Comhairle na nDochtúirí Leighis
Medical Council

Medical Council Public Consultation regarding the Guide to Professional Conduct and Ethics for Registered Medical Practitioners.

The consultation process will remain open for six weeks and will close on 4th August 2021. Please send this completed document before the 4th August to consultations@mcirl.ie

If you have any questions about this public consultation or require further information, please email consultations@mcirl.ie

Introduction

The Medical Council, through its Ethics Committee, is commencing a review of the 8th Edition of the Guide to Professional Conduct and Ethics for Registered Medical Practitioners. ("the Guide"). This process will contribute to the publication of the 9th edition of the 'Guide'.

We are holding an open consultation process to obtain the views of medical practitioners, members of the public, individuals and organisations to assist in informing us as we undertake this review.

Why should I participate?

This public consultation process provides an opportunity for individuals and organisations to submit comments and suggestions for consideration by the Ethics Committee as it undertakes to review the current Guide.

How will the results be used?

We will use findings from this survey to inform the Ethics Committee in their review of the Guide and their further engagement with all relevant stakeholders as part of the process. Submissions content will be provided to the Committee. Themes emerging from the consultation will be included in a Consultation Report which will be published. Demographic data, where provided, will be processed for statistical purposes, with your consent.

Is my information confidential?

- As a Data Controller, the Medical Council is subject to the requirements of the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. All information given in this survey will be treated in strict confidence and only used for the purpose to which you agreed to it being collected; to inform the Ethics Committee in its review of the Guide. Analysis of the dataset is conducted in-house by the Medical Council staff and participation in this survey is entirely voluntary.
- The Medical Council intends to publish a Consultation Report following conclusion of the consultation processes. Organisations who make submissions will be listed in the Consultation Report as contributors to the process. We may seek verification from organisations to confirm their authorisation of submissions. Individuals who make submissions on their own behalf will not be named in the Report as contributors to the consultation process.
- At the end of the survey you will be asked whether you consent to being contacted, at a later stage in the review process, in relation to your submission. If you indicate that you consent to being so contacted, we will retain your contact details until the review process has concluded and the 9th Edition of the Guide has been published.
- Responses to this survey are held securely by the Medical Council for up to four years. After four years the data-set and detailed information will be securely deleted from our systems. The Consultation Report will remain on the Medical Council website, and as part of the Medical Council's report archive.
- You have several rights under data protection legislation, including but not limited to, the right to access the data you have provided; the right to rectification of your data; the right to be erased from the dataset; the right to restrict or object to the processing of the data you have provided. If you would like further information on your rights as a data subject, please contact our Data Protection Officer at dp@mcirl.ie. In addition you can contact the consultation team at consultations@mcirl.ie if you wish to exercise any of your rights as listed above and we would be happy to assist you.

Freedom of Information

The Medical Council is subject to the Freedom of Information Act 2014 (FOI Act). The FOI Act is designed to allow public access to information held by public bodies which is not routinely available through other sources, and access to the documentation and results generated, including opinions, from this survey may be sought in accordance with the FOI Act. Subject to the FOI Act, exemptions to personal data and other information will be applied as appropriate and necessary.

Submissions

Please note that submissions received will not generally be responded to, but their receipt will be acknowledged at the end of the survey. Submissions will be collated with a view to informing the deliberations of the Ethics Committee.

Do you consent to participate?

Do you understand what this survey is for and agree to take part?
(Please pick ONE of the following options)

☐ Yes, I understand what the consultation survey is for, how the data will be used, the confidentiality arrangements in place and I agree to take part.

☐ No, I do not agree to take part in the consultation

Which category best describes you?

- ☐ Registered Medical Practitioner
- ☐ Other healthcare professional
- ☐ Patient or service user
- ☐ Caregiver
- ☐ Patient advocate
- ☐ Member of the public
- ☐ Government or public representative
- ☐ Doctor representative group member
- ☐ Employer
- ☐ Interest group member
- ☐ Regulator
- ☒ Indemnifier
- ☐ Legal advisor
- ☐ Other

Are you responding on your own behalf, or on behalf of an organisation?

- ☐ Individual
- ☒ Organisation (please detail below)

Medical Protection Society (MPS)

Which of the following best describes your gender identity?

