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)

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## 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)

Expectations in relation to doctors professional practice and performance must be realistic and take into account the difficulties facing doctors where resources are constrained.

## 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 | ☒ | ☐ | There are a number of grounds on which the complaints of poor professional performance can be made against a doctor including complaints about unacceptable behaviour or poor communication, a physical or mental disability, including addiction to alcohol or drugs, which may impair the doctor's ability to practise medicine or a particular aspect of medicine.<br><br>At the same time, a recent survey by the IMO revealed that while 90% of doctors have experienced mental health issues |

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| | | | made worse by work, the majority of doctors believe there is a perceived stigma around mental health issues and few doctors seek help from support services or a GP. While protecting public is a priority for the Medical Council, the public would be equally well served through greater support in addressing the underlying issues contributing to poor mental health in doctors, tackling stigma and encouraging help seeking. |

## 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) |

Prevention of disease, whether through primary prevention programmes, early detection or slowing down the progression of disease, is a key role of the doctor however, prevention is largely absent from the guide.

## 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 | ☐ | ☐ | |

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## 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)

## 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 | ☐ | ☐ | |
| 9. Consent – general principles | ☐ | ☐ | |

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| 10. Capacity to consent | ☒ | ☐ | Capacity to consent should be aligned with the Assisted Decision Making (Capacity) Act 2015 which recognises a functional approach to determining capacity at the time of decision -making. However, it should be noted that the Assisted Decision Making (Capacity) Act 2015 has yet to be fully commenced and the practical implications of the legislation have yet to be assessed. |
| 11. Information for patients | ☐ | ☐ | |
| 12. Timing of consent process | ☐ | ☐ | |
| 13. Responsibility for seeking consent | ☐ | ☐ | |
| 14. Emergency situations | ☐ | ☐ | |
| 15. Refusal of treatment | ☐ | ☐ | |
| 16. Advance healthcare plan or directive | ☒ | ☐ | The Assisted Decision-Making (Capacity) Act 2015 provides a legislative basis for Advance Healthcare Directives in Ireland.<br><br>However, there is some disconnect between Part 8 of the Assisted Decision Making (Capacity) Act 2015 and the Guide to Professional Conduct and Ethics for Registered Medical Practitioners.<br><br>In the Guide "*An advance healthcare plan or directive has the same status as a decision by a patient at the actual time of an illness and should be followed provided that: the request or refusal was an informed choice in line with the principles in paragraph 9;…*", however, there is no such requirement under the Act.<br><br>There is no legal clarity as to what action a medical professional should take if he/she suspects (for example, through the course of a conversation with the Designated Healthcare Representative) that an Advance Healthcare Directive has been made without the Directive Maker having received the information necessary to make an informed choice. To expect a medical practitioner to comply with an Advance Healthcare Directive when no medical advice or |

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| | | | input has been provided poses a significant ethical and legal challenge for practitioners.<br><br>It is essential that Directive-makers consult with a medical professional before making an Advanced Healthcare Directive, ideally such consultation should be with a medical professional who has in-depth knowledge of the relevant condition(s) to which the Advance Care Directive will apply and who is likely to be responsible for complying with the Directive.<br><br>Directive-makers and Designated Healthcare Representatives should be informed of the possibility of making a non-legally binding advance healthcare plan. Treating illness is a complex and dynamic process, with priorities for the patients and those looking after them changing as circumstances change and sometimes very quickly. A non-legally binding plan rather than a legally binding Advance Healthcare Directive may better serve the patient. |
| 17. Consent to genetic testing | ☐ | ☐ | |
| 18. Children and young people | ☒ | ☐ | Paragraph 18.2 highlights the inconsistencies in law in relation to children. Patients aged 16 years and over can consent to surgical, medical and dental treatment while a patient must be over 18 to consent to psychiatric treatment unless they are or have been married. At the same time the age of consent to sexual activity is 17 although patients aged 15 and 16 may consent to sexual activity provided that: the age difference between them is not more than 24 months; there is no material difference in their maturity or capacity to consent; the relationship does not involve intimidation or exploitation of either person; and neither is in a position of authority. Under Children First legislation, Doctors are required to report illegal underage sexual activity to Tusla.<br><br>The IMO is calling for a clear and unambiguous definition of “A Child” that is consistent across all health care services. |
| | Yes | No | Comments |
| 19. Personal relationships with patients | ☐ | ☐ | |
| 20. Using social media | ☐ | ☐ | |

