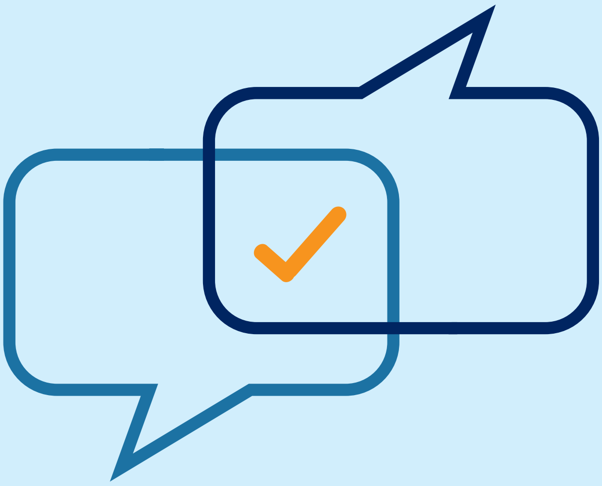
General
Medical
Council



Decision making and consent:

a public consultation on our guidance

Full questionnaire

Consultation runs: 24 October 2018 to 23 January 2019

Working with doctors Working for patients

Your personal information

We will process your data in line with General Data Protection Regulation. Our privacy[*] and cookies policies explain how your data will be used, how cookies will be set and how to control or delete them.

At the end of the consultation process, we will publish reports explaining our findings and conclusions. We won't include any personally identifiable information in these reports, but may include illustrative quotes from consultation responses. We may also provide responses to third parties for quality assurance or to approved research projects, which are anonymised before disclosure where possible.

Freedom of information

Your response to this consultation may be subject to disclosure under the *Freedom of Information Act 2000*, which allows public access to information we hold. This doesn't necessarily mean your response will be made available to the public as there are exemptions relating to information given in confidence and information to which the General Data Protection Regulation applies.

Would you like your response to be treated as confidential?

☐Yes ☒ No

If yes, please also tell us why:

---

[*] www.gmc-uk.org/privacy_policy.asp

Consultation summary

We're updating our guidance on decision making and consent

We're consulting on our revised guidance for doctors on decision making and consent which explains the good practice principles for making decisions about care.

We've worked with a group of doctors, patients, and other health and care professionals to update our guidance, to make sure it's still clear, relevant, consistent with the law across the UK and structured in a way that's easy for doctors to refer to and use.

We're now consulting on the revised guidance and welcome your feedback.

How do I take part?

We welcome responses from anyone with a view on the draft guidance. We've developed this questionnaire for medical and lay professionals who have a detailed working knowledge of the policy, practice and law around consent. **You'll need to read the guidance to complete it.**

We've also developed short versions of this questionnaire for respondents who may not have time to review the guidance in detail:

- **Short questionnaire for doctors, other healthcare professionals** and anyone with a detailed working knowledge of the issues.

- **Short questionnaire for patients, carers and members of the public** with views on decision making and consent.

You can access the questionnaires and the draft guidance on our consultation website[*] and respond online or download the questionnaire and send your completed response by:

- email to gmcconsent@gmc-uk.org or

- post to Consent consultation, Standards and Ethics Team, General Medical Council, Regents Place, 350 Euston Road, London NW1 3JN.

You can also ask for print versions of the guidance and questionnaires using these contact details. If you need these documents in Welsh, or in another format or language, call us on 0161 923 6602 or email us at marketingcommunications@gmc-uk.org.

---

[*] www.gmc-mpts.smartconsultations.co.uk is our consultation website. You must register to take part in a consultation, but can then respond to all future consultations using your log in details.

Background

Good communication and decision making are at the heart of the doctor-patient relationship. But we know it can be challenging to get it right.

Our current *Consent* guidance[*] (originally published in 2008) explains the good practice principles for making decisions about care, from the treatment of minor conditions to major interventions with significant risks or side effects.

Our guidance applies to all doctors registered with us, whatever their grade, specialty or UK location, so it is necessarily high level. It is important that it represents common ground between the profession, public and service providers, established through extensive consultation. It must also reflect how individual patients, carers and members of the public experience healthcare - particularly those with unequal access to care or with significant needs, such as patients with impaired capacity.

What's in scope?

We explain the principles of consent and decision making in a few pieces of our explanatory guidance and we'll make sure all references are consistent. But the focus of this review is our core guidance document *Consent: patients and doctors making decisions together (2008)*.