☐Male

☒Female

☐Non-Binary

☐Prefer not to say

☐I prefer to self-describe, below:

Do you reference the Guide to Professional Conduct & Ethics as part of your work?

☒Yes, I use the Guide as part of my work.

☐No, my work does not involve me making reference to the Guide.

How often does the Guide currently meet the requirements you have in this work?

- ☐ Always sufficiently
- ☒ Mostly- In the main meets my requirements sufficiently
- ☐ Sometimes meets my requirements sufficiently
- ☐ Rarely meets my requirements sufficiently
- ☐ Never, the Guide is insufficient.

Why does this not meet your requirements? Please choose all that apply:

- ☐ Outdated legislation cited in the current Guide
- ☐ Unclear language in paragraphs of the Guide
- ☒ Changes in practice make aspects outdated
- ☐ Contradictions or inconsistencies within the Guide
- ☒ Specific practice or ethical issues not addressed in the Guide
- ☐ Guidance is not specific enough
- ☐ Other (please describe below).

Values

As part of the review of the Guide, we wish to hear from medical practitioners and others about whether they consider that the current Guide includes, and appropriately refers to, the professional values that a registered medical practitioner is expected to hold and to demonstrate. The current (8th) edition of the Guide refers to 'values' as follows;

Foreword:

"We have identified three 'pillars of professionalism'. These are values, principles and behaviours we expect of all doctors from the moment they enter medical school right through until retirement, so that the highest possible standard of care is provided to patients."

Chapter 2

Paragraph 3. The Three Pillars of Professionalism – Partnership, Practice and Performance

3.1 Good professional practice is based on a shared understanding between the profession and public of the principles and values that underpin good care. These principles and values, and how they should be applied in practice, are set out in this guide, using the three pillars of professionalism – Partnership, Practice and Performance – as a framework.

Paragraph 4. Partnership

4.1 Trust
4.2 Patient-centred care
4.3 Working together
4.4 Good communication
4.5 Advocacy.

Paragraph 5. Practice

This describes the behaviour and values that support good care. It relies on putting the interests and well-being of patients first. The main elements of good practice are:
5.1. Caring
5.2. Confidentiality
5.3. Promoting patient safety
5.4. Integrity

5.5. Self-care
5.6. Practice management
5.7. Use of resources
5.8. Conflicts of interest

Paragraph 6 – Performance

This describes the behaviours and processes that provide the foundation for good care. It requires:

6.1. Competence
6.2. Reflective practice
6.3. Acting as role models
6.4. Teaching and training medical students and doctors new to practice

These are the values and principles we expect all doctors to share. Doctors will also be influenced by their personal, ethical and moral values and experiences. These are also important to good practice, and doctors should reflect on how they underpin their relationships and decisions, making sure they do not result in non-compliance with the standards set out in this guide.

Do you consider that the current Guide deals appropriately and comprehensively with 'professional values'?

☒ Yes
☐ No (please describe why below)
☐ Undecided (please describe below)

Chapter 1: Purpose of the Guide

This describes the purpose of the Guide, and sets out the principles of professional practice that all doctors registered with the Council are expected to follow. Professional misconduct and poor professional performance are also defined.

Does this chapter require amendment in your opinion?

(Individual paragraphs will be explored in the subsequent question.)

☒ Yes (please comment below)

☐ No (please describe why below)

☐ Undecided (please comment below)

Chapter 1: Purpose of the Guide

Do the following paragraphs of Chapter 1 require amendment in your opinion?

(Links to each paragraph are included below)

Paragraph	Yes	No	Comment
1. How to use this guide	☐	☒	
2. Professional misconduct and poor professional performance	☒	☐	We believe the wording is a bit vague and too open to interpretation. MPS would welcome a clear definition of misconduct or a supporting document what is misconduct with examples.

Chapter 2: Professionalism

This includes the Three Pillars of Professionalism: Partnership Practice and Performance.

Does this chapter require amendment in your opinion?

☐	Yes (please provide comment below)
☒	No (please provide comment below)
☐	Undecided (please provide any additional comments below)

Chapter 2: Professionalism

Do the following paragraphs of Chapter 2 require amendment in your opinion?

