CODE OF ETHICS

FOR THE NEW ZEALAND MEDICAL PROFESSION (2019)

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Preliminary Statement

The profession of medicine has a duty to maintain and improve the health and wellbeing of the people, and to reduce the impact of disease. Its knowledge and consciousness must be directed to these ends. The medical profession has a social contract with its community. In return for the trust patients and the community place in doctors, ethical codes are produced to guide the profession and protect patients. This document represents a further stage in that evolutionary process.

This document does not purport to set out rigid, immutable rules. It revises the Code of Ethics and provides guidelines endorsed by the Council of the New Zealand Medical Association. The Code will be reviewed at regular intervals and, to this end, comment and feedback is invited.[1]

The basis of the moral framework for medical practice has been developed gradually over several thousand years, and is therefore well established, whereas guidelines for professional behaviour must reflect the changing social and cultural environment in which doctors practise. The moral basis for practice has its expression through what is commonly termed medical ethics. Integral to an ethical basis for professional practice is the overriding acceptance of an obligation to patients,[2] and recognition of their autonomy.

Standard treatises on medical ethics cite four moral principles: autonomy, beneficence, non-maleficence and justice. Autonomy recognises the rights of patients to make decisions for themselves. Beneficence requires a doctor to achieve the best possible outcome for an individual patient, while recognising resource constraints. Non-maleficence implies a duty to do no harm. (This principle involves consideration of risks versus benefits from particular procedures.) Justice incorporates notions of equity and of the fair distribution of resources. In New Zealand, we also recognise the principle of partnership – between doctor and patient; profession and society; and different cultures – as an important aspect of the ethos of professional practice.

The concept of the autonomy of doctors also needs to be considered. Professional autonomy and clinical independence ensure individual doctors have the freedom to exercise their professional judgment in the care and treatment of their patients without undue or inappropriate influence by outside parties or individuals. However, this principle must be tempered with common sense, taking into account the structure of the health system, available resources, ethical rules, professional standards, the evidence base, applicable law, and recognition of the duty to act within the limits of one's own capabilities.

[1] Comments should be sent to: New Zealand Medical Association, PO Box 156, Wellington or nzma@nzma.org.nz

[2] The NZMA strongly favours retention of the word "patient" because it reflects accurately the nature of the relationship between a doctor and the person seeking help.

Doctors have an obligation, where appropriate, to work in collaborative groups, sharing their skills, experience and judgement with others. In today's world, doctors also have an increased ethical responsibility to participate in reviewing their own and others' work to maintain standards of practice. The NZMA recognises no distinction between conventional and alternative medicine when practised by a registered medical practitioner. All treatments should be subject to the same standards in respect of the rigour with which they are subjected to scientific testing and the ethics applicable to their use.

The medical profession wrestles with a widening set of social responsibilities and commercial relationships. An increasing number of statutory and commercial organisations interact with doctors in relation to issues of accountability. Consequently, doctors are experiencing a dilemma in balancing the requirements of their primary obligation to individual patients and families/whānau with their responsibilities to the wider community. Many commercial concepts, including those of intellectual property and contracting with various funding bodies, create risks to aspects of medical organisation and professional practice.

Faced with this complex and changing situation, the New Zealand Medical Association affirms its adherence to certain ethical principles. Patients have a legal right (under the Code of Health and Disability Services Consumers' Rights) to services that comply with ethical standards such as this Code of Ethics. While the Medical Council of New Zealand has developed Good Medical Practice as a foundation document for professional and legal standards, the Council recognises the New Zealand Medical Association's Code of Ethics as the key source of advice on ethics for the medical profession. The Association accepts responsibility for delineating standards of ethical behaviour expected of doctors in New Zealand and has consulted widely in the development of this Code.

