Ineffective team working must not be allowed to compromise patient care.

Surgeons should:

- work effectively and amicably with colleagues in multi-disciplinary teams, attend multi-disciplinary team meetings, share decision making, develop common management protocols where possible and discuss problems with colleagues
- continue to participate in the care of, and decisions concerning, their patients when they are in the intensive care unit or the high dependency unit
- willingly and openly participate in regular appraisal of both themselves and of trainee surgeons and other staff
- always respond to calls for help from trainees and others in the operating theatre and elsewhere as a matter of priority
- ensure there is a formal handover of continuing care of patients to another colleague at the commencement of leave; and
- ensure that, when acting as manager or director, their practice and appraisal processes are subject to the same scrutiny as others.

Further reading

- 1 *Consultant Surgeons – Team Working in Surgical Practice*. The Senate of Surgery of Great Britain and Ireland, 2000.
- 2 *Management of Healthcare: the Role of Doctors*. GMC, 1999. Paragraphs 19-21.

6 Probity in professional practice

Surgeons should adhere to all the principles set out in *Good Medical Practice*. In particular, when providing information surgeons must:

- avoid any material that could be interpreted as designed to promote their own expertise, either in general or in a particular procedure
- declare any commercial involvement that might cause a conflict of interest
- avoid denigrating others
- ensure that the literature provided by the institution where they work and any interview they give to the media does not make unreasonable claims; and
- demonstrate honesty and objectivity when providing references for colleagues and team members.

6.1 Private practice

All surgeons working in the private sector must:

- make arrangements for the continuity of care of any inpatients
- maintain the standard of record keeping as listed in section 1.5 and audit all surgical activity
- be honest in financial and commercial matters relating to work and in particular:
 - ensure that patients are made aware of the fees for their services and cost of any treatment by quoting, where possible, their professional fees in advance
 - inform patients if any part of the fee goes to any other doctor
 - not allow commercial incentives to influence treatment given to a patient
- make clear to patients the limits of care available in any independent hospital used, for example, the level of critical care provision provided and the qualifications of the resident medical cover; and
- if working solely in private practice, enable peer review of their surgical activities and participate in meaningful audit, continuing professional development and appraisal.

Doctors working in England and Wales who are wholly engaged in private practice in premises which are otherwise unregistered must register under the Care Standards Act 2000.

Surgeons who work in both the NHS and the independent sector should:

- undertake similar types of procedures in both
- fulfil their NHS contracted duties; and
- not use NHS staff or resources to aid their private practice unless specific arrangements have been agreed in advance.

6.2 Research

Surgeons who undertake research should:

- submit full protocols of proposed research and details of intended new technical procedures to the research/ethics committee before starting
- treat patients participating in research as partners
- fulfil the regulations of the World Medical Association Declaration of Helsinki (www.wma.net)
- fully inform research participants about aims, intentions, values, relevance, methods, hazards and discomforts and record this in their notes
- fully inform patients in randomised trials about the procedures being compared and their risks and benefits and record this in their notes
- inform participants how their confidentiality will be respected and protected
- accept that a patient may refuse to participate or withdraw during the programme, in which case their treatment must not be adversely influenced
- seek guidance from the ethics committee concerning the need for consent for the use of tissue removed during an operation for research purposes in addition to routine histopathology
- seek permission to remove tissue beyond that excised diagnostically or therapeutically
- acquire specific permission to use any removed tissue for commercial purposes, for example, to grow cell lines or for genetic research
- fulfil the strict regulations of the Animals (Scientific Procedures) Act 1986 when obtaining permission to carry out research on animals
- discourage the publication of research findings in non-scientific media before reporting them in reputable scientific journals or at meetings

- disclose any financial interest in, for example, pharmaceutical companies or instrument manufacturers
- ensure that anything regarding the project that may be published on the internet or elsewhere follows ethical principles; and
- report any fraud that is detected or suspected to the local research/ethics committee.

Further information on research governance can be found at www.doh.gov.uk and on the Scottish Executive website at www.show.scot.nhs.uk/cso.

Further reading

Research: The Role and Responsibilities of Doctors. GMC, 2001

7 Health

Surgeons must not compromise patient safety because of ill health, fatigue or the effects of drugs or alcohol.

Surgical operations place surgeons at particular risk of acquiring and transmitting blood-borne viruses which can cause serious communicable diseases such as hepatitis and HIV (see *Serious Communicable Diseases*. GMC, 1997).

The approximate risks of infection following a single percutaneous exposure are 1:3 for hepatitis B (surface eAg positive), 1:30 for hepatitis C and 1:300 for HIV. In the event of a needlestick injury, surgeons must follow established Trust guidelines.

Surgeons must take precautions and follow established guidelines when operating on high-risk patients.

All surgeons have a duty of care to their patients and must seek advice from an appropriately qualified doctor if they believe they have a serious communicable disease. Surgeons also have a duty of care to inform the appropriate authority if they know of a colleague who may have a serious communicable disease or any illness which is liable to put patients at risk.

Additional guidance: armed conflict, developing countries and prisons

Additional guidance is given for surgeons working in the following circumstances.

Armed conflict

- Ideally, only operate at the request of the patient. If the patient is incapable of giving consent then act only in the patient's best interests
- Do not discriminate between the protagonists. Treat on the basis of clinical need alone
- Within the limitations of the circumstances, maintain the highest professional standards; and
- Take personal precautions consistent with providing the highest level of care.

Developing countries

Those seeking to assist healthcare professionals in developing countries by providing surgical services should aim to do so in the spirit of mutual partnership based on humanitarian service and avoid any patronising or dominant attitudes. This includes humanitarian deployment following natural or man-made disasters.

Surgeons should:

- ensure that whatever is done is for the benefit of the individual and for the local population
- retain the highest standards of care, compatible with the local conditions
- ensure that, as written informed consent may not always be obtainable, the patient understands and voluntarily agrees to the planned procedure. This must always be in the interest of the patient

- adhere to local legal requirements; and
- never participate in mutilating operations.

Research projects should be undertaken with the highest ethical standards and with the full awareness and agreement of the local and national communities and health agencies.

Prisons

The duty of care remains the same when treating prisoners. Surgeons should not condone or contribute to inflicting physical or mental suffering whether deliberately, systematically or wantonly (see *The Surgeon's Duty of Care*. The Senate of Surgery of Great Britain and Ireland, 1997, pp 28-29). Surgeons should report evidence of abuse and deliberate injuries to the appropriate authority.

Further reading

Seeking Consent: Working With People in Prison. Department of Health, 2002

Further reading

Good Medical Practice. General Medical Council. May 2001.

The Surgeon's Duty of Care: Guidance for Surgeons on Ethical and Legal Issues. The Senate of Surgery of Great Britain and Ireland. October 1997.

Maintaining Good Medical Practice. General Medical Council. July 1998.

A First Class Service – Quality in the New NHS. Department of Health. 1998.

Supporting Doctors, Protecting Patients. Department of Health, 1999.

Towards Standards for Organ and Tissue Transplantation in the UK. The British Transplantation Society. 1998.

The Doctor as a Teacher. General Medical Council. September 1999.

Seeking Patients' Consent: The Ethical Considerations. General Medical Council. November 1998.

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British Association of Oral and Maxillofacial Surgeons

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Safety and Efficacy Register of New Interventional Procedures (SERNIP)

All enquiries should be directed to the National Institute for Clinical
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Scottish Audit of Surgical Mortality

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