	Yes	No	Comment
3. The Three Pillars of Professionalism	☐	☒	
4. Partnership	☐	☒	
5. Practice	☐	☒	
6. Performance	☒	☐	We believe that it may be helpful to advise doctors to understand & respect the limits of practice as the guidance doesn't specify them.

Chapter 3: Partnership

This chapter includes issues of: Dignity of the patient; equality and diversity; consent – general principles; capacity to consent; information for patients; timing of consent process; responsibility for seeking consent; emergency situations; refusal of treatment; advance healthcare plan or directive; consent to genetic testing; children and young people; personal relationships with patients; using social media; relationships between colleagues; delegation and referral; handover; healthcare resources and clinical trials and research.

Does this chapter require amendment in your opinion?

☒ Yes (please provide comment below)

☐ No (please provide comment below)

☐ Undecided (please provide comment below)

MPS believes that some parts of the guidance can be expanded upon to provide further clarity for doctors.

Chapter 3: Partnership

Do the following paragraphs of Chapter 3 require amendment in your opinion?

	Yes	No	Comment
7. Dignity of the patient	☐	☒	
8. Equality and diversity	☒	☐	MPS believes this section could be expanded including further detail.
9. Consent – general principles	☒	☐	MPS believes that this section could be expanded in several areas to provide further clarity. We suggest that the guidance should explain that consent must be freely given and without evidence of coercion. We believe that including the difference between implied and specific consent would be helpful; as well as situations where written consent are preferable to verbal consent could be added.
10. Capacity to consent	☒	☐	We believe that an expansion of what is meant by legal authority to consent would be useful with reference to relevant legislation. In addition clarity over steps to be taken in cases of conflict would be of assistance. Moreover, in relation to paragraphs 10.5 and 10.6, the Assisted Decision Making (Capacity) Act 2015 and the preparation of a code of conduct is due to be enacted. Within that Act there are parts relating to assisting patients lacking capacity to make a decision which will impact the two paragraphs mentioned. We suggest that the Medical Council looks at the wording of these two paragraphs with the pending Act in mind. The Supreme Court's Judgment in AC: If a patient wishes to leave hospital and following assessment of capacity, it is concluded that they lack capacity in relation to that decision, the

			hospital must bear in mind that it has no general power of detention and no general right to make itself a substitute decision-maker. Hence, the hospital must seek the assistance of the courts, if it is felt that the patient is at risk. However, the doctrine of necessity permits the hospital to detain the patient, in the interests of the patient's personal safety, provided that such detention lasts no longer than is necessary to take appropriate legal steps. This is also relevant in relation to restraint. It will be useful for the guidance to include or direct the consultant to the relevant legislation.
11. Information for patients	☐	☒	
12. Timing of consent process	☒	☐	We believe that this section could be expanded to include information about the need to allow patients to consider the information before invasive procedure. Unless there is an emergency situation, it is not usually appropriate for patients to give consent for an invasive surgery on the same day as the procedure(12.2). The General Medical Council in the UK have set out guidance in this area that the Medical Council could find relevant. Doctors could get into difficulties if complications arise as patients frequently complain that they were pressurised as they felt that they had no choice but to consent as the procedure was imminent. Consent should be freely given and without coercion and it would be helpful if that was expanded upon in the ethical guidance.
13. Responsibility for seeking consent	☐	☒	
14. Emergency situations	☒	☐	MPS believes that the word "should" should be replace with "must", being read as "[…]you must provide medical treatment to anyone who needs it […]". We believe that further information about what should happen after the emergency procedure would be beneficial. For example, informing patient and seeking consent for further treatment as and when capacity is retained.

