

Tomorrow's Doctors

Response to the General Medical Council's
Consultation

Picker Institute Europe

March 2009

Picker Institute Europe

The Picker Institute works with patients, professionals and policy makers to promote understanding of the patient's perspective at all levels of healthcare policy and practice. We undertake a unique combination of research, development and policy activities which together work to make patients' views count. There are three key strands to our work:

- Measurement - researching and evaluating patients' experience
- Improvement - leading initiatives that make improvements happen
- Policy - building evidence to inform health policy.

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Overview

The Picker Institute welcomes the opportunity to contribute to the General Medical Council's consultation on the revised draft of *Tomorrow's Doctors*.

The Picker Institute's response focuses on Outcomes 2 and 3, the doctor as a practitioner and a professional and, in particular, on the doctor-patient partnership elements.

We regard the draft as a very substantial improvement on the 2003 document, particularly the competence-based approach.

The Picker Institute also welcomes references to the *Good Medical Practice* partnership standards and criteria within *Tomorrow's Doctors*. In our view, however, the GMC should give more consideration to how *Good Medical Practice* is taught and learned within the curriculum, and to the specific competences that graduates will need genuinely to work in partnership with patients in clinical practice. The Picker Institute also notes some inconsistencies within *Tomorrow's Doctors* and between this document and existing GMC guidance.

The Picker Institute asks the GMC to ensure that *Tomorrow's Doctors* reflects the shift from informed decision-making in *Good Medical Practice* (2006) to shared decision-making (Appendix 2) in *Consent: doctors and patients making decisions together* (2008). Available evidence suggests that graduates will need competences other than generic 'communication' and 'information' skills, and that there are currently inequities of involvement which the curriculum should equip graduates to recognise and address.

Page 14 of this response outlines the Picker Institute's suggestions for core competences for shared decision-making, derived from the requirements within *Good Medical Practice* and *Consent: doctors and patients making decisions together*.

Appendix 1 describes the shared decision-making model, while **Appendix 2** collates the most relevant *Consent* requirements.

Finally, the Picker Institute believes that the way that the relationship between 'working in partnership' and 'obtaining informed consent' is portrayed in *Tomorrow's Doctors* risks creating confusion and misunderstanding about the rationale for working in partnership with patients and for sharing decision-making. The GMC should consider how this risk will be managed.

Recommendations

The Picker Institute's view is that *Tomorrow's Doctors* should:

1. by introducing a specific criterion, require medical schools more effectively to integrate the *Good Medical Practice* standards and principles into curriculum design, delivery and assessment
2. apply evidence from national survey data about variations and inequities in patients' involvement in decision-making to shape the undergraduate curriculum
3. translate professional standards and the concepts of patient partnership, involvement and shared decision-making into specific competences that can be taught, learned and assessed
4. convey that 'obtaining informed consent' is a consequence of working in partnership and sharing decision-making with patients – not the aim.

Response in detail

1. Integrating *Good Medical Practice* standards into the curriculum

The Picker Institute understands that the medical schools, and not the GMC, are responsible for the design and management of the undergraduate curriculum.

We believe, however, that the GMC has an important role to play in requiring medical schools more effectively to integrate *Good Medical Practice* standards of partnership and patient-centred care into and across the curriculum structure and its delivery. In our view, this is an important aspect of making sure that teaching and learning opportunities allow students to meet the GMC's requirements.

One of the key issues identified by the Picker Institute's Patient-Centred Professionalism research project was a need to review the opportunities that medical education provides for graduates to understand and **practise applying** the principles and standards of *Good Medical Practice*.

In particular, the research suggested that there would be value in ensuring that medical education creates opportunities for discussing *Good Medical Practice* application 'in real life' situations, and for exploring potential tensions and ways of managing them.

The recommendation was that:

“Good Medical Practice should not be taught as a small, distinct element in particular years but should run right through the medical curriculum.”¹

The Picker Institute recommends including a further criterion within Domain 5 of *Tomorrow’s Doctors* (design and delivery of curriculum):

“The curriculum will be structured so as to integrate *Good Medical Practice* principles and standards into the core curriculum and student-selected components (SSCs), and to provide ongoing opportunities for describing and discussing their application in clinical practice”.