The NZMA urges Members and all doctors to follow the standards set out below:

Principles

All medical practitioners, including those who may not be engaged directly in clinical practice, will acknowledge and accept the following Principles of Ethical Behaviour:

1. Consider the health and well-being of the patient to be your first priority.
2. Respect the rights, autonomy, relationships and freedom of choice of the patient.
3. Develop a relationship of trust and avoid exploiting the patient in any manner.
4. Practise the science and art of medicine to the best of your ability with moral integrity, compassion and respect for human dignity.
5. Protect the patient's private information throughout his/her lifetime, and following death, unless there are overriding considerations in terms of public interest or patient safety.
6. Strive to improve your knowledge and skills so that the best possible advice and treatment can be offered to the patient.
7. Adhere to the scientific basis for medical practice while acknowledging the limits of current knowledge and contributing responsibly to innovation and research.
8. Honour the profession, its values and its principles in the ways that best serve the interests of patients.
9. Recognise your own limitations and the special skills of others in the diagnosis, prevention and treatment of disease.
10. Accept a responsibility to assist in the protection and improvement of the health of the community.
11. Accept a responsibility to advocate for adequate resourcing of medical services to assist in achieving optimal and equitable health outcomes across the community.
12. Accept a responsibility for maintaining and improving the standards of the profession.

Recommendations

Given the complexities of doctor-patient relationships, and the increasing difficulties brought about by the need for rationing of resources and direct intervention of third-party providers of funding, no set of guidelines can cover all situations. The following set of recommendations is designed to convey an overall pattern of professional behaviour consistent with the principles set out above in the Code of Ethics.

RESPONSIBILITIES TO THE PATIENT

1. Doctors should ensure that all conduct in the practice of their profession is above reproach. Exploitation of any patient, whether it be physical, sexual, emotional or financial, is unacceptable and the trust embodied in the doctor-patient relationship must be respected.
2. Doctors, like a number of other professionals, are involved in relationships in which there is a potential or actual imbalance of power. Relationships between doctors and their patients or students fall within this category. The NZMA expects doctors to be familiar with Medical Council policy in relation to sexual boundaries in doctor-patient relationships. It is the responsibility of the doctor to maintain appropriate sexual boundaries with their patients.
3. The NZMA considers that breaching sexual boundaries with a current patient is unethical and that, in most instances, a breach of sexual boundaries with a former patient would be regarded as unethical. It is acknowledged that in some cases the patient-doctor relationship may be brief, minor in nature, or in the distant past. In such circumstances and where a sexual relationship has developed from social contact away from the professional environment, impropriety would not necessarily be inferred. Any complaints about a sexual relationship with a former patient therefore need to be considered on an individual basis before being regarded as unethical.
4. Doctors should ensure that patients are involved, as far as possible, in understanding the nature of their problems, the range of possible solutions, and the likely benefits, risks and costs, to assist them in making informed choices.
5. Doctors should, within reason, provide adequate information to their patients about their assessment and treatment options, including those not readily available.
6. Doctors should take reasonable steps to ensure that each patient receives appropriate available investigation into their complaint or condition, including adequate collation of information for optimal management.
7. Doctors should recommend only those diagnostic or screening procedures and treatments which seem necessary to assist in the care of the patient or the management of public health risks.
8. Doctors should ensure that patients are promptly informed of any adverse event that occurs during care for which the doctor has individual or direct overall responsibility.

9. Doctors should access patient health records only when there is an appropriate reason.
10. Doctors should ensure that information is recorded in an accurate and timely manner.
11. Doctors have an obligation to guard against unauthorised access to any health information they have collected pertaining to identifiable patients, including when transferring data.
12. Doctors should keep in confidence information derived from a patient, or from a colleague regarding a patient, and divulge it only with the permission of the patient or in those unusual circumstances when it is clearly in the patient's best interests or there is an overriding public good, including the risk of serious harm to another person. If there is any doubt, doctors should seek guidance from colleagues or an appropriate ethics committee.
13. When appropriate, doctors should 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. Patients should be made aware of this information sharing, which enables the delivery of good quality medical care. Where a patient expressly limits possession of particular information to one practitioner, this must ordinarily be respected. Patients should be made aware in advance, if possible, where there are limits to the confidentiality that can be provided.
14. When it is necessary to divulge confidential patient information without patient consent, this must be done only to the proper authorities, and a record kept of when reporting occurred and its significance. Whenever possible, the patient should be informed this has occurred.
15. Where a doctor is performing an assessment on behalf of a third party, the patient must be clearly informed of the identity of the third party, the purpose of the assessment and the limits of confidentiality. Where the assessment occurs in the context of a treating relationship, the patient should be made aware that the doctor is ethically obliged to provide a complete and professional report.
16. Doctors should recognise the right of patients to choose their doctors freely.
17. Doctors have the right, except in an emergency, to refuse to care for a particular patient. In any situation which is not an emergency, doctors may withdraw from or decline to provide care as long as an alternative source of care is available and the appropriate avenue for securing this is known to the patient. Where a doctor does withdraw care from a patient, reasonable notice should be given and an orderly transfer of care facilitated.
18. When a patient is accepted for care, doctors should render medical service to that person without discrimination (as defined by the Human Rights Act).
19. Doctors should recognise the needs of patients to receive culturally sensitive and competent care.
20. Doctors should ensure that continuity of care is available to all patients, whether seen urgently or unexpectedly, or within a long-term contractual setting, and should assure themselves that appropriate arrangements are available to cover absence from practice or hours off duty, informing patients of these.