15. Refusal of treatment	☒	☐	We are surprised by the lack of reference to refusal made under duress – eg young person but not underage under pressure from family to refuse treatment – such as a blood transfusion. We would welcome clarity on this area.
16. Advance healthcare plan or directive	☒	☐	We believe that the guidance could be expanded to provide further clarity. Equally, the Assisted Decision Making (Capacity) Act 2015 due to be enacted should be taken into account.
17. Consent to genetic testing	☒	☐	MPS would welcome the inclusion of guidance about disclosure of genetic information, similar to the one provided by the General Medical Council in the UK[1].
18. Children and young people	☒	☐	MPS would welcome more information regarding underage sexual activity/contraception would be of assistance, as well as details or a reference to legislation.
	Yes	No	Comments
19. Personal relationships with patients	☒	☐	MPS believes advice on how to deal with situations where a patient forms an inappropriate emotional attachment to a doctor would be helpful. We would also welcome the inclusion of advice on what doctors should do if they form a relationship with a patient.
20. Using social media	☒	☐	MPS would welcome the addition of how to respond to online reviews as well as what complaint process to follow if there are complaints received on social media.
21. Relationships between colleagues	☐	☒	
22. Delegation and referral	☒	☐	MPS believes this is a crucial issue for GPs as they are often asked to undertake prescribing of novel or unusual medications without the necessary support from secondary care, where there may not be up to date, relevant or any shared care protocols for follow up and monitoring. This causes a lot of practical problems for the GPs who can face

[1] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality/disclosures-for-the-protection-of-patients-and-others

			complaints from patients and advocacy groups. This is particularly relevant for transgender patients. It would be helpful if the delegation paragraphs could be expanded to include the roles and responsibility of each doctor involved in shared care / transfer of care from secondary to primary case. This should include the responsibilities of consultants to ensure that all necessary information and support is provided to GPs, as well as responsibilities of GPs to raise concerns where the referral is inappropriate or problematic.
23. Handover	☐	☒	
24. Healthcare resources	☐	☒	
25. Clinical trials and research	☐	☒	

Chapter 4: Practice

This chapter includes issues such as: Protection and welfare of children; protection and welfare of vulnerable persons; reporting of alleged historic abuse; confidentiality; disclosure with consent; disclosure without consent; disclosure after death; medical records; recording; physical and intimate examinations; continuity of care; retirement and transfer of patient care; referral of patients; refusal to treat; medical reports; certification; prescribing; telemedicine; provision of information to the public and advertising; nutrition and hydration; end of life care; assisted human reproduction;

termination of pregnancy; conscientious objection; patients who pose a risk of harm to others; treatment of prisoners; restraint; emergencies; registration; premises and practice information; employment issues; professional indemnity; health and well-being of doctors; concerns about a colleague's abuse of alcohol or drugs or other health problems; treatment of relatives; medical ionising radiation; managing conflicts of interest, and doctors in management roles.

Does this chapter require amendment in your opinion?

☒ Yes (please provide comment below)

☐ No (please provide comment below)

☐ Undecided (please provide comment below)

MPS believes that this section can be expanded and more clarity is needed in the areas highlighted below.

Chapter 4: Practice

Do the following paragraphs of Chapter 4 require amendment in your opinion?

	Yes	No	Comment
26 Protection and welfare of children	☒	☐	MPS believes that it would be helpful to reference providing a link to the legislation and national guidelines referred to in the guidance. We would also like to see more clarity regarding reporting obligations as well as clarification on who relevant authorities are. It would be useful to make clear that this is a responsibility of all registrants and not solely the remit of those working with children and vulnerable adults. All registrants should be alive to the risk of neglect and possible abuse of these groups eg when