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| 21. Relationships between colleagues | ☒ | ☐ | This section makes some reference to bullying and harassment but fails to address the issue in any substantive way. Numerous surveys from the Medical Council and the IMO have highlighted a high prevalence of bullying, harassment and undermining behaviour experienced by medical trainees in Ireland.<br><br>The Guide states that doctors should avoid any form of sexual harassment, bullying or undermining of colleagues particularly when doctors are in a position of authority or trust, however a stronger stance from the Medical Council is needed to tackle these issues.<br><br>Bullying and sexual harassment are unacceptable behaviours that have no place in the medical profession. These behaviours cause stress, anxiety and loss of self-confidence, impair teamwork, and put patient care and safety at risk. All forms of discrimination, bullying and sexual harassment must no longer be tolerated. Doctors must be free to be themselves and achieve their full potential. The onus in code of conduct should be to foster a culture of respect and collaboration in medical practice and education. |
| 22. Delegation and referral | ☒ | ☐ | Issues in relation to referrals and discharge were raised at a recent forum on Transitional care hosted by the Medical Council. This section refers to both delegation to a team member and referral to specialist care while paragraph 38 also refers to the topic if referral. Delegation and referral are two distinct topics and should be treated as such in the Guide.<br><br>Investment in secure electronic health records that allow for embedding of national summary patient records as well as standardised referral and discharge summaries will support two-way communication between healthcare settings.<br>As per the ***Terms of Agreement between the Department of Health, the HSE and the IMO regarding GP Contractual Reform and Service Development (2019),*** - summary records will be populated from GP practice management systems according to the data set agreed in Appendix D of the Agreement. It is important, however ,that practitioners are aware that summary |

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| | | | health care records are auto-populated from practice management systems and are a snap shot at a point in time. This does not obviate the need for a practitioner to take a patient history where possible. GPs cannot be held responsible for data that is incomplete, inaccurate or not fully up to date. |
| 23. Handover | ☒ | ☐ | As mentioned in 22 above, issues in relation to referrals and discharge were raised at a recent forum on Transitional care hosted by the Medical Council. Handover at the end of a shift and discharge of a patient back to the GP again are not the same and again the guidance should be distinct on these two separate topics. See 22 above.<br><br>Comprehensive discharge letters should be sent to the patient's GP in a timely manner. Any action required by the GP must be agreed and documented clearly. |
| 24. Healthcare resources | ☒ | ☐ | The guide fails to sufficiently address the constraints placed on doctors due to the under resourcing of the health service. While reference is made to the advocacy role there is no guidance provided for what doctors should do where resources are insufficient to allow doctors to deliver on their role. |
| 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)

## Chapter 4: Practice

| Do the following paragraphs of Chapter 4 require amendment in your opinion? | | | |
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| | Yes | No | Comment |
| 26 Protection and welfare of children | ☐ | ☐ | |
| 27 Protection and welfare of vulnerable persons | ☐ | ☐ | |
| 28 Reporting of alleged historic abuse | ☐ | ☐ | |
| 29 Confidentiality | ☐ | ☐ | |
| 30 Disclosure with consent | ☐ | ☐ | |
| 31 Disclosure without consent | ☐ | ☐ | |
| 32 Disclosure after death | ☒ | ☐ | Some guidance will be required for medical practitioners in balancing the requirement to maintain confidentiality after death with the mandatory requirement to disclose certain patient safety incidents which will be introduced under the Patient Safety (Notifiable Patient Safety Incidents) Bill 2019. Initially the list of notifiable patients safety incidents under the draft legislation are incidents which result in the death of a patient. |
| 33 Medical records | ☐ | ☐ | |
| 34 Recording | ☐ | ☐ | |
| 35 Physical and intimate examinations | ☐ | ☐ | |
| 36 Continuity of care | ☐ | ☐ | |
| 37 Retirement and transfer of patient care | ☐ | ☐ | |
| 38 Referral of patients | ☒ | ☐ | See 22 above |
| 39 Refusal to treat | ☒ | ☐ | Paragraph 39.2 suggests that by refusing one specific treatment a doctor is refusing to provide an alternative form of treatment. |
| 40 Medical reports | ☐ | ☐ | |
| 41 Certification | ☐ | ☐ | |

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| 42 Prescribing | ☐ | ☐ | |
| | Yes | No | Comment |
| 43 Telemedicine | ☒ | ☐ | The COVID-19 pandemic has accelerated the use of telemedicine, in the provision of healthcare. While telemedicine has the potential to be a useful additional tool in a number of clinical scenarios, it is not without risk and is not suitable in all scenarios. Face-to-face consultations should remain the priority. Guidance from the Medical Council should reflect the policies of the CPME (Standing Committee of European Doctors) Policy on Telemedicine March 2021 and the WMA (World Medical Association) Statement on the Ethics of Telemedicine, October 2007, amended October 2018. |
| 44 Provision of information to the public and advertising | ☐ | ☐ | |
| 45 Nutrition and hydration | ☐ | ☐ | |
| 46 End of life care | ☐ | ☒ | *When patients are nearing the end of life, it is your responsibility to make sure they are comfortable, suffer as little as possible and die with dignity. You should treat them with kindness and compassion.*<br><br>Doctors have a key role in supporting patient's nearing the end of life and palliative care must be appropriately resourced. |
| 47 Assisted human reproduction | ☐ | ☐ | |
| 48 Termination of Pregnancy | ☐ | ☐ | |
| 49 Conscientious objection | ☐ | ☐ | |
| 50 Patients who pose a risk of harm to others | ☐ | ☐ | |
| 51 Treatment of prisoners | ☐ | ☐ | |
| 52 Restraint | ☐ | ☐ | |
| 53 Emergencies | ☐ | ☐ | |
| 54 Registration | ☐ | ☐ | |
| 55 Premises and practice information | ☐ | ☐ | |

