CONSULTATION QUESTIONS

The GMC is the independent regulator for doctors in the United Kingdom. Our statutory purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. We do that by controlling entry to the medical register and setting the standards for medical schools and postgraduate education and training.

We are responsible for advising doctors on good practice to help them provide better care for patients. Our core publication, *Good medical practice* sets out the principles and values on which good practice is founded and all doctors are required to be familiar with and follow the guidance in GMP and our explanatory guidance on a range of issues including seeking consent and maintaining confidentiality. If a doctor seriously or persistently breaches the guidance we act to protect patients, if necessary by removing the doctor from the register and restricting or removing their right to practise medicine.

We have referenced sections of our guidance which are relevant to the advice in the draft code of practice and have indicated where we have comments on specific paragraphs.

Chapter 4 – Council duties and powers, definition and role of the council officer and cooperation across organisations and professionals, and the role of the independent and third sectors

Paragraph 20

Paragraph 20 explains GPs responsibilities in contributing to adult protection processes as set out within the Scottish Government's *Guidance on the involvement of GPs in multi-agency protection arrangements* (2013). We support the involvement of GPs in adult protection processes and recognise their role in identifying the first signs of potential harm.

We give doctors advice on participating in child protection procedures in our guidance *Protecting children and young people: the responsibilities of all doctors* and the same principles would apply to taking part in of adult protection processes. http://www.gmc-uk.org/static/documents/content/Child_protection_guidance.pdf
We say that doctors should cooperate fully in child protection procedures, including going to meetings to provide information and give their opinion. We say that doctors should try to go meetings even if they are called at short notice and if this is not possible, must try to provide relevant information either through a telephone or video conference, written report or by discussing the information with another professional who can give an oral report at the meeting (paragraphs 26 and 27) You may want to consider adding a reference to this guidance.

Chapter 9 – Medical examinations conducted as part of an adult protection investigation

In chapter 9 the code provides guidance on conducting medical examinations as part of an adult protection investigation and usefully explains that patients have a right to

refuse a medical examination. Our guidance in *Good medical practice* says that doctors must be satisfied that they have consent or other valid authority before they carry out any examination (paragraph 17). Our explanatory guidance *Consent: patients and doctors making decisions together* provides more detailed advice on ensuring consent is informed and says that doctors must listen to patients, share with them the information they want or need in order to make decisions and must respect patients' decisions (paragraph 2)

We also give doctors advice on conducting non-clinical examinations where the aim is not to establish what is wrong with a person but instead to look for signs of abuse. We provide this guidance in the context of child protection in *Protecting children and young people: the responsibilities of all doctors*, though the same principles would apply to examinations conducted as part of adult protection investigations. Our advice makes clear that where examinations are being carried out to look for signs of abuse, the person giving consent must understand the purpose of the examination, what it will involve and how the results of the examination might be used - for example, as evidence in court (paragraph 64). We think that doctors would be further supported if the guidance in this chapter reflected our advice on seeking consent for examining patients in these kinds of circumstances.

Paragraph 4

Paragraph 4 lists circumstances where a medical examination should be considered as part of an adult protection investigation. The final example on this list – *'the adult is ill or injured and no medical treatment has been sought'* – does not seem to us to be an example that is directly supported by Part 1 of the Act. However, it does seem to be a sensible suggestion that medical treatment be sought for injured persons who cannot arrange it for themselves. You may wish to consider clarifying what is being suggested in this paragraph and how it relates to the Act.

Paragraph 5

The advice in this paragraph on adults' rights to refuse to answer questions and to be examined could be strengthened by making clear that there is nothing in the Act that would justify overriding an adult's right to refuse a medical examination and therefore that doctors must get consent before conducting medical examinations.

Paragraph 6

Paragraph 6 of the draft code says that '*where it is not possible to obtain the informed consent of the adult because they lack the mental capacity or have difficulty communicating in order to provide consent, the council should contact the Office of the Public Guardian to ascertain whether the person has completed a welfare power of attorney with the relevant powers. Where no guardian or attorney has such powers consideration may be given to whether it is appropriate to use the provisions in the Adults with Incapacity (Scotland) Act 2000 or the Mental Health (Care and Treatment) Act 2003*."