			treating adults who have access to children and vulnerable adults, who disclose information that could put these others at risk.
27 Protection and welfare of vulnerable persons	☒	☐	As per the above answer, MPS believes that it would be helpful to reference providing a link to the legislation and national guidelines referred to in the guidance. We would also like to see more clarity regarding reporting obligations as well as clarification on who relevant authorities are. It would be useful to make clear that this is a responsibility of all registrants and not solely the remit of those working with children and vulnerable adults. All registrants should be alive to the risk of neglect and possible abuse of these groups eg when treating adults who have access to children and vulnerable adults, who disclose information that could put these others at risk.
28 Reporting of alleged historic abuse	☒	☐	MPS believes that this is an unreasonable burden to be placed on GPs. However, if the Medical Council believes that it should be included in this guidance, we would request that clear obligations and limitations of the doctors' duty are set out. This should include clear guidance on doctor's obligation how far to investigate (assess) if alleged perpetrator has access to children, clarity over the role of the doctor to encourage an adult patient with capacity to report in the first instance to appropriate authorities; and clarity on reporting role of manager in accordance with employer/hospital policies.
29 Confidentiality	☐	☒	
30 Disclosure with consent	☐	☒	
31 Disclosure without consent	☒	☐	We are concerned with the information in this section, concretely under disclosure in the public interest as we believe the idea that a disclosure in the public interest may be made to protect the patient is a slightly outdated one. We believe that unless the patient lacks capacity, and there is a real risk to other people, confidentiality should not be broken. We would refer the UK's General Medical Council guidance in this area as an example of helpful guidance to refer registrants to which the Medical Council could find relevant (GMC's position in Confidentiality 58 & 59)[2]. Also of reference is the following case law: the appropriate test to apply as per The Child and Family Agency v A.A. & Anor [2018] IEHC 112: "on the balance of probabilities, the failure to breach patient confidentiality creates a significant risk of death or very serious harm to an innocent third party." Moreover, we would welcome guidance on who doctors need to disclose to if required by law.
32 Disclosure after death	☒	☐	MPS believes there should be a reference to the obligation to disclose information to the Coroner after death. There is absolutely no reference to the Coroner at all in the ethical guide – no professional obligation to engage with the coroner and no reference to their statutory duty. The Coroners (Amendment) Act 2019 has amended the Coroners Act 1962 such that doctors are obliged to provide medical records for the purposes of

[2] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/confidentiality/disclosures-for-the-protection-of-patients-and-others

			post mortem examinations as well as to the Coroner for the purpose of the inquisitorial investigation.
33 Medical records	☒	☐	MPS believes that there is insufficient reference on redaction/ requirement to redact. The emphasis should be on note-taking and doing them in a timely and accurate manner. It could also include the principle that doctors should act as though the patient may have access to their records at some point. We suggest that the Medical Council includes a link to HSE on recommended retention periods. Lastly, all of this guidance including recording may require expansion to take account of developments in telemedicine and a specific section on the use of telemedicine added
34 Recording	☒	☐	MPS believes guidance when a patient wants the consultation recorded should be included as well as general guidance of covert recording and how can a doctor deal with the situation. See also the above re reference to telemedicine – online consultations and recording. The ICGP has guidance on consultations and recording which perhaps could be referenced here.
35 Physical and intimate examinations	☒	☐	MPS would like to see the advocacy of the use of a trained chaperone included in this guidance. We also believe the Medical Council should clarify what constitutes an 'intimate examination'.
36 Continuity of care	☒	☐	MPS would like to see an expansion on the guidance on removal of patients as own section; as well as a link to fair procedures to HSE guidance, although the issue is also present with private patients. We have noticed it has become increasingly common for doctors to become embroiled in increasingly difficult positions with patients following the breakdown of the therapeutic relationship where patients can become threatening and harassing, be it open or implied. It can involve patients openly being verbally abusive and threatening, or using online forums to criticise doctors, make disparaging posts and misrepresentations of consultations, as well as threats to sue or make a complaint to the Medical Council in an effort to coerce a doctor. It can also involve the recording of doctors without their consent either openly or surreptitiously and patients persistently attending or contacting a practice for medical advice (non-emergency situations) when they have been removed from the practice. The current ethical guidance is helpful to some extent, but it does include a provision that the doctor should continue to provide care to a patient until they have found an alternative practitioner and isn't clear on whether this only refers to the provision of emergency treatment. Providing ongoing non-emergency treatment is often impossible following the breakdown in the therapeutic relationship and it would be helpful if this was reflected in the guidance
37 Retirement and transfer of patient care	☒	☐	MPS would suggest to include a link to retention periods for medical records; as well as to state in the guidance that the doctor should ensure that the person you are transferring the care to has the same competency's/ specialty.
38 Referral of patients	☐	☒	