21. Doctors should respect the right of a patient to have access to further management in situations where there is a moral or clinical disagreement about the most appropriate course to take.
22. Doctors should recognise their own professional limitations and, when indicated, recommend to patients that additional opinions and services be obtained, and accept a patient's right to request other opinions. In making a referral to another health professional, so far as practical, the doctor should have a basis for confidence in the competence of that practitioner.
23. When requested or when need is apparent, doctors should provide patients with information required to enable them to receive benefits to which they may be entitled.
24. When undertaking remote consultation, a doctor should always exercise their judgement as to whether diagnosis and treatment by this means is appropriate. It is essential that the doctor and patient be able to reliably identify each other when engaging in remote consultation. The interaction should be documented in the patient's clinical record.
25. Doctors must be aware of statutory provisions, the Treaty of Waitangi, the codes of the Privacy Commissioner, the Human Rights Commissioner and the Health and Disability Commissioner, and the requirements of the Medical Council of New Zealand.
26. Doctors should accept that autonomy and relationships of patients remain important in childhood, chronic illness, ageing and in the process of dying.
27. When patients are not capable of making an informed choice or giving informed consent, doctors should consider any previously expressed preferences from the patient, the wishes of the family/whānau, guardian or other appropriate person, and consult colleagues before making management decisions, which may include recourse to the courts for determination.
28. Doctors should always bear in mind the obligation of preserving life wherever possible and justifiable, while allowing death to occur with dignity and comfort when it appears to be inevitable. It is important to recognise the need for every patient to receive adequate support and a sense of their own value, particularly in terminal illness. In such inevitable terminal situations, treatment applied with the primary aim of relieving patient distress is ethically acceptable, even when it may have the secondary effect of shortening life.
29. Doctors should be prepared to discuss and contribute to the content of advance directives and give effect to them. In the case of conflicts concerning management, doctors should consult widely within the profession, with the family/whānau and, if indicated, with ethicists and legal authorities.
30. In relation to transplantation and requests for organ donation, doctors should accept that when death of the brain has occurred, the cellular life of the body may be supported if some parts of the body might be used to prolong or improve the health of others. They should recognise their responsibilities to the donor of organs that will be transplanted by disclosing fully to the donor or relatives the intent and purpose of the procedure. In the case of a living donor, the risks of the donation procedures must be fully explained. Doctors are obliged to provide reassurance and support to all donors

and/or their family/whānau members (in the case of a deceased donor). Doctors should ensure that the determination of death of any donor patient is made by doctors who are in no way concerned with the transplant procedure or associated with the proposed recipient in a way that might exert any influence upon any decisions made.

