Annex B

General Medical Council – *Consent: Patients and Doctors Making Decisions Together*

(Updated – June 2008)

Responsibility for seeking a patient's consent – section 26

If you are the doctor undertaking an investigation or providing treatment, it is your responsibility to discuss it with the patient. If this is not practical, you can delegate the responsibility to someone else, provided you make sure that the person you delegate to:

a. Is suitably trained and qualified
b. Has sufficient knowledge of the proposed investigation or treatment, and understands the risks involved
c. Understands and agrees to act in accordance with, the guidance in this booklet

Responsibility for seeking a patient's consent – section 27

If you delegate, you are still responsible for making sure that the patient has been given enough time and information to make an informed decision, and has given their consent, before you start any investigation or treatment.

Department of Health - *Guide to Consent for Examination or Treatment*

(July 2009)

Who should seek consent?

30 The clinician providing the treatment or investigation is responsible for ensuring that the person has given valid consent before treatment begins, although the consultant responsible for the person's care will remain ultimately responsible for the quality of medical care provided. The GMC guidance states that the task of seeking consent may be delegated to another person, as long as they are suitably trained and qualified. In particular, they must have sufficient knowledge of the proposed investigation or treatment, and understand the risks involved, in order to be able to provide any information the patient may require. The practitioner who eventually carries out the investigation or treatment must also be able to determine whether the person has the capacity to make the decision in question and what steps need to be taken if the person lacks the capacity to make that decision (see chapter 2). Inappropriate delegation (for example where the clinician seeking consent has inadequate knowledge of the procedure) may mean that the 'consent' obtained is not valid. Clinicians are responsible for knowing the limits of their own competence, and should seek the advice of appropriate colleagues when necessary.

General Medical Council – *Guidance on Delegation and Referral*

(Published – 25 March 2013, Live From – 22 April 2013)

Delegation

3 Delegation involves asking a colleague† to provide care or treatment on your behalf.

4 When delegating care you must be satisfied that the person to whom you delegate has the knowledge, skills and experience to provide the relevant care or treatment; or that the person will be adequately supervised.

5 When you delegate care you are still responsible for the overall management of the patient.

† Anyone a doctor works with, whether or not they are also doctors.

General Medical Council – *Good Medical Practice*

(Updated – April 2014)

Domain 2: Safety and quality

Continuity and coordination of care - section 45

When you do not provide your patients' care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient.[5]

(Above reference [5] relates to General Medical Council document on Delegation and referral)

Royal College of Ophthalmologists - *Cataract Surgery Guidelines*

(September 2010)

11.5 Taking Consent

GMC guidelines make it clear that the person taking consent does not have to be the person who will carry out the surgery, nor does it have to be someone who is capable of undertaking the procedure. The person must, however, be someone who is familiar with cataracts and cataract surgery who has been trained to communicate effectively and to take patient's consent, and whose professional practice is audited. It is the surgeon's responsibility to ensure that before any treatment is started, the patient has been given appropriate information, and that valid informed consent to surgery has been obtained and documented.

Royal College of Ophthalmologists and Clinical Council for Eye Health - *Commissioning Guide: Cataract Surgery*

(February 2015)

12 Recommended high quality cataract care pathway

The cataract pathway starts with an assessment where a patient with disabling visual symptoms is confirmed to have a cataract, which accounts for those symptoms and where the patient indicates their willingness to have cataract surgery following an explanation of the risks and benefits. Most referrals for consideration for cataract surgery are made following assessment by a community Optometrist, although a significant minority of patients listed for cataract surgery are already under the care of the hospital eye service for other conditions such as glaucoma and are listed directly. The postoperative phase of the cataract pathway includes a clinical examination to check for, or treat any postoperative complications, assess visual outcome and refractive status and ascertain the patient's satisfaction. In many cataract services, community optometrists are commissioned to deliver much of the preoperative and postoperative phases of the cataract pathway, though

commissioning arrangements may vary depending on geographical factors and the needs of the local population.

19 Appendix B: Recommended high quality cataract care pathway

An overview of an exemplar cataract care pathway is shown below and this is derived from the Royal College of Ophthalmologists Cataract Surgery Guidelines, the NHS Institute for Innovation and Improvement for best practice guidance on cataract and incorporates the recommendations previously made by the Royal College of Ophthalmologists on cataract surgery commissioning.

Key points

1. Patient visits GP or optometrist for assessment and is referred directly to the hospital eye service. Patients may also be listed for cataract surgery from hospital eye clinics.
2. Pre-operative assessment:
    - Measurement of visual function and ocular examination including biometry.
    - Provision of patient information leaflets.
    - Verification of suitability for day case surgery including discussion of anaesthesia options (usually topical or sub-tenons anaesthesia, but general anaesthesia may be required in some circumstances).
    - Identification of need for second eye surgery if there is cataract affecting both eyes, postoperative anisometropia or another indication for second eye surgery. (see ‡ below)
    - Completion of cataract consent form and discussion / choice of postoperative refractive target.
    - Verification that the case is appropriate to the level of expertise of the operating team and its clinical facilities. Adequate account must be made for any ocular or systemic co-morbidity which might increase the technical difficulty of the procedure, or increase the risk of complications.
3. Day of surgery:
    - Ophthalmologist or appropriately trained nurse marks eye and confirms consent. Preoperative check using NPSA surgical safety checklist performed prior to surgery.
    - Patient reviewed by a trained nurse following surgery- postoperative patient information, post-operative appointment date confirmed, and postoperative drops already dispensed.
4. After-care:
    - 2-4 week review by nurse, optometrist or ophthalmologist
    - 4-6 weeks post-operative refraction by optometrist.

General Medical Council - *Guidance for doctors who offer cosmetic interventions*

1 June 2016

Seeking patients' consent

15. You must be familiar with the guidance in Consent: Patients and Doctors Making Decisions Together. In the following paragraphs, we've highlighted key points from the guidance, which are important to protecting patients' interests in relation to cosmetic interventions.

Responsibility for seeking consent for cosmetic interventions

16. If you are the doctor who will be carrying out the intervention, it is your responsibility to discuss it with the patient and seek their consent – you must not delegate this responsibility. It is essential to a shared understanding of expectations and limitations that consent to a cosmetic intervention is sought by the doctor who will perform it, or supervise its performance by another practitioner.

Giving patients time for reflection

24. You must give the patient the time and information they need to reach a voluntary and informed decision about whether to go ahead with an intervention.
25. The amount of time patients need for reflection and the amount and type of information they will need depends on several factors. These include the invasiveness, complexity, permanence and risks of the intervention, how many intervention options the patient is considering and how much information they have already considered about a proposed intervention.
26. You must tell the patient they can change their mind at any point.
27. You must consider whether it is necessary to consult the patient's GP to inform the discussion about benefits and risks. If so, you must seek the patient's permission and, if they refuse, discuss their reasons for doing so and encourage them to allow you to contact their GP. If the patient is determined not to involve their GP, you must record this in their notes and consider how this affects the balance of risk and benefit and whether you should [still] go ahead with the intervention.

Being clear about fees and charges

28. You must explain your charges clearly so patients know the financial implications of any decision to proceed to the next stage or to withdraw.
29. You must be clear about what is included in quoted prices and what other charges might be payable, including possible charges for revision or routine follow-up.