39 Refusal to treat	☒	☐	MPS would like to see some examples of what are 'exceptional circumstances'.
40 Medical reports	☒	☐	We would suggest consider adding a possible subsection for different types of reports – more detail on what types of report and details of special consideration that may need to be given to specific types of report. Further clarity on rights of patients to see reports and storage of reports , including retention periods would be beneficial. We believe that paragraph 40.1 should open as follows: "If you choose to prepare a report at the request of a patient or their representative, you should ask for the patient's consent…". This is in order to make clear that there is no general ethical obligation to provide a report, unless a contractual or legal obligation arises.
41 Certification	☒	☐	MPS believes there should be a note on this section not to provide under duress. There should be an independent assessment of the patient rather than obligation.
42 Prescribing	☒	☐	MPS believes there should be guidance on intended use/ off label use . We would also suggest that the Council makes reference to prescribing on the recommendation of a colleague eg GPs being asked to transcribe hospital 'scripts to GMS 'scripts. There is a well-recognised risk of medication errors occurring during the transition from secondary to primary care, so the Council could expand this section to make reference to the fact that externally generated prescriptions require special attention given that they often get transferred into the repeat prescribing system without a face to face consultations. Prescribers can maximise patient safety by ensuring that the prescription is needed; appropriate for the patient; and within the limits of their competence to prescribe. Streamlined guidance on GP/hospital interface prescribing issues would also be very helpful in the context of transgender prescribing. These prescribing issues have been exacerbated by the rise on telemedicine.
	Yes	No	Comment
43 Telemedicine	☒	☐	MPS believes that this section requires further expansion and clarity and suggests that when developing guidance on telemedicine, the Council should ensure that it covers all the below issues: • Confidentiality and medical record keeping as above • Consent • Intimate examinations • Pictures • Liability/Risk We are also concerned with the issue of telemedicine and the various machinations of 'out of State' practice eg 'doctor in ROI but the patient, at the time of the consultation is outside of ROI or alternatively where the patient is based in ROI at the time of the remote consultation but the doctor undertaking the consultation is based outside of ROI and the regulatory implications for that as far as the Medical Council is concerned -this practice potentially places s37 of the Medical Practitioners Act in partial conflict with EU Directive 2011/24/EU-. We believe that guidance around this issue should be included.

			It's also really relevant to the issue of transgender prescribing as transgender services in ROI is very limited and a lot of patients seek online support from a UK based service called Transgender GP. That service undertakes a review process and then sends the patient a list of medication that the GP is expected to prescribe. There is a need for guidance on that specific issue and the Medical Council could look at the guidance drafted by the General Medical Council about two years ago which details what the obligations are in terms of prescribing.
44 Provision of information to the public and advertising	☐	☒	
45 Nutrition and hydration	☐	☒	
46 End of life care	☐	☒	
47 Assisted human reproduction	☐	☒	
48 Termination of Pregnancy	☒	☐	MPS would like to see a clarification in the guidance that there is an obligation not to impose the doctor's own beliefs on the patient.
49 Conscientious objection	☒	☐	MPS believes this guidance needs to be broader and not specifically linked to Termination of Pregnancy.
50 Patients who pose a risk of harm to others	☒	☐	MPS believes that section 50.1 is somewhat vague. We would welcome clarity or examples on what can be interpreted as 'harm', as some of the situations mentioned above such as removal of patients and their abusive/threatening behaviors that can arise are harmful to the doctors and other staff.
51 Treatment of prisoners	☐	☒	
52 Restraint	☒	☐	MPS believes this section needs to be updated to reflect what the regulator considers reasonable and appropriate Para 52.1- 52.4 will need to be updated in light of the Supreme Court's Judgment in *AC*. 1. If a patient wishes to leave hospital and following assessment of capacity, it is concluded that they lack capacity in relation to that decision, the hospital must bear in mind that it has no general power of detention and no general right to make itself a substitute decision-maker. Hence, the hospital must seek the assistance of the courts, if it is felt that the patient is at risk. However 2. The doctrine of necessity permits the hospital to detain the patient, in the interests of the patient's personal safety, provided that such detention lasts no longer than is necessary to take appropriate legal steps.