Guidance on consent to share information is out of scope for this review as it's addressed in *Confidentiality: good practice in handling patient information (2017)*. These pieces of guidance are also out of scope:

- *0–18 years: guidance for all doctors* (2007)
- *Consent to research (2010)*
- *Treatment and care towards the end of life: decision making (2010)*
- *Good practice in prescribing and managing medicines and devices (2013)*

While our *0–18 years* and *Consent to research* guidance are not in scope for this review, you can share any feedback on these publications (see question 17, 'overall comments') and we will take this into account in any future reviews.

---

[*] You can read the existing Consent guidance along with all our ethical guidance at www.gmc-uk.org/ethical-guidance

What have we done so far?

We've gathered evidence through our own and commissioned research[*] as well as engagement, to understand what issues to address. We've redrafted our guidance to:

- focus on how doctors can support patient decision making and involve patients in decisions about their care as far as possible
- focus on the importance of doctors finding out what is meaningful for their patients and helping them explore the different options
- include practical suggestions and examples to explain how the principles apply
- make it more accessible by referring less to the law and more to the principles on which the law is based.

You can read more about the review on our website.[†]

Putting the principles into practice

We develop learning materials to show how our guidance applies in practice. This includes our mental capacity decision support tool[‡] and interactive scenarios in *Good medical practice in action*[§]. We welcome views on what other topics or issues we could cover in these materials and have asked for your suggestions.

Equality and diversity

We carry out an equality analysis as we develop our guidance to identify the steps we must take to comply with the three aims of the public sector equality duty under the *Equality Act 2010*. Your responses help us understand how our guidance might impact on doctors, patients and members of the public who share protected characteristics.[**] We ask for diversity information from respondents to help us understand if any groups have raised specific issues about our guidance. This information helps us consider what steps we might need to take to reflect the issues raised.

---

[*] www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/doctors-attitudes-to-consent-and-shared-decision-making

[†] www.gmc-uk.org/about/get-involved/consultations/review-of-our-consent-guidance

[‡] www.gmc-uk.org/ethical-guidance/learning-materials/mental-capacity-tool

[§] www.gmc-uk.org/ethical-guidance/learning-materials/good-medical-practice-in-action

[**] The nine protected characteristics under the *Equality Act 2010* are race, disability, age, sex, gender reassignment, sexual orientation, religion and belief, pregnancy and maternity and marriage and civil partnership.

Purpose

What are we asking for your views on?

There are 22 questions in total (17 on the guidance and the rest about the wider consultation process) and some questions asking about you. While you don't have to answer all of them, your views are important, so please complete as many as you can.

We believe these issues in the guidance will be of most interest to you (though you can of course tell us about any aspect of this guidance update too):

- about the guidance, scope and application (question 1)
- summary of the main principles (question 2)
- how decisions are made (including the decision making framework and responsibility and delegation) (questions 3-4)
- guidance on supporting patient decision making (sharing information, maximising ability to make a decision, assessing and explaining benefits and harms, time and when patients don't want to be involved) (questions 5-9)
- guidance on making a decision (expressions of consent, planning future care, making sure patient decision making is voluntary, assessing capacity, assessing the overall benefit of different options, the scope of treatment in emergencies and if you have legal authority to make a decision to protect the patient or other people) (questions 10-16)
- overall comments on the guidance, including anything we haven't specifically asked about (question 17)
- putting the principles into practice (question 18)
- equality and diversity consideration (question 19)
- the consultation documentation and process (20-22)
- and finally, some information about you.

We aim to publish a final version of the guidance in 2019, but the date depends on the outcomes of this consultation.

About the guidance, scope and application

We've revised and restructured our guidance to make it easier for doctors to find the information they need and to make sure it's as clear and helpful as possible about what's expected of doctors when supporting patients to make decisions.

Revised structure

Our current *Consent* guidance (published in 2008) is in three main parts: Principles; Making decisions about investigations and treatment and Capacity issues. There are now two main sections introduced by explanatory text, which doesn't form part of the main guidance, on:

- applying the principles in the guidance
- the relationship between this guidance and action against a doctor's registration
- the scope of the guidance
- the ethical and legal framework which underpins the guidance, and
- the main principles.

Part 1 of the guidance, *Supporting patient decision making,* covers the importance of supporting patients to make decisions and the steps that doctors should take to do this. We've brought some of the information about maximising capacity into this section, to highlight the importance of helping all patients to make decisions, not just those whose capacity is in doubt.