2. Applying national survey data to shape the undergraduate curriculum

Expectations of the doctor-patient relationship, GMC standards and healthcare policy have advanced considerably since *Tomorrow’s Doctors* was last revised.

Professional standards and contemporary understandings of the optimal relationship between patients and health professionals place considerable emphasis on working in partnership and, especially, on patients’ rights and expectations to share decisions about their care and treatment.

To date, however, evidence from the NHS national survey programme shows no overall impact on patient involvement in decision-making. It also demonstrates inequities in involvement.

For the foreseeable future, the national policy arena includes:

- high-level recognition that the NHS’ sustainability depends on patients working with doctors and NHS staff to improve health and manage long-term conditions:

“And this means health professionals building on the plethora of good evidence-based practice that exists already - and becoming champions and advocates of more empowered patients...”²

- a Constitution³ that emphasises involvement and shared decision-making:
 - “NHS services must reflect the needs and preferences of patients, their families and their carers. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment.”
 - “You have the right to be involved in discussions and decisions about your healthcare, and to be given information to enable you to do this.”

¹ Implementing Good Medical Practice: outcomes of a conference to gather momentum for patient-centred professionalism. Academy of Royal Medical Colleges and Picker Institute Europe, 2007.

² Prime Minister’s speech on the NHS, 7th January 2008. <http://www.number10.gov.uk/Page14171>

³ The NHS Constitution for England and the handbook to the NHS Constitution for England. Department of Health, 2009.

- “What this means for patients - your doctor should listen to you and respond to your concerns and preferences about your healthcare. That way you can find out what is the best treatment for you. NHS staff will give you the information you need to support these discussions and decisions.”
- “You have the right to be involved, directly or through representatives, in the planning of healthcare services, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.”
- “The NHS also commits:
 - to provide you with the information you need to influence and scrutinise the planning and delivery of NHS services (pledge); and
 - to work in partnership with you, your family, carers and representatives (pledge).”

The Picker Institute’s view is that *Tomorrow’s Doctors* should reflect the direction of travel and the evidence base. The undergraduate curriculum must more adequately prepare graduates to deliver the vision of ‘making quality improvement the organising principle of everything we do in the NHS, where quality comprises safety, effectiveness and the most positive possible patient experience.’^{4, 5}

Tomorrow’s graduates will need to be able - actively and equitably - to involve patients in health and healthcare. They will need the skills and abilities to share decisions and decision-making processes with patients as equal and knowledgeable partners.

They will also need to be able to work with and avoid compounding inequalities, recognising that:

“Over half of England’s adult population have literacy skills below Level 2 – the level of skills needed to discuss a condition interactively with a doctor or specialist.”⁶

Evidence from the NHS national survey programme

Patient experience data from the NHS national survey programme suggests that there is considerable room for improving:

- the extent to which patients are as involved, as much as they wish to be, in decisions about their care and treatment
- equity of involvement, across clinical settings and between different patient groups.

In all the national surveys, questions relating to doctor-patient communication and information skills achieve more positive responses than questions that relate to shared decision-making.

⁴ High Quality Care for All: NHS Next Stage Review final report. Department of Health, 2008.

⁵ http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_090444

⁶ http://www.dh.gov.uk/en/Publichealth/Healthimprovement/Healthliteracy/DH_095382

Further, trend data⁷ show some significant improvements in responses to questions about doctor-patient communication and information sharing – but no improvement in the (consistently lower) proportion of patients who respond ‘yes, definitely’ when asked whether they were involved as much as they wanted to be in decisions.

This suggests that generic ‘communication’ and ‘information’ competences are necessary *but not sufficient* to achieve patient involvement. The curriculum needs to ensure that undergraduates learn and practise additional competences that prepare them for patient involvement and shared decision-making.

The national surveys also provide evidence of unacceptable inequities in patient involvement, which the GMC should be concerned to address within the undergraduate curriculum.

The primary care, emergency department and inpatient survey questionnaires all ask respondents whether they were involved, as much as they wanted to be, in decisions about their care and treatment.

The primary care survey also asks whether patients were involved, as much as they wanted to be, in decisions about the best medicine for them. The inpatient survey asks whether patients felt involved in decisions about their discharge from hospital.