Our understanding of capacity legislation is that there is a responsibility on those caring for adult who have problems communicating to make every effort to facilitate

communication with them before taking any more formal steps. Our guidance to doctors in *Consent: patients and doctors making decisions together* supports this approach and says that advocates, interpreters, those close to the patient or the use of written or audio records of discussions, may aid communication where patients need extra support. Our guidance at paragraph 21 says:

> *You should check whether the patient needs any additional support to understand information, to communicate their wishes, or to make a decision. You should bear in mind that some barriers to understanding and communication may not be obvious; for example, a patient may have unspoken anxieties, or may be affected by pain or other underlying problems. You must make sure, wherever practical, that arrangements are made to give the patient any necessary support. This might include, for example: using an advocate or interpreter; asking those close to the patient about the patient's communication needs; or giving the patient a written or audio record of the discussion and any decisions that were made.*

And paragraph 65 says:

> *65. You must not assume that a patient lacks capacity to make a decision solely because of their age, disability, appearance, behaviour, medical condition (including mental illness), their beliefs, their apparent inability to communicate, or the fact that they make a decision that you disagree with.*

You may therefore want to consider reviewing this part of the code, and may also give thought to whether it might usefully include a cross-reference to the advice on advocacy, and assessing and managing communication difficulties in Chapter 3 on participation and decision making.

Chapter 10 – Examination of records as part of an adult protection investigation

In chapter 10 the code provides guidance on examining medical records as part of an adult protection investigation. Our guidance to doctors *Confidentiality* advises doctors to treat patient information as confidential, as confidentiality is central to the trust between doctors and patients, but we say that confidential patient information can be disclosed if it is required by law, if the patient consents to its disclosure, or if it is justified in the public interest.

We appreciate that the Adult Support and Protection (Scotland) Act 2007 gives council officers powers to examine records as part of adult protection investigations. However it can be difficult in individual cases to strike a balance between apparently overriding the wishes of an adult with capacity and acting to protect vulnerable adults from harm. We think that some parts of this chapter need further consideration in light of our guidance to doctors on *Confidentiality*.

Paragraph 2

Paragraph 2 sets out the legal position around disclosing confidential information in the public interest. Our understanding of this area of law is set out between

paragraphs 36 and 56 of *Confidentiality*: http://www.gmc-uk.org/static/documents/content/Confidentiality_0513_Revised.pdf
In particular paragraphs 51 and 52 say that whilst it may be appropriate to encourage patients to consent to disclosures that may be necessary for their protection, doctors should usually abide by a competent adult's refusal to consent to disclosure, even if that leaves them, but no one else, at risk of serious harm.

Our understanding is that public interest disclosures must be necessary as well as proportionate. Crime *per se* would not provide a sufficient basis for disclosure of confidential health records. Legal precedent, professional guidance and NHS codes are all clear that crime must be serious to justify disclosure, e.g. abuse of vulnerable, incapacitated people. Our guidance *Confidentiality* explains that there is no definition of 'serious crime' but mentions the examples listed in *Confidentiality: NHS Code of Practice* (Department of Health 2003) of serious crime, including murder, manslaughter, rape and child abuse. It also lists crimes that are not usually serious enough to warrant disclosure of confidential information, which include theft and fraud.

We see it as important that any new or revised guidance is consistent with advice that already informs healthcare professionals' practice in this area, since we know that confusion over legal and ethical issues can have a major impact on good practice.

Paragraph 14

Paragraph 14 helpfully lists circumstances in which it may not be possible to seek consent from a patient to share their confidential information. We would suggest you consider adding some further examples which are listed in our guidance. *Confidentiality* says that seeking a patient's consent may not be practicable if there is reason to believe doing so would put anyone at risk of serious harm or if seeking consent would undermine the purpose of the disclosure, for example by prejudicing the prevention or detection of a serious crime (Paragraph 38 b and c).

Paragraph 15

The second sentence of this paragraph helpfully references relevant professional guidance. However, it is important that General Medical Council guidance is accurately cited so we would suggest amending the paragraph to say: 'For example, guidance from the General Medical Council advises that doctors should seek patients' consent to disclosure. Where disclosure is required (by this or any other statutory requirement), doctors should still inform patients about the disclosure wherever that is practicable and would not undermine the purpose of the disclosure or put anyone at risk of serious harm, but their consent is not required'. The relevant guidance can be found at paragraphs 17 and 19 of *Confidentiality.*

Paragraph 21

Paragraph 21 deals with how records may be 'accessed. This is an area which may generate difficulties and give rise to confusion if it isn't clear that access means 'be given' rather than 'inspect'. You may wish to consider amending the code to say that

council officers should be able to demonstrate that they are authorised to require records to be 'given' under s10(1), not 'accessed'. In the case of health records, the council officer cannot access (or inspect) them; only health professionals can. Similar terminology in subsequent paragraphs of the guidance could also be clarified in this way.

Chapter 12 – Assessment Orders

Paragraph 8

We would stress the same points as those made about chapter 9 paragraph 5.

Paragraphs 20 to 25

As above, please consider the points made about chapter 9, paragraph 5.

Annex A

Reference should be included to the General Medical Council's guidance on confidentiality and consent (see www.gmc-uk.org/guidance/ethical_guidance/index.asp).