Part 2 of the guidance, *Making decisions,* covers:

- where your patient is able to make the decision and give consent
- where your patient may lack the capacity to make the decision
- where you have legal authority to make a decision to protect the patient or other people
- recording decisions
- reviewing decisions.

We'd welcome your views on whether the revised structure is helpful.

Applying the principles and the relationship between this guidance and action against a doctor's registration

We've revised and expanded the explanation of how our guidance should be applied, to confirm that our guidance is not a rulebook and doctors must use their professional judgement when applying the principles in practice.

And to clarify when the GMC will take action to investigate concerns about fitness to practise, we now explain in this section that there is no automatic link between failure to follow our guidance and a doctor's registration.

We'd like your views on the amended explanation of how the guidance applies.

The scope of the guidance

We've removed the paragraphs on *Involving children and young people in making decisions* from the body of the guidance and instead made it clear in the *Scope of the guidance* where to find this information. This is because many of the principles in our guidance are relevant to decision making with young people, we have detailed guidance on this in *0–18 years: guidance for all doctors*.[*]

In this section, we've also confirmed that the same good practice principles apply:

- in the same way to decisions about mental and physical health (to confirm the equal status of these decisions, we've made this explicit in our guidance)
- whether doctors communicate with patients face to face or remotely (eg by telephone or online).

We'd like your views on the scope of this guidance.

The ethical and legal framework

Our guidance takes account of, and is consistent with, the law in all four countries of the UK. It's written to make sure doctors who follow it are acting within the law.

As the legal framework is complex, and in light of concerns about the extent of ethical and legal obligations following recent case law, we've added a section explaining the legal and ethical principles that underpin our guidance. This section is supplementary to the main guidance, so doesn't include any '*must*' or '*should*' statements. It's for anyone who wants to understand the framework and our approach.

---

[*] Read the guidance at www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/0-18-years

In this update we've also removed references to legal cases in the guidance. Instead, we focus on explaining the principles that arise from legal cases, and what they mean for doctors. Doctors, and others who want to know the case law, can refer to the legal annex which we will also update to make sure it remains accurate and helpful.

We'd like your views on this approach and on the usefulness of the legal annex.

1 Comments on scope and application

We are disappointed regarding the absence of a draft legal annex to accompany the consultation. Although certain paragraphs in the draft guidance indicate that this will be consulted upon later, that intimation is at odds with this question which expressly seeks our views on the usefulness of the this legal annex.

We would have preferred to comment on the legal guidance at the same time as the other sections and we trust that when the draft legal annex (which we perceive will form an essential part of the guidance) is produced we will be afforded opportunity to comment and to review and revise our comments on the draft consent guidance accordingly.

We recognise that the GMC intervened in the case of Montgomery, and that in many respects the findings of the Supreme Court simply brought the law in line with professional guidance, as stated in the GMC's existing 2008 consent guidance. However the absence of a draft legal annex has prevented our ability to form a view of the weight that the GMC may ascribe to the nuances of cases that have been reported since Montgomery.

The irony of this approach is brought to focus by the statement in the draft guidance that doctors must act within the law - yet there is no legal annex against which to bench-mark our comments.

Main principles of the guidance

We've included a summary of the principles at the beginning of the guidance so doctors and others can see what's expected, before looking at the detailed guidance. We'd like your feedback on whether it's helpful to include a summary. When considering this, please also let us know if these are the right principles to include.

2 Is the summary helpful?

☒ Yes ☐ No ☐ Not sure

Comments

- We welcome the express statement that the guidance is not a set of rules - rather, guidance to aid and support professional judgments.

- The Montgomery case can be considered to set out a 2-stage test, the first of which relates to the selection of reasonable treatment options and the second which mandates that all material risks of those treatment options must be disclosed to the patient as part of the consenting process. It seems to us that the first part of the test is rather overlooked in the draft guidance generally. We will make further reference to the case in later sections. However there seems to be a lost opportunity to make pertinent reference to 'material risk' in the context of 'share information that is relevant to your patient'.

- Under the principle 'recognise the importance of the decision-making process' the guidance appears to play down the importance of accurately recording discussions and decisions, by stating that the way in which consent is given is "less important" than the quality of the decision making process. We think the term "less important" is unhelpful when defending claims in clinical negligence. If a clinician does not have good evidence of the process (because they felt it was less important to do this), and an allegation is made that they failed to obtain consent appropriately, then it is more difficult to refute the claim. (We believe that this is also slightly at odds with paragraph 51 on page 14 which states the process must be recorded.)