PROFESSIONAL RESPONSIBILITIES

31. Doctors have both a right and a responsibility to maintain their own health and well-being at a standard that ensures that they are fit to practise.
32. Doctors should seek guidance and assistance from colleagues and professional or healthcare organisations whenever they are unable to function in a competent, safe and ethical manner. When approached in this way, doctors should provide or facilitate such assistance.
33. Doctors should ensure that their personal conduct does not risk adversely affecting their reputation or that of the profession.
34. In general, doctors should not treat themselves or members of their own families. However, it may be indicated to do so in limited circumstances such as in an emergency, or where no other alternative is available.
35. Doctors have a responsibility to assist colleagues who are unwell or under stress. Doctors have a general responsibility for the safety of patients and should therefore take appropriate steps to ensure unsafe or unethical practices on the part of colleagues are curtailed and/or reported to relevant authorities without delay.
36. Doctors should seek to improve their standards of medical care through continuing self-education and thoughtful interaction with appropriate colleagues.
37. Doctors have a responsibility to participate in reviewing their own practice and that of others, and to develop a ~~critical~~ properly informed attitude towards accepted and traditional practices.
38. When appropriate, doctors should make available to colleagues, with the knowledge of the patient, a report or summary of their findings and treatment relating to that patient.
39. When in a team environment, doctors have a responsibility to work co-operatively and respectfully with team members.
40. Doctors should recognise that the doctor/patient relationship has value and should not be disturbed without compelling reasons. Disruption of such a relationship should, wherever possible, be discussed in advance with an independent colleague.
41. Doctors should avoid impugning the reputations of colleagues. In normal circumstances, information about colleagues divulged as a part of quality assurance exercises (including peer groups) should remain confidential.
42. Doctors have an obligation to draw the attention of relevant bodies to inadequate or unsafe services. Where doctors are working within a health service they should first raise issues in respect of that service through appropriate channels, including the organisation responsible for the service, and consult with colleagues before speaking publicly.

43. Doctors should not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, no matter what offence the victim of such procedures is suspected, accused or guilty of.
44. Doctors should not use secret remedies.
45. Advances and innovative approaches to medical practice should be subject to review and promulgation through professional channels (including ethics committees) and medical scientific literature. Doctors should accept responsibility for providing the public with carefully considered, generally accepted opinions when presenting scientific knowledge. In presenting any personal opinion contrary to a generally held viewpoint of the profession, doctors must indicate that such is the case and present information fairly.
46. Doctors should exercise caution when using social media in a professional or private capacity. The risk of boundary violations in this area is considerable. All the ethical obligations set out in this Code, such as confidentiality and appropriate doctor-patient relationships, are applicable to social media.

RESEARCH

47. Before initiating or participating in any clinical research, doctors should assure themselves that the particular investigation is justified in the light of previous research and knowledge. Any proposed study should reasonably be expected to provide the answers to the questions raised. There must be an assessment of predictable risks and burdens in comparison with foreseeable benefits to the participants or to others. All studies involving patients should be subject to the scrutiny of an appropriately constituted ethics committee, which must be independent of the investigator and the sponsor and of any kind of undue influence.
48. Doctors should be assured that the planning and conduct of any particular study is such that it minimises the risk of harm to participants, and every precaution is taken to protect their privacy and personal information. When comparing active treatments, the control group should receive the best currently available and accepted treatment, in accordance with a reasonable body of medical opinion.
49. A placebo-controlled trial may be ethically acceptable, even if an established therapy is available for a certain condition, under the following circumstances:
    - The established treatment has never been demonstrated to be effective by evidence-based criteria; or
    - Where for compelling and scientifically sound methodological reasons its use is necessary to determine the efficacy or safety of a prophylactic, diagnostic or therapeutic method; or
    - Where a prophylactic, diagnostic or therapeutic method is being investigated for a minor condition and the patients who receive placebo will not be subject to any additional risk of serious or irreversible harm; AND

- There must be a robust mechanism for curtailing the trial if at any stage the treatment group is demonstrated (by adequate statistical methods) to be different from the placebo group.