53 Emergencies	☒	☐	MPS believes that the word “should” should be replaced with the word “must” and it should read: “In emergencies, either in clinical settings or in the community, you **must** provide assistance or care unless you are satisfied that appropriate […]”
54 Registration	☐	☒	
55 Premises and practice information	☐	☒	
56 Employment issues	☒	☐	MPS believes that guidance on what a self employed doctor should do or single handed practitioner if they cannot identify a locum should be included. We would also suggest including advice on situations where the doctor is unfit to work.
57 Professional indemnity	☐	☒	
58 Health and well-being of doctors	☒	☐	MPS would like to see this section expanded to include guidance to employed doctors that may be utilizing occupational health service and duty to comply with policies of employer.
59 Concerns about a colleague’s abuse of alcohol or drugs or other health problems	☒	☐	MPS believes the Medical Council should consider adding sections regarding reporting concerns re driving to RSA for both colleagues and patients.
	Yes	No	Comment
60 Treatment of relatives	☐	☒	
61 Medical ionising radiation	☐	☒	
62 Managing conflicts of interest	☐	☒	
63 Doctors in management roles	☐	☒	

Chapter 5: Performance

This chapter covers issues including: A culture of patient safety; raising concerns; maintaining competence; open disclosure and duty of candour; teaching and training; training and trainees; teaching and medical students; allowing school students and others access to patients; language skills and concerns about colleagues.

Does this chapter require amendment in your opinion?

☒ Yes (please provide comment below)

☐ No (please provide comment below)

☐Undecided (please provide comment below)

Requires Clarity ad expansion as detailed below

Chapter 5: Performance

Do the following paragraphs of Chapter 5 require amendment in your opinion?

	Yes	No	Comment
64 Culture of patient safety	☐	☒	
65 Raising concerns	☒	☐	MPS believes there should be clarification of who is 'appropriate person or authority' as well as on what 'outside the organisation' means, who outside of the organisation. The Medical Council should also consider including a section on Whistleblowing. The GMC in the UK has guidance on raising concerns that the Medical Council could find helpful. Overall, we believe this is very brief and it would be very helpful if it could be expanded to include reference to the importance of being aware of the workplace policy (where it exists) – as in our experience few doctors seem aware of the existence of the Protected Disclosures Act 2014 and the HSE Authorised Person for Protected Disclosures, for example. The Medical Council may want to consider adding a link to the above.
66 Maintaining competence	☐	☒	
67 Open disclosure and duty of candour	☒	☒	MPS would like to note that the Patient Safety (Notifiable Patient Safety Incidents) Bill 2019 will make mandatory open disclosure necessary in certain circumstances, therefore the wording of

			paragraph 67 may need to be amended, so that it is ready, as much as possible, for the implementation of future likely legislation.
68 Teaching and training	☐	☒	
69 Training and trainees	☐	☒	
70 Teaching and medical students	☐	☒	
71 Allowing school students and others access to patients	☐	☒	
72 Language skills	☒	☐	We believe that the Medical Council could include that doctors need to obtain the consent from patients in order to use a translator.
73 Concerns about colleagues	☐	☒	

Appendices to the Guide

These currently include:

- Appendix A: Principles of Freedom of Information (FOI) Legislation
- Appendix B: Confidentiality – Relevant Legislation
- Appendix C: Information for Patients before giving Consent

We are aware that some of this legislation is outdated and this will be reviewed and updated accordingly.
Aside from this, is there any additional information/legislation that should be contained within the appendices of the Guide going forward?

☒ Yes (please comment below)

☐ No (please comment below)

☐ Unsure (please comment below)

GDPR and other relevant legislation referred to in guidance

How do you wish to access the Guide in the future?

Please choose all that apply:

☐Paper-based copy

☒ Downloadable PDF file or similar online

☒ Mobile enabled file with links to paragraphs available online

☒ Mobile application

☐ Other (please detail below)

Follow-up contact

Following this initial stage of consultation, we may wish to follow-up with some respondents through a series of targeted consultative fora. Contact details provided for this purpose will be retained until the Guide to PC&E (9th Edition) is published and will be deleted thereafter.

Do you consent to your contact details being retained for use if the Ethics Committee/ relevant sub-group wishes to contact you in relation to your submission?

☐ **Yes (please enter contact details below)**

☐ **No**

Many thanks for taking the time to complete this submission to the public consultation regarding the Guide to Professional Conduct and Ethics for Registered Medical Practitioners.

The consultation process will remain open for six weeks and will close on 4th August 2021. Please send this completed document before the 4th August to consultations@mcirl.ie

If you have any questions about this public consultation or require further information, please email consultations@mcirl.ie