How decisions are made (paragraphs 1-8)

Decision-making frameworks (paragraphs 1-2)

We've introduced this section to highlight the different approaches to making decisions where:

- a patient is able to make a decision and give or withhold their consent; or
- a patient doesn't have capacity to give or withhold their consent; or
- a doctor has legal authority to make a decision about a patient to protect them or the public.

We've done this to clarify the circumstances in which a decision might rest on consent or another legal authority on which to provide care and direct the reader to relevant guidance on *Making a decision* (paragraphs 39-102).

3 Is it helpful to include these frameworks?

▣ Yes ☐ No ☐ Not sure

Comments

No Comments

Responsibility and delegation (paragraphs 3-8)

In this section we explain how the high level guidance in *Good medical practice* and our explanatory guidance on this[*] applies when doctors delegate the responsibility for discussing treatment options with patients. As this is an area that doctors have told us they would like more advice on, we've outlined the requirements and considerations for delegation. We've also explained what we expect of those to whom this responsibility is delegated.

4 Is the guidance on delegation helpful?

☒ Yes ☐ No ☐ Not sure

Comments

The reference to cosmetic interventions (responsibility and delegation - paragraph 4) at footnote 3 would benefit from greater emphasis, such as by the creation of a stand-alone paragraph.

The draft guidance itself does not refer expressly to the GMC's guidance Good Medical Practice or the explanatory guidance on Delegation. We believe it should do so.

---

[*] See *Good medical practice* (paragraphs 15c, 44a and 45) and our explanatory guidance *Delegation and referral (2013)* which expands on these principles.

Part 1: Supporting patient decision making (paragraphs 9-38)

Doctors and patients sharing information (paragraphs 11-19)

The legal expectation for information sharing has changed following the decision in *Montgomery v Lanarkshire* [2015] and we know that doctors are concerned about whether they're meeting the requirements to share information with patients in a way that will support good decision making.

But we also know that many doctors do this well, even with time and resource constraints, so we've amended the guidance to make it clearer what doctors can do to overcome the barriers to good information sharing. For example, we've emphasised throughout our guidance that doctors should tailor their approach to take into account the needs of each individual patient and draw on additional support where possible, which could include the wider health and care team.

We've also emphasised the importance of listening to patients, as this will help the patient feel involved and minimise the risk of missed information about what the patient wants or needs. We've therefore changed the level of the obligation on doctors from 'should' to 'must' at paragraph 11, to reflect the fact that listening to patients is an overriding duty (see *Applying the principles*).

5 Is the guidance on sharing information helpful?

☒ Yes ☐ No ☐ Not sure

Comments

We have commented above regarding 'materiality'. In that context we believe that there is also a lost opportunity to refer to 'material risk' in relation to paragraphs 11 and 13. Whilst paragraph 11 is helpful in highlighting that a clinician should not make assumptions about the information the patient wants or the factors they might consider significant, there is no mention of the fact that it is what the patient may consider to be "materially" important.

Paragraph 16 of our current *Consent* guidance says doctors shouldn't withhold information necessary for making decisions unless they believe that giving it would cause the patient serious harm. This is known as the therapeutic exception. The exception was confirmed in the judgement in the *Montgomery v Lanarkshire Health Board* [2015] case, which said a doctor could withhold information about risk from a patient if they 'reasonably considered that its disclosure would be seriously detrimental to the patient's health.' But the court was clear this is a limited exception to the general principle that patients should be given the information they need to make a decision.

The feedback we've received is that the exception is so limited that it's unhelpful to include it in the main body of the guidance. So we've redrafted the guidance to emphasise the importance of considering the time and way in which information is shared (paragraphs 18 and 19), and we've moved the reference to the exception into a footnote, which directs readers to the legal annex.

6 Do you agree with this approach?

☐ Yes ■ No ☐ Not sure

Comments

Rather than address therapeutic exception' by a footnote, we believe there is merit in positively and strongly stressing in the main text the expectation that 'therapeutic exception' would only rarely be used.

Further, reliance is placed on the legal annex in the footnote (paragraph 18, footnote 5), which is, as commented upon above, absent.

Maximising your patient's ability to make a decision (paragraphs 20-24)

We've moved and restructured this section to emphasise the principle that it's important to maximise a patient's ability to make decisions in all cases, not just when the patient's capacity is in doubt. At paragraph 23, we've listed the steps doctors can take to maximise a patients' ability to make their own decisions about their care.