50. Patient consent for participating in clinical research (or permission of those authorised to act on their behalf) should be obtained, where appropriate in writing, only after a full written and verbal explanation of the purpose of that research has been made, and any foreseeable health hazards outlined. Opportunity must be given for questioning and withdrawal at any time. When indicated, an explanation of the theory and justification for double-blind procedures should be given. Acceptance or refusal to participate in, or withdrawal from, a clinical study must never compromise the doctor-patient relationship or access to appropriate treatment. No degree of coercion is acceptable.
51. Research involving subjects who are physically or mentally incapable of giving consent, may be done only if the physical or mental condition that prevents giving informed consent is a necessary characteristic of the research group, and the research is intended to promote the health of the group represented by the potential subject. In such circumstances informed consent must be sought from an appropriate representative. If no such representative is available and if the research cannot be delayed, the study may proceed without informed consent provided that consent to remain in the research must be obtained as soon as possible from the subject or an appropriate representative.
52. For medical research on identifiable human material or data contained in biobanks or similar repositories, informed consent must be sought for its collection, storage and/or reuse. In those exceptional situations where consent would be impossible or impracticable to obtain, the research may be done only after consideration and approval of a research ethics committee.
53. Boundaries between formalised clinical research and various types of innovation have become blurred to an increasing extent. Doctors retain the right to recommend, and any patient has the right to receive, any new drug or treatment which, in the doctor's considered judgement, offers hope of saving life, re-establishing health or alleviating suffering. Doctors are advised to document carefully the basis for any such decisions and also to record the patient’s perception and basis for a decision. In all such cases the doctors must fully inform the patient about the drug or treatment, including the fact that such treatment is new or unorthodox, if that is so.
54. In situations where a doctor is undertaking an innovative or unusual treatment on his or her own initiative, he or she should consult suitably qualified colleagues before discussing it with, or offering it to, patients. Doctors should carefully consider whether such treatments should be subject to formal research protocols.
55. It is the duty of doctors to ensure that the first communication of research results is through recognised scientific channels, including journals and meetings of professional bodies, to ensure appropriate peer review. Participants in the research should also be informed of the results as soon as is practicable after completion.
56. Doctors should not participate in clinical research involving control by the funder over the release of information or results, and should retain the right to publish or

otherwise release any findings they have made. Doctors involved as principals in research should not participate if they do not have access to the base data. Negative as well as positive results should be published or otherwise made publicly available. Any dispute or ethical issue that may arise in respect of the research should be considered openly, eg, by consultation with the appropriate ethics committee.

TEACHING

57. Clinical teaching is the basis on which sound clinical practice is based. It is the duty of doctors to share information and promote education within the profession and the wider healthcare team. Education of colleagues and medical students should be regarded as an ethical responsibility for all doctors.
58. Teaching involving direct patient contact should be undertaken with sensitivity, compassion, respect for privacy, and, whenever possible, with the consent of the patient, guardian or appropriate agent. Particular sensitivity is required when patients are disabled or disempowered, eg, children or those with impaired states of consciousness.
59. Whenever possible, patients should be given sufficient information on the form and content of the teaching, and adequate time for consideration, before consenting or declining to participate in clinical teaching. Refusal by a patient to participate in a study or teaching session must not compromise other aspects of the doctor-patient relationship or access to appropriate treatment.
60. Patients' understanding of, or perspective on, their medical problems may be influenced by involvement in clinical teaching. Doctors should be sensitive to this possibility and ensure that information is provided in an unbiased manner, and that any questions receive adequate answers. It may be appropriate for the doctor to return later to address these issues.

MEDICINE AND COMMERCE

61. Doctors should not allow their standing as medical practitioners to be used inappropriately in the endorsement of commercial products. When doctors are acting as agents for, or have a financial or other interest in, commercial organisations or products, their interest should be declared. If endorsing a product, doctors should use only the proper chemical name for drugs, vaccines and specific ingredients, rather than the trade or commercial name. Any endorsement should be based on specific independent scientific evidence, and that evidence should be clearly outlined.
62. Doctors should accept that their professional reputation must be based upon their ability, technical skills and integrity. Doctors should advertise professional services or make professional announcements only in circumstances where the primary purpose of any notification is factual presentation of information reasonably needed by any person wishing to make an informed decision about the appropriateness and availability of services that may meet his or her medical needs. Any such

announcement or advertisement must be demonstrably true in all respects and contain no testimonial material or endorsement of clinical skills. Qualifications not recognised by appropriate New Zealand statutory bodies should not be quoted.