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| 56 Employment issues | ☒ | ☐ | The recent survey by the IMO on doctor mental health and well-being found that 36% of doctors had been unable to take time off since the start of the pandemic and 59% of GPs stated that they were unable to take time off due to difficulties in sourcing locum cover. The onus rests with the employer to ensure that locum cover is in place. Where doctors are self-employed access to a bank of locums is required. |
| 57 Professional indemnity | ☐ | ☐ | |
| 58 Health and well-being of doctors | ☒ | ☐ | This section places too much emphasis on the individual doctor to look after their own health and well-being. While self-care is important, it is of minimal use to doctors working in a system where understaffing, long working hours and excessive workload are the norm.<br><br>A recent survey carried out by the IMO on Doctor Mental Health and Well-being revealed that 90% of doctors reported having experienced some form of depression, anxiety, stress, emotional stress or other mental health condition related to or made worse by work while 7 out of 10 doctors are at high risk of burnout – with NCHDs and Public Health Doctors at the highest risk.<br><br>While absenteeism, redeployment and new ways of working during the pandemic have no doubt compounded issues of stress and burnout in the workforce it is clear that long standing issues in relation to staff shortages, long working hours and excessive workload, difficulties getting locum cover, are the major factors contributing to poor mental health and well-being among the medical workforce.<br><br>In addition to the impact on mental health, excessive workload also impacts on physical health. A recent article published by the WHO and ILO shows a strong correlation between working more than 55 hours a week and premature death. An important takeaway is the relationship between working hours and heart problems and stroke:<br><br>*Evidence from previous studies suggests working long hours can increase mortality and morbidity from ischemic heart disease and stroke through psychosocial stress. Two primary causal pathways are conceivable (Fig. 1). The first is through biological responses to psychosocial stress: release of excessive stress hormones due to working long hours (Chandola et al., 2010; Jarczok et al., 2013; Nakata, 2012) may trigger functional dysregulations in the cardiovascular system and structural lesions (Kivim¨aki and Steptoe, 2018). The second pathway is through behavioral responses to stress that are established cardiovascular risk factors, including tobacco use, harmful alcohol use, unhealthy diet, physical inactivity, and resultant impaired sleep (Sonnentag et al., 2017; Taris et al., 2011; Virtanen et al., 2009).* |
| 59 Concerns about a colleague's abuse | ☒ | ☐ | This section prioritises the reporting of health concerns among doctors above supporting colleagues. As per paragraph 2 above while risks to patient |

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| of alcohol or drugs or other health problems | | | safety is a priority, greater support is needed from the Medical Council in addressing the underlying issues contributing to poor mental health in doctors, tackling stigma and encouraging help seeking. |
| | 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)

## 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 | ☐ | ☐ | |
| 66 Maintaining competence | ☒ | ☐ | |
| 67 Open disclosure and duty of candour | ☒ | ☐ | Fear of litigation, fitness to practice procedures and damage to reputation have been identified as major barriers to open disclosure and the reporting of patient safety incidents. While the IMO supports the protections provided for open disclosure under Part 4 of the Civil Liability (Amendment) Act 2017 the forms and procedures under the Act are not fit for purpose.<br>While currently under review for the Patient Safety (Notifiable Patient Safety Incidents) Bill 2019, the Medical Council should engage with the Department of Health to ensure the procedures and forms are conducive to an open and honest conversation with patients and their relatives following an adverse event.<br>Clear guidance on open disclosure must be provided detailing when to disclose, how, as well as who is responsible for disclosure. Non-medical factors such as resource issues, understaffing, systems failures must be included in the disclosure process. |
| 68 Teaching and training | ☐ | ☐ | |
| 69 Training and trainees | ☐ | ☐ | |
| | ☐ | ☐ | |

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|---|---|---|---|
| 70 Teaching and medical students | | | |
| 71 Allowing school students and others access to patients | ☐ | ☐ | |
| 72 Language skills | ☐ | ☐ | |
| 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)

## 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)

The Guide should be a living document that is regularly updated to ensure that Medical Practitioners in Ireland are provided with the most up-to-date guidance.
The IMO would welcome the opportunity to comment further on a draft of the Guide to be produced as a result this consultation process.

## 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)**

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☐ **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