7 Is the guidance at paragraphs 20-24 helpful?

☐ Yes ☐ No ■ Not sure

Comments

In relation to giving patients an appropriate time to digest information (paragraph 23 (e)), we believe it would be helpful if the GMC might provide more detail as to what the GMC considers 'appropriate' might mean in this situation.

Assessing and explaining benefits and harms (paragraphs 25-30)

Doctors and others ask us about how best to assess benefits and harms and explain them to patients. Our advice focuses on the need to understand the individual patient's priorities and wishes and provide information which takes into account the patient's particular level of knowledge.

While the principles in this update haven't changed, we've updated the language and now refer to risks of harms and potential benefits rather than 'risks and benefits'. This is because risks and benefits are not equivalent. A risk is the probability of a particular (negative) outcome happening, while a benefit is itself an outcome. We feel this is a clearer way of explaining that doctors should explore the extent and the likelihood of both positive and negative outcomes occurring with their patients.

8 Is the guidance on benefits and harms helpful?

☐ Yes ☒ No ☐ Not sure

Comments

We referred earlier to materiality. In addition, there is no mention in these paragraphs to "materiality". We understand that the guidance is written in plain language, nevertheless the Montgomery case turns on the interpretation of what is a material risk, and it is therefore surprising that this term is not used within the guidance. There have been at least two cases (one of which is currently subject to appeal) in which the key question in the context of the "consent case" has been that of materiality of risk, and so it is clearly a crucial issue. (The cases in question are the 2016 case of R v Lanarkshire Health Board and the 2018 case of LT v NHS Lothian; the latter has been appealed by the pursuer.)

In the context of these comments we would again like to emphasise that the process is hampered by the absence of a draft legal annex.

When patients do not want to be involved (paragraphs 33-35)

During our research and pre-consultation engagement, doctors told us that they can feel unsure of their role in circumstances where patients don't want to be involved in decisions about their health and care.

So in this section we've explained the steps that doctors should take if patients don't want to be involved. This includes for example, doctors and the health and care team (where appropriate with relatives/carers) exploring the reasons for the objection and whether there is anything that can be done to reassure and support the patient.

9 Are paragraphs 33-35 helpful?

☒ Yes ☐ No ☐ Not sure

Comments

These paragraphs correctly identify that when a patient declines to have a discussion, a clinician must explain the potential consequences of this and must record the fact that the patient has declined this information. We consider the GMC's use of the term "must" demonstrates the importance of recording the discussion and therefore reiterates our point in response to question 2 that use of the term "less important" in the context of recording discussions is unhelpful and somewhat inconsistent.

Part 2: Making a decision (paragraphs 39-102)

Where your patient is able to make the decision and give consent (paragraphs 39-65)

Expressions of consent (paragraphs 45-50)

We've updated the guidance to include more specific references to the ways patients can express consent (eg non-verbal cues). We also emphasise that, while written consent may be a legal requirement in some cases, doctors should focus more on the quality of the dialogue leading to the decision than on how consent is expressed.

10 Is the guidance on expressions of consent helpful?

☐ Yes ☒ No ☐ Not sure

Comments

In relation to paragraph 50 we would like to comment (similarly to our earlier comment in relation to cosmetic treatment) that the reference to fertility treatment and the legal need for written consent might be stated more clearly were a specific paragraph dedicated to the point.

We have further comments in relation to materiality and the case of Montgomery.

The Montgomery case can be considered to set out a 2-stage test, the first of which relates to the selection of reasonable treatment options and the second which mandates that all material risks of those treatment options must be disclosed to the patient as part of the consenting process.

We perceive that the first part of the test is rather overlooked in the draft guidance. We refer specifically to paragraph 42, which provides guidance on what to do when a patient asks for treatment or care that the doctor does not think would be beneficial to them. We do not disagree with the content of that paragraph but consider the scenario envisaged at the start to be too restrictive. It seems to MDDUS that there will be circumstances in which a patient does not specifically request an alternative treatment, but where a doctor is aware that an additional alternative treatment (which they would not recommend) is available. We perceive there is merit in inserting an additional paragraph to address that scenario. This matter has been addressed in case law, in relation to mesh litigation (AH V Greater Glasgow Health Board and Johnson & Johnson Medical [2018] CSOH 57). In that case, where a patient had not been offered the full range of alternatives to a mesh implant, on the basis that the surgeon did not consider them to be reasonable treatment

Planning future care (paragraphs 53-60)

In our current *Consent* guidance, the ‘Advance care planning’ section focuses on situations where a patient may have a life-limiting condition or is facing a situation where loss or impairment of capacity is likely.