63. Doctors should exercise careful judgement before accepting any gift, hospitality or gratuity which could be interpreted as an inducement to use or endorse any product, equipment or policy. Doctors must not allow any gifts to influence clinical judgement. In all cases of doubt, advice should be sought from relevant professional organisations.
64. Commercial interests of an employer, health provider or doctor must not interfere with the free exercise of clinical judgement in determining the best ways of meeting the needs of individual patients or the community, nor with the capacities of individual doctors to co-operate with other health providers in the interests of their patients, nor compromise standards of care or autonomy of patients in order to meet financial or commercial targets.
65. Where potential conflict arises between the best interests of particular patients and commercial or rationing prerogatives, doctors have a duty to explain the issues and dilemmas to their patients. Doctors should state quite clearly what their intentions are and why they advocate particular patterns of diagnosis, treatment, referral or resource use. Commercial arrangements that have the potential to impinge on the patient's care should be declared to the patient.
66. Doctors who provide capital towards health services in the private sector are entitled to expect a reasonable return on investment. Where there may be a conflict of interests, the circumstances should be disclosed and open to scrutiny.
67. Like all professionals, doctors have the right to fair recompense for the use of their skills and experience. However, motives of profit must not be permitted to influence clinical judgement.
68. Doctors should insist that any contracts into which they enter, including those involving patients, be written in clear language such that all parties have a clear understanding of the intentions and rules.
69. Doctors who find themselves in a potentially controversial contractual or commercial situation should seek the advice of a suitable colleague or organisation.

MEDICINE AND INDUSTRIAL ACTION

70. It is recognised that certain extreme circumstances may lead to consideration of industrial action by doctors. Such action may compromise care to individual patients, which is contrary to one of the ethical principles, so a decision to take industrial action must be based on a reasonable expectation that the desired outcome will result in improved patient care and safety. A doctor's primary duty is to their patient, but the secondary duty to all other patients may mean that action has to be considered. In the case of industrial action, doctors should take care to minimise any detrimental effect on patient care. Services to preserve life and prevent permanent disability must

always be provided. Self-interest alone, by individuals or the profession, is not an ethical basis on which to take action.

DOCTORS IN A JUST AND CARING SOCIETY

71. Doctors should accept a share of the profession's responsibility toward society in matters relating to the health and safety of the public, health promotion and education, and legislation affecting the health or well-being of the community.
72. Doctors have a role in ongoing efforts to achieve health equity. This includes working collaboratively with public health and other colleagues to shape services and programmes that address health inequities and the broader social and environmental factors that influence health and well-being.
73. While doctors have a primary responsibility to the individual patient, they have a concurrent responsibility to all other patients and the community. Doctors therefore have an ethical responsibility to manage available resources equitably and efficiently. Wherever possible, doctors should use their influence to advocate for appropriate resources to improve health outcomes for their patients and populations.
74. Rationing of resources must be open to public scrutiny and points of conflict identified and presented in a rational, non-biased manner to the public.
75. In an environment of resource constraint, priorities need to be assigned to achieve the wisest use of limited resources. Doctors have a duty to work with others in developing rules to set priorities. Doctors also have a duty to abide by such rules, provided the rules conform to ethical principles. The rules should be just, open, valid and reliable.
76. Doctors should recognise the responsibility to assist courts, commissioners, commissions and disciplinary bodies, in arriving at just decisions. When doctors are providing expert opinions, the doctor has a duty to assist the body impartially on relevant matters and to confine such opinion within their area of expertise.
77. Doctors should certify or give in evidence only that which has been personally verified when they are testifying as to circumstances of fact.

This code will undergo major review by May 2024.

However, minor changes may be introduced before then in response to further alterations in the environment in which medicine is practised. To this end, the NZMA welcomes feedback and comment on this code at any time.

WMA 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 by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005 and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006 and amended by the 68th WMA General Assembly, Chicago, United States, October 2017

The Physician's Pledge

AS A MEMBER OF THE MEDICAL PROFESSION: I SOLEMNLY PLEDGE to dedicate my life to the service of humanity; THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration; I WILL RESPECT the autonomy and dignity of my patient; I WILL MAINTAIN the utmost respect for human life;

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 RESPECT the secrets that are confided in me, even after the patient has died; I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice; I WILL FOSTER the honour and noble traditions of the medical profession; I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due; I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare; I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard; I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat; I MAKE THESE PROMISES solemnly, freely, and upon my honour.