In all surveys, there are three response options; ‘yes, definitely’, ‘yes, to some extent’ and ‘no’.

It is important to emphasise that survey questions about involvement in decisions about care and treatment and about medicines do not demand any particular level of involvement from patients. All patients, from those who wish doctors to make all decisions on their behalf to those who wish to be fully involved in decision-making, can respond that they were ‘yes, definitely’ involved *as much as they wanted to be*. Responses describe patients’ experiences of involvement, not their expectations.

Variations in involvement – healthcare settings

There are significant differences in reported patient involvement in decision-making in different healthcare settings. Primary care consistently scores highest. Inpatient care consistently scores lowest on involvement, and scored lower in 2007 than in 2005 and 2006.

⁷ Trends in patients’ experience of the NHS. Picker Institute Europe, 2006.

Proportion of patients who responded “Yes, definitely” when asked “Were you involved as much as you wanted to be in decisions about your care and treatment?”

Primary care survey	Survey Year		
	2004	2005	2008
	69%	69%	70%
Emergency Department survey	Survey Year		
	2003	2004	2008
	63%	64%	62%
Adult inpatient survey	Survey Year		
	2005	2006	2007
	53%	52%	51%

Inequities in involvement – self-defined ethnic groups

There are also significant and substantial inequities in involvement between demographic groups. Patients who described their ethnic group as white are more likely than patients from other ethnic groups to say that they:

- were ‘yes, definitely’ involved as much as they wanted to be in decisions about their care and treatment, in all three healthcare settings
- felt ‘yes, definitely’ involved in decisions about their discharge from hospital
- were ‘yes, definitely’ involved as much as they wanted to be in decisions made in primary care about the best medicine for them.

Primary care survey 2008	Were you involved as much as you wanted to be in decisions about your care and treatment?			Were you involved as much as you wanted to be in decisions about the best medicine for you?		
	Yes, definitely	Yes, to some extent	No	Yes, definitely	Yes, to some extent	No
Self-defined ethnic group	%	%	%	%	%	%
White	72	24	4	61	29	10
Asian or Asian British	54	36	10	54	36	10
Black or Black British	57	33	10	46	31	23

Emergency Department survey 2008	Were you involved as much as you wanted to be in decisions about your care and treatment?		
	Yes, definitely	Yes, to some extent	No
Self-defined ethnic group	%	%	%
White	63	27	9
Asian or Asian British	46	39	15
Black or Black British	50	34	16

Inpatient survey 2007	Were you involved as much as you wanted to be in decisions about your care and treatment?			Did you feel you were involved in decisions about your discharge from hospital?		
	Yes, definitely	Yes, to some extent	No	Yes, definitely	Yes, to some extent	No
Self-defined ethnic group	%	%	%	%	%	%
White	52	37	10	54	30	16
Asian or Asian British	39	43	18	42	32	25
Black or Black British	41	41	19	46	33	21

Inequities in involvement – age and sex

Patients' age and sex also influence their involvement. In the 2008 primary care survey, for example, older people were more likely than younger people to say that they were 'yes, definitely' involved in decisions about their care and treatment, and in decisions about the best medicine for them.

Primary care survey 2008	Men				Women			
	16-35	36-50	51-65	>65	16-35	36-50	51-65	>65
'Yes, definitely' involved as much as wanted to be :	%	%	%	%	%	%	%	%
"... in decisions about your care and treatment?"	58	66	73	78	61	69	74	77
"... in decisions about the best medicine for you?"	50	53	59	66	56	58	63	64

In the 2008 emergency department survey, men and women aged 16 to 35 years (56% and 52% respectively) were less likely to say that they were 'yes, definitely' involved in decisions about their care and treatment than men and women aged 36 to 50 years (61% and 60% respectively).

In the 2007 inpatient survey, women aged 51 to 65 years were the group most likely to say that they were 'yes, definitely' involved as much as they wanted to be in decisions about their care and treatment (56%), and in decisions about discharge from hospital (58%).

At 43%, women aged over 80 were least likely to say that they were 'yes, definitely' involved as much as they wanted to be in decisions about their care and treatment as inpatients. Women aged over 80 and men and women aged 16-35 were the groups least likely to say that they 'yes, definitely' felt involved in decisions about discharge from hospital (46%, 46% and 45% respectively).