In this update, we’ve changed the title of this section and broadened the scope to highlight the many situations where thinking about care options in advance can be helpful. We’ve also given some examples of this.

11 Is the guidance on planning future care helpful?

☐ Yes ☒ No ☐ Not sure

Comments

Paragraph 58 makes reference to the legal annex - please see our earlier comments above.

Footnote (7) indicates that the legal annex will be drafted post-consultation. This declaration is inconsistent with Question 1 of this consultation and diminishes the quality consistency and utility of the consultation.

If you are concerned that a patient may not be able to make a decision freely (paragraphs 61-65)

This is another issue doctors and others ask for advice on, so we've updated the guidance with more examples of the factors that can affect decision making. We've also included more advice on the steps doctors should take if patients are under pressure to proceed with an intervention.

12 Is the guidance at paragraphs 61-65 helpful?

☐ Yes ☒ No ☐ Not sure

Comments

Again, please see our comments above regarding the absence of the legal annex. Again footnote (9) refers to the annex, which is absent.

Where your patient may lack the capacity to make the decision (paragraphs 66-91)

Assessing capacity (paragraphs 72-78)

We've made it clearer that in cases where a patient may lack capacity, it isn't necessary to make decisions immediately. We've also outlined the steps that doctors should take and the factors they should weigh up before making a final decision about capacity.

We know this is an area some doctors find difficult, so we welcome feedback on our draft guidance and will explore with doctors and others during the consultation if there is anything else we could say, or if there are any resources we could signpost or develop, that would be helpful.

13 Is the guidance on assessing capacity helpful?

☒ Yes ☐ No ☐ Not sure

Comments

Again, please see our comments above regarding the absence of the legal annex. It is specifically referred to in paragraph 69 of your consultation and it is again emphasised that clinicians must comply with the laws. We have also pointed this out in our response to Questions 1 and 17.

Assessing the overall benefit of different options (paragraphs 79-85)

We've updated this section to be explicit about what we expect of doctors and to make sure the guidance reflects practice and law across the UK.

As our guidance applies across the UK, when there are different legal terms used in different countries, we believe it's clearer to use a broader term that has the same meaning across all the countries. So in our current *Consent* guidance, we use 'overall benefit' to describe the ethical basis for decisions about treatment and care for adult patients who lack capacity to decide. This would for example be consistent with the term 'best interests' in England and Wales. However, we want to make sure the guidance is clear and won't cause confusion, so want to test if this approach remains helpful.

14 Should use the term 'overall benefit'?

☒ Yes ☐ No ☐ Not sure

Comments

The preamble to this question explains that the term 'overall benefit' is used and that there are different legal terms used in different countries and it refers specifically to the term 'best interests' in usage in England & Wales. There is equivalent terminology in Scotland and Northern Ireland and while we agree agree the term 'overall benefit' is helpful, it may be worth adding a footnote to set out the different terms used in different countries.

The scope of treatment in emergencies (paragraphs 90-91)

We’ve emphasised the importance of considering capacity even in emergency situations and clarified that while the presumption of capacity still applies, the steps that can be taken to maximise capacity in an emergency situation may be limited.

In some circumstances it may be immediately clear that the patient does not have capacity, but in others, the patient may be able to be involved in the decision. The principle remains that it’s important to involve patients in the decisions about their care as far as practicable, even in emergency situations.

15 Is the guidance on emergencies clear?

☒ Yes ☐ No ☐ Not sure

Comments

Where you have legal authority to make a decision to protect the patient or other people (paragraphs 92-95)

We've included this new section to emphasise that while these circumstances will be limited, doctors must follow the law and codes of practice that apply. And they must seek advice if they have any doubts about the extent of their interventions.

As this is new guidance, we want to make sure it's helpful to doctors who will have to make these decisions in practice, so would like your views on this.

16 Are paragraphs 92-95 helpful?

☐ Yes ☒ No ☐ Not sure

Comments

We have commented earlier - see above - regarding the problems generated by the absence of a draft legal annex. The legal annex - which is absent - is again referred to at footnote (13) in relation to paragraph 92.

Overall comments

In this section, we'd like your views on the guidance overall, including:

- the clarity of the wording
- the accuracy of the content
- if there is anything missing
- if there is anything we should remove
- sections of the guidance we haven't asked a question about
- how easy it is to find the information you need.