Shaping the undergraduate curriculum

The Picker Institute acknowledges that *Tomorrow's Doctors* refers to partnership-working, and that patient involvement is to some extent implied in elements of Outcomes 2.

Tomorrow's graduates will however need to be able to meet tomorrow's patients' expectations of involvement, and should be expected to take responsibility for ensuring equity.

Survey data do not provide explanations for age, sex, ethnic group and care setting variations and inequities in involvement. There are many possibilities, including:

- doctors misunderstanding, or making assumptions about, the extent to which different patients wish to be involved in decision-making
- doctors being willing, and/or having the competences, to involve some patients more than others
- environmental and cultural factors e.g. differing expectations of the patient role in different healthcare settings, differences between single-disciplinary and multi-disciplinary working.

Whatever the causes, the Picker Institute suggests that the best approach is to ensure that medical education and training equips graduates to:

- systematically, consistently and accurately assess the role that patients wish to play in decision-making
- create opportunities for patients to formulate and express their views and preferences
- share the decision-making process with patients, taking their views and preferences into account
- recognise and take practical steps to minimise barriers to involvement that arise from the characteristics of the doctor, the care setting and the patient
- support people to be as involved, as much they want to be, in sharing information and decisions about their care and treatment.

3. Translating standards and concepts into competences

Consistency

The Picker Institute has concerns about internal and external inconsistencies in the way *Tomorrow's Doctors* describes the doctor-patient relationship. Our view is that *Tomorrow's Doctors* should be internally consistent, and consistent throughout with *Good Medical Practice*; with *Consent: patients and doctors making decisions together*; and with the postgraduate Foundation Year 1 outcomes.⁸

Cross-checking with *Good Medical Practice* and *Consent* highlights significant gaps and assumptions in *Tomorrow's Doctors*, for example:

⁸ The New Doctor. GMC 2007.

- *Tomorrow's Doctors* Outcomes 2 – the doctor as a practitioner - reflects *Good Medical Practice* in stating that graduates will be able to work 'in partnership' with patients, but not at all points in the care pathway. The concept of working in partnership with patients is first introduced in para 158(c) 'formulate a plan of investigation in partnership with the patient'. Para 157 'carry out a consultation with a patient' requires no patient involvement, other than relating their history.
- Para 158(f), on the other hand, states that the graduate will be able to '...make clinical judgements and decisions, based on the available evidence, *in conjunction with colleagues* and as appropriate for the level of training and experience...' (our emphasis).
- Outcomes 3 – the doctor as a professional - describes a more hierarchical relationship in which graduates are expected to 'deal with' patients' healthcare needs 'in consultation' with them. This is not consistent with the relationship described in *Good Medical Practice* or the *Consent* guidance.
- Para 158(g) requires graduates to appreciate diverse factors in interpreting findings, but does not expect them to be able to involve patients in the interpretation.
- Para 158(g) also states that graduate will be to able to 'respond to patients' concerns and preferences' without requiring that graduates will be able to elicit patients' concerns and preferences.
- Similarly, being able to respect patients' rights 'to reach decisions with their doctors and to refuse or limit treatment' is not the same competence as being able to involve patients in decision-making or being able effectively to support their involvement.
- Being able to respect patients rights 'to hold religious or other beliefs and take these into account' is not the same as being able to support patients' right to express their beliefs, values and preferences.

The Picker Institute's view is that *Tomorrow's Doctors* should - throughout, and at all stages of the care pathway - require graduates to be able to work in partnership and share decision-making with patients. There should be overarching competences that apply to doctors as practitioners and professionals, across all points in the care pathway, including patient partnership in reaching clinical judgements and decisions.

Partnership competences

Good Medical Practice 2006 requires, as a professional standard, that doctors work in partnership with patients.

In describing the doctor-patient partnership, *Good Medical Practice* states that:

"Relationships based on openness, trust and good communication will enable you to work in partnership with your patients to address their individual needs."

Para 22(a) of the 'good communication' section specifies that: "to communicate effectively you must listen to patients, ask for and respect their views about their health, and respond to their concerns and preferences".