When answering these questions, please bear in mind that our guidance isn't legal or clinical advice and applies to doctors in all four countries of the UK, in all areas of practice and specialties.

17 Overall comments

We have commented throughout our response about the absence of the draft annex but have further comments to add in that context.

Whilst we agree that the draft guidance is not intended to be 'legal advice', there are inconsistencies and contradictions arising from this approach that we believe need to be flagged; for example, in terms of acting within the law the draft guidance states that doctors have an overriding duty such that they MUST act within the law, and in so doing makes reference to the not yet drafted/absent legal annex. How can the GMC expect doctors slavishly to follow law that the GMC is either as yet unwilling or unable to state or make clear reference to.

The consultation has no specific section or questions in relation to paragraphs 96-102. Given the other inconsistencies in the draft guidance we can only presume this is an oversight. Overall, such an oversight only serves to detract from the quality of the exercise.

Putting the principles into practice

To show how the guidance might apply in a range of situations doctors ask us about, we plan to develop online resources such as case studies and interactive flowcharts (see our website[*] for existing materials).

For example, we know assessing capacity can be difficult, so we've developed a mental capacity decision support tool[*] to help doctors identify the steps to take if a patient's capacity is in doubt. We'd like to hear your ideas for other topics we could include in the tool, or other resources we could develop to help address this issue.

We know that there are some good examples of how to assess benefits and harms and explain these to patients, so would like to hear about any that we could share with the profession.

We're also planning to develop a patient resource, such as a discussion aid or leaflet, to accompany the guidance.

As well as developing online resources, we work closely with a wide range of organisations to embed the guidance in doctors' education, training and everyday practice. We'd like your suggestions on how to embed the guidance in practice and make sure it's followed. Specifically:

- topics around decision making and consent (for doctors or patients) we could cover and what format would be helpful
- how to put the principles into practice.

18 Comments

No comments

---

[*] https://www.gmc-uk.org/ethical-guidance/learning-materials

Equality and diversity

We'd like your views on the potential impact of this guidance on people who share protected characteristics under the *Equality Act 2010* (the protected characteristics are race, disability, age, sex, gender reassignment, sexual orientation, religion and belief, pregnancy and maternity and marriage and civil partnership).

19 E&D comments

No comment

The consultation process

We value feedback to help us continue to improve how we consult. Please answer these questions based on your thoughts of the questionnaire and how well we explained our proposals.

20 Was the consultation questionnaire clear?

☐ Yes ■ No ☐ Not sure

Comments

As already indicated our answers have been limited in some areas by the absence of the draft legal annex (to which the draft guidance refers and the consultation specifically invited comment upon at Question 1).

21 Was it easy to respond?

☐ Yes ■ No ☐ Not sure

Comments

No - having sight of the legal annex at the same time would have been much more helpful.

22 How did you hear about this consultation? Please select all that apply.

☒ GMC website

☐ Another website

☐ GMC News ebulletin

☐ Other GMC newsletter/ebulletin

☐ Social media

☐ GMC event, workshop or meeting

☐ Non-GMC event

☐ Newspaper/radio

☐ Word of mouth

☐ Search engine

☐ Other (please say what)

The consultation was also directly flagged to MDDUS by the GMC.

About you

First name:
Jenifer

Last name:
Stirton

Job title (if responding on behalf of an organisation):

Interim Head Public Affairs and Strategic Communications

Organisation name (if responding on behalf of an organisation):

MDDUS (Medical and Dental Defence Union of Scotland)

Email address:
jstirton@mddus.com

Would you like to receive updates about GMC / MPTS consultations you've participated in?

☒ Yes
☐ No

Are you responding as an individual or on behalf of an organisation?

☐ Individual (please continue to 'Responding as an individual')

☒ Organisation (please go to 'Responding on behalf of an organisation')

Responding as an individual

Which of these categories best describes you? Please only select one.