Partnership criteria are described according to the model of *informed* decision-making:

- listening to patients and respond to their concerns and preferences
- giving patients the information they want or need in a way they can understand
- respecting patients' right to reach decisions with you about their treatment and care
- supporting patients in caring for themselves to improve and maintain their health

The partnership standard and its associated criteria are cited, or implied, in *Tomorrow's Doctors*. We welcome the *Tomorrow's Doctors* requirements of providing information and support; communicating clearly, sensitively and effectively; and behaving with respect.

The Picker Institute is concerned, however, that *Tomorrow's Doctors* imports the concepts of 'partnership' and 'involvement' wholesale rather than translating them into specific competences that can be taught, learned and assessed.

Our view is that *Tomorrow's Doctors*' should include:

- partnership and communication competences that are **derived from the *Good Medical Practice*** requirements and criteria, rather than simply re-stating them
- specific shared decision-making competences, derived from the GMC's 2008 guidance *Consent: patients and doctors making decisions together*.

Shared decision-making competencies

The Picker Institute welcomes the GMC's adoption of shared decision-making as the model for doctor-patient relationships guidance *Consent: patients and doctors making decisions together*.

Appendix 1 of this response describes the shared decision-making approach. Appendix 2 tabulates the requirements of *Consent* that seem most relevant to *Tomorrow's Doctors*.

Combining these with *Good Medical Practice*, the Picker Institute suggests the following as essential shared decision-making competences for the undergraduate curriculum:

Partnership and shared decision-making - core competences

In order to adhere to *Good Medical Practice* and the GMC's *Consent* guidance graduates will need - at least - to be able to:

Determine:

- patients' capacity to consent to examinations, investigations and treatment and to share decision-making about care and treatment
- the extent to which patients want to be involved in decision-making about their care and treatment
- whether patients need additional support to understand and use information, to express their views, wishes and preferences, to be involved in decisions or to manage their condition
- how much information patients want to receive about their condition, prognosis and treatment options
- which information patients want or need in order to be involved, as much as they want to be, in decisions about their care and treatment
- which other sources of information and support would be appropriate for patients, and how to introduce, provide or signpost these.

Elicit:

- patients' questions
- patients' knowledge and understanding of their condition, prognosis and treatment options
- patients' views, values and preferences that may be significant in considering treatment options
- the importance that patients attach to different outcomes
- the adverse outcomes that patients would most prefer to avoid
- patients' understanding of risk and of the terms used to describe risk and probability
- whether patients would like more information, and/or more time, before making a decision about treatment.

4. Understanding the relationship between 'partnership' and 'informed consent'

In *Tomorrow's Doctors Outcomes 2 – the patient as a practitioner*:

Para 158(c) states that the graduate will be able to 'formulate a plan of investigation in partnership with the patient, obtaining informed consent as an essential part of this process.'

Similarly, Para 158(g) states that the graduate will be able to 'respond to patients' concerns and preferences, obtain informed consent, and respect the rights of patients to reach decisions with their doctors about their treatment and care and to refuse or limit treatment.'

In describing 'obtaining informed consent' as an essential part of the process of working in partnership with patients, and placing it before 'respecting the rights of patients to reach decisions with their doctors', there is a risk that medical schools will, explicitly or implicitly, teach that the **primary aim** of partnership working and shared decision-making is to obtain informed consent.

The purpose of working in partnership and sharing decision-making with patients should rather be to ensure that treatment choices, particularly preference-sensitive choices, are optimal for patients by:

- providing the best 'fit' with patients' values and preferences
- being most likely to achieve patients' desired outcomes
- being most likely to avoid the risks and adverse outcomes that the patient most wishes to avoid
- being most likely to achieve adherence to treatment regimens.⁹

The Picker Institute recognises that obtaining informed consent is a key competence for graduates, and that the doctor-patient partnership forms the context in which patients are able to give, limit or withhold consent.

Our view however is that *Tomorrow's Doctors* should more clearly convey to medical schools, tutors and graduates that obtaining informed consent is a **consequence** of working in partnership with patients and sharing decision-making, not the rationale.

⁹ Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence. NICE 2009.

Shared decision-making

Shared decision-making is a process in which patients are involved as active partners with the clinician in clarifying acceptable medical options and choosing a preferred course of clinical care.¹

What is involved?

Choosing an appropriate treatment with full patient involvement can be a complex process.² It involves a number of steps:

- recognise and clarify the problem
- identify potential solutions
- discuss options and uncertainties
- provide information about potential benefits, harms and uncertainties of each option
- check understanding and reactions
- agree a course of action
- implement the chosen treatment
- arrange follow-up
- evaluate the outcome.

When is it appropriate?

Shared decision-making is appropriate in any situation when there is more than one reasonable course of action and no one option is self-evidently best for everyone.

This situation is very common since there are often many different ways to treat a health problem, each of which may lead to a different set of outcomes. In these cases the patient's attitude to the likely benefits and risks should be a key factor in the decision. The principles of shared decision-making ought to be observed whenever clinicians have to obtain informed consent or communicate risks.

Two experts

Shared decision-making relies on two sources of expertise:

- the health professional is an expert on the effectiveness, probable benefits, and potential harms of treatment options
- the patient is an expert on herself, her social circumstances, attitudes to illness and risk, values and preferences.

Both parties must be willing to share information and accept responsibility for joint decision-making. The clinician must provide patients with information about the diagnosis and treatment options. The patient must tell the clinician about their preferences.

¹Sheridan SL, Harris RP, Woolf SH. Shared decision making about screening and chemoprevention: A suggested approach from the U.S. Preventive Services Task Force. *AM-J-PREV-MED* 2004;26:56-66.

²Elwyn G, Charles C. Shared decision making: the principles and the competences. In Edwards A, Elwyn G, eds. *Evidence-based patient choice*, pp 118-43. Oxford: Oxford University Press, 2001

Appendix 2

<p>Consent: patients and doctors making decisions together. GMC 2008.</p> <p>Requirements most relevant to Tomorrow's Doctors</p>	
Sharing information	
'How the guidance applies to you'	<p>You should discuss with [patients] their condition and treatment options in a way they can understand</p> <p>In deciding how much information to share with your patients you should take account of their wishes</p>
2(c)	[you must] share with patients the information they want or need in order to make decisions
7	<p>You should tailor your approach to discussions with patients according to:</p> <ul style="list-style-type: none"> (a) their needs, wishes and priorities (b) their level of knowledge about, and understanding of, their condition, prognosis and the treatment options (c) the nature of their condition (d) the complexity of the treatment, and (e) the nature and level of risk associated with the investigation or treatment
8	<p>You should not make assumptions about:</p> <ul style="list-style-type: none"> (a) the information a patient might want or need (b) the clinical or other factors a patient might consider significant, or (c) a patient's level of knowledge or understanding of what is proposed
9	You must give patients the information they want or need about: (12 point list)

11	You should check whether patients have understood the information they have been given, and whether or not they would like more information before making a decision. You must make it clear that they can change their mind about a decision at any time.
12	You must answer patients' questions honestly and, as far as practical, answer as fully as they wish
18	<p>You should:</p> <ul style="list-style-type: none"> (a) share information in a way that the patient can understand and, whenever possible, in a place and at a time when they are best able to understand and retain it (b) give information that the patient may find distressing in a considerate way (c) involve other members of the healthcare team in discussions with the patient, if appropriate (d) give the patient time to reflect, before and after they make a decision, especially if the information is complex or what you are proposing involves significant risks (e) make sure the patient knows if there is a time limit on making their decision, and who they can contact in the healthcare team if they have any questions or concerns.
34	You must use clear, simple and consistent language when discussing risks with patients. You should be aware that patients may understand information about risk differently from you. You should check that the patient understands the terms that you use, particularly when describing the seriousness, frequency and likelihood of an adverse outcome. You should use simple and accurate written information or visual or other aids to explain risk, if they will help the patient to understand
64	You must work on the presumption that every adult patient has the capacity to make decisions about their care, and to decide whether to agree to, or refuse, an examination, investigation or treatment. You must only regard a patient as lacking capacity once it is clear that, having been given all appropriate help and support, they cannot understand, retain, use or weigh up the information needed to make that decision, or communicate their wishes