☐ Doctor (if you select this, please also answer the next question otherwise go to ‘age’)

☐ Medical student

☐ Medical educationalist (non-doctor)

☐ Other healthcare profession

☐ Patient

☐ Carer/Relative or Advocate

☐ Member of the public

☐ Lay GMC/MPTS Associate

☐ Other (please say what)

If you selected ‘doctor’ which of these categories best describes you? Please only select one

☐ GP

☐ Consultant

☐ Doctor in training

☐ Staff and Associate Grade

☐ Locum (GP)

☐ Locum (secondary care)

☐ Trainer/medical educationalist

☐ Responsible Officer/Medical Director

☐ Other leadership or management role

☐ Academic researcher

☐ Practising outside the UK

☐ GMC/MPTS Associate

☐ Retired

☐ Other clinical practice (eg prison health service)

☐ Other non-clinical practice. Please say what:

In this section we ask for information about your background. We use this information to help make sure we are consulting as widely as possible. Specifically, we use this information when we analyse responses to make sure we understand the impact of our proposals on diverse groups.[*] Although we will use this information in the analysis of the consultation response it will not be linked to your response in the reporting process.

What is your age?

☐ 0–18

☐ 19–24

☐ 25–34

☐ 35–44

☐ 45–54

☐ 55–64

☐ 65+

☐ Prefer not to say.

---

[*] www.gmc-uk.org/about/how-we-work/equality-and-diversity

What is your gender?

☐ Female

☐ Male

☐ Prefer not to say

☐ I prefer to use my own term (please say what):

Do you have a disability?

☐ Yes

☐ No

☐ Prefer not to say

The *Equality Act 2010* defines a person as disabled if they have a physical or mental impairment, which has a substantial and long term (ie has lasted or is expected to last at least 12 months) and adverse effect on the person's ability to carry out normal day to day activities.

What is your ethnic group? (Please tick one)
White
☐ English, Welsh, Scottish, Northern Irish or British
☐ Irish
☐ Gypsy or Irish traveller
☐ Any other white background, please specify______________________________________

Mixed or multiple ethnic groups
☐ White and black Caribbean
☐ White and black African
☐ White and Asian
☐ Any other mixed or multiple ethnic background, please specify ______________________

Asian or Asian British
☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese
Any other Asian background, please specify ____

Black, African, Caribbean or black British
☐ Caribbean ☐African
☐ Any other black, African or Caribbean background, please specify____________________

Other ethnic group
☐ Arab
☐ Any other ethnic group, please specify____

☐ Prefer not to say

What is your religion?

☐ No religion

☐ Buddhist

☐ Christian – Baptist

☐ Christian – Brethren

☐ Christian – Catholic

☐ Christian – Church of England

☐ Christian – Church of Ireland

☐ Christian – Church of Scotland

☐ Christian – Free Presbyterian

☐ Christian – Methodist

☐ Christian – Other

☐ Christian – Presbyterian

☐ Christian – Protestant

☐ Christian – Pentecostal

☐ Hindu

☐ Jewish

☐ Muslim

☐ Sikh

☐ Other (please say what)

☐ Prefer not to say

Which of these options best describes your sexual orientation?

☐ Bisexual

☐ Heterosexual or straight

☐ Gay man

☐ Gay woman/lesbian

☐ Other

☐ Prefer not to say

What is your country of residence?

☐ England

☐ Northern Ireland

☐ Scotland

☐ Wales

☐ Other (European Economic Area)

☐ Other (rest of the world). Please say where

Responding on behalf of an organisation

Which of these categories best describes your organisation? Please select only one.

☐ Patient organisation

☒ Doctor organisation

☐ Independent Healthcare provider

☐ Medical school (undergraduate)

☐ NHS / HSC organisation

☐ Postgraduate body

☐ Regulatory body

☐ Public body

☐ UK government department

☐ Other (please say what)

Medical indemnity provider

In which country does your organisation operate? Please select only one.

☐ England

☐ Northern Ireland

☐ Scotland

☐ Wales

▣ UK wide

☐ Other (European Economic Area) (please say where)

☐ Other (rest of the world) (please say where)

Thank you for responding to our consultation.

Email: **gmc@gmc-uk.org**
Website: **www.gmc-uk.org**
Telephone: **0161 923 6602**

Standards and Ethics Section, General Medical Council, Regent's place 350 Euston Road, London NW1 3JN.

Textphone: **please dial the prefix 18001** then
0161 923 6602 to use the Text Relay service

Join the conversation

@gmcuk

facebook.com/gmcuk

linkd.in/gmcuk

youtube.com/gmcuktv

To ask for this publication in Welsh, or in another format or language, please call us on **0161 923 6602** or email us at **publications@gmc-uk.org**.

Published October 2018

The GMC is a charity registered in England and Wales (1089278) and Scotland (SC037750).

GMC/DMC/PCG/QF/1018

General
Medical
Council