66	A patient's ability to make decisions may depend on the nature and severity of their condition, or the difficulty or complexity of the decision. Some patients will always be able to make simple decisions, but may have difficulty if the decision is complex or involves a number of options. Other patients may be able to make decisions at certain times but not others, because fluctuations in their condition impair their ability to understand, retain or weigh up information, or communicate their wishes.
71	You must assess a patient's capacity to make a particular decision at the time it needs to be made. You must not assume that because a patient lacks capacity to make a decision on a particular occasion, they lack capacity to make any decisions at all, or will not be able to make similar decisions in the future.
Roles in decision-making	
3	Each person has a role to play in making decisions about treatment or care
4	No single approach to discussions about treatment or care will suit every patient, or apply in all circumstances. Individual patients may want more or less information or involvement in making decisions depending on their circumstances or wishes.
41	Patients may be put under pressure by employers, insurers, relatives or others, to accept a particular investigation or treatment. You should be aware of this and of other situations in which patients may be vulnerable. Such situations may be, for example, if they are resident in a care home, subject to mental health legislation, detained by the police or immigration services, or in prison.
Supporting patient involvement	
2(d)	[you must] maximise patients' opportunities, and their ability, to make decisions for themselves
4	... some patients may need additional support to understand information and express their views and preferences

20	You may need to support your discussions with patients by using written material, or visual or other aids. If you do, you must make sure the material is accurate and up to date.
21	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.
23	It is sometimes difficult, because of pressures on your time or the limited resources available, to give patients as much information or support in making decisions as you, or they, would like. To help in this, you should consider the role that other members of the healthcare team might play, and what other sources of information and support are available. These may be, for example, patient information leaflets, advocacy services, expert patient programmes, or support groups for people with specific conditions.
Respecting patients' views, values and preferences	
2(a)	[you must] listen to patients and respect their views about their health
5(b)	The doctor uses specialist knowledge and experience and clinical judgement, and the patient's views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient.
5 (d)	If the patient asks for a treatment that the doctor considers would not be of overall benefit to them, the doctor should discuss the issues with the patient and explore the reasons for their request
6	If patients are not able to make decisions for themselves, the doctor must work with those close to the patient and with other members of the healthcare team. The doctor must take into account any views or preferences expressed by the patient and must follow the law on decision-making when a patient lacks capacity.

10	You should explore these matters with patients, listen to their concerns, ask for and respect their views, and encourage them to ask questions.
29	<p>In order to have effective discussions with patients about risk, you must identify the adverse outcomes that may result from the proposed options. This includes the potential outcome of taking no action. Risks can take a number of forms, but will usually be:</p> <ul style="list-style-type: none"> (a) side effects (b) complications (c) failure of an intervention to achieve the desired aim.
Roles in assessment, diagnosis and formulation of treatment plan	
5(a)	The doctor and patient make an assessment of the patient's condition, taking into account the patient's medical history, views, experience and knowledge.
5(b)	The doctor uses specialist knowledge and experience and clinical judgement, and the patient's views and understanding of their condition, to identify which investigations or treatments are likely to result in overall benefit for the patient.
5(c)	The patient weighs up the potential benefits, risks and burdens of the various options as well as any non-clinical issues that are relevant to them. The patient decides whether to accept any of the options and, if so, which one
31	You should do your best to understand the patient's views and preferences about any proposed investigation or treatment, and the adverse outcomes they are most concerned about. You must not make assumptions about a patient's understanding of risk or the importance they attach to different outcomes. You should discuss these issues with your patient

40	<p>You should discuss with patients the possibility of additional problems coming to light during an investigation or treatment when they might not be in a position to make a decision about how to proceed. If there is a significant risk of a particular problem arising, you should ask in advance what the patient would like you to do if it does arise. You should also ask if there are any procedures they object to, or which they would like more time to think about</p>
58	<p>Such [advance care planning] discussions might cover:</p> <ul style="list-style-type: none">(a) the patient's wishes, preferences or fears in relation to their future care, including any treatments they would want to refuse, and under what circumstances(b) the feelings, beliefs or values that may be influencing the patient's preferences and decisions(c) the relatives, friends, carers or representatives that the patient would like to be involved in decisions about their care(d) interventions that are likely to become necessary in an emergency, such as cardio-pulmonary resuscitation (CPR)

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