

# **MEDICAL ETHICS EXPERT GROUP**

**Report dated: 3 August 2026**

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## PART A

### Your qualifications and background and approach to the report

**1. Please set out details of your qualifications, including your professional and/or academic experience. Please exhibit professional CVs with your report.**

1.1. This report was prepared by Professor Richard Huxtable, Dr Catriona McMillan, and Professor Angus McNair. The group agreed that Professor Huxtable would serve as chair to the group.

1.2. Richard Huxtable (LLB (Hons), MA, PhD) is Professor of Medical Ethics and Law, University of Bristol. With qualifications in law and ethics, Professor Huxtable has been based in the Medical School at Bristol since 2000, where he has directed the Centre for Ethics in Medicine since 2015. An experienced educator, Professor Huxtable co-leads the teaching on medical ethics and law in Bristol's MBChB Medicine course. Surgery, innovation, and clinical ethics are amongst Professor Huxtable's research interests. He has published extensively on these and other topics, and has collaborated on research projects funded by such organisations as the NIHR, the Wellcome Trust, and the EPSRC. Professor Huxtable has served as a member or chair of the boards of the UK Clinical Ethics Network, EACME (European Association of Centres of Medical Ethics), and the Institute of Medical Ethics. He has also served on various local, regional, and national ethics committees, including those of the British Medical Association and the Royal College of General Practitioners. Professor Huxtable has provided advice and guidance on various topics in medical ethics and law to the Royal College of Surgeons, General Medical Council, Jersey Government, Resuscitation Council, and Nuffield Council on Bioethics, amongst others. Professor Huxtable engages extensively with the public and professionals. He led the team that won the University of Bristol's Engagement Award 2016, for public engagement on end-of-life ethics. He was awarded the Ted Shotter Lifetime Achievement Award for Endeavour in Medical Ethics by the Institute of Medical Ethics in 2025. [ELJ0002-00183]

1.3. Catriona McMillan (LLB (Hons), LLM, PhD), is a Reader in Medical Law and Ethics at the University of Edinburgh, and Deputy Director of the Mason Institute for Medicine, Life Sciences, and the Law. Her research focuses on health, medical law and bioethics, with expertise in the ethics and regulation of medical devices, digital

health technologies, health research, and human reproduction. She has led funded research on the governance of women's health technologies and medical devices as a British Academy Postdoctoral Fellow and previously contributed to the Wellcome-funded Senior Investigator Award project on the regulation of health research. She has published extensively in the field and is the author of *The Human Embryo in vitro: Breaking the Legal Stalemate* (Cambridge University Press, 2021), and co-editor of the *Cambridge Handbook of Health Research Regulation*. She has also published widely on medical devices regulation, reproductive technologies, and other legal and ethical dimensions of innovation in healthcare. Dr McMillan has played an active role in engaging with professionals and policymakers, and regularly advises and reviews for funders, journals, and policy organisations. She served as Convener of the Law Society of Scotland's Health and Medical Law Committee, where she led committee legislative responses and gave expert evidence to the Scottish Parliament on multiple occasions. In November 2025 she was awarded the Royal Society of Edinburgh's Dame Muriel Spark Medal for her impact and achievements in research. [ELJ0002-00184]

- 1.4. Angus McNair (MB ChB, PhD, FRCS, SFHEA) is Professor of Colorectal Surgery, University of Bristol and Honorary Consultant Colorectal Surgeon, North Bristol NHS Trust. His clinical and academic work focuses on improving outcomes of surgery and developing patient-centred approaches to shared decision-making. He has a longstanding research interest in surgical ethics stemming from his doctoral fellowship on informed consent for major surgery in 2007, which was developed further by a prestigious NIHR Clinician Scientist Fellowship (2018) on improving decision-making for innovative surgery. He has published highly cited research on these and other topics (H-Index of 31) in leading journals including *Annals of Surgery*, *Journal of Clinical Oncology* and *PLOS Medicine*. This output has shaped international standards, influencing regulators, funders, and guideline developers such as NICE, EMA, and the Cochrane Collaboration. Professor McNair has secured funding from leading funders including NIHR and MRC, with a current programme monitoring patients' experience of surgical decision-making that has impacted over 40,000 patients. He served on several national committees including the NICE Interventional Procedures Advisory Committee, Board of the National Cancer Research Institute, NIHR Research for patient benefit funding panel and co-led the NIHR Oncology Translational Research Collaboration surgery theme. Beyond research, Professor McNair leads the final year of the Bristol Medical School MBChB programme that oversees professional training of c.300 future

doctors annually. His clinical practice focuses on the care of patients with complex pelvic malignancy including delivery of multivisceral pelvic exenteration. [ELJ0002-00185]

**2. Please set out in the report how you have gone about compiling it, including which sections have been allocated to each of the members of the expert group (if applicable) and why.**

Allocation of questions

- 2.1. Each member of the group prepared a first draft of a specific section and/or specific questions within a section. The sections and questions were allocated according to members' expertise and/or the time available to them. Each draft was then reviewed by the other two members of the group and any revisions agreed with the first author.
- 2.2. The allocation of sections and questions is set out in **Table 1**, in which the members of the group are referred to as: RH (Richard Huxtable); CM (Catriona McMillan); and AM (Angus McNair).

**Table 1: Allocation of questions**

| <b>PART</b> | <b>Question(s)</b> | <b>First author</b> |
|-------------|--------------------|---------------------|
| <b>A</b>    | 1                  | RH, CM, AM          |
|             | 2                  | RH                  |
| <b>B</b>    | 3-10               | RH                  |
|             | 11-12              | CM                  |
| <b>C</b>    | 13-20              | CM                  |
| <b>D</b>    | 21-30              | AM                  |
| <b>E</b>    | 31-35              | RH                  |
| <b>F</b>    | 36-38              | RH                  |
|             | 39-44              | CM                  |
| <b>G</b>    | 45                 | CM                  |
| <b>H</b>    | 46-48              | RH                  |

|   |       |    |
|---|-------|----|
| I | 49-52 | RH |
|---|-------|----|

### Understanding key terms

- 2.3. The questions we have been asked use such terms as “ethics”, “ethical obligations”, “ethical principles”, and “ethical standards”. In our answers, we refer to “theoretical ethical”, “professional ethical”, and “legal” obligations, positions, standards, etc. We explain here how we understand and use these terms in this report. **Table 2** summarises the key points, including the main distinctions between the three domains; such differences have long been recognised, and would certainly have been recognised by the 1990s.

### Theoretical ethical obligations

- 2.4. We use the phrase “theoretical ethical obligation(s)” (and related terms) to refer to those ethical obligations specified in particular ethical schools of thought, which generally derive from academic sources, in particular the academic field of moral philosophy.
- 2.5. We will primarily refer to theoretical ethical obligations when addressing questions about what should be (or become) the legal or professional ethical position.
- 2.6. Different types of obligations can share similar content: e.g., theoretical ethical obligations can inform the content of professional and legal obligations. But there are also differences between the various obligations, including in the consequences that can follow from failure to honour the obligation in question. Someone might judge a person negatively for failing to honour a theoretical ethical obligation, but their non-compliance is unlikely to result in the imposition of any formal penalty, such as might flow from failure to honour a professional or legal obligation. Although theoretical ethical sources lack overt authority, some may nevertheless exert influence over practice, e.g., publications that are widely-read and/or are authored by esteemed figures. As the Francis Report put it, “The messages transmitted [from academic learning, teaching and training] range from the near mandatory, where there is no room for controversy, to the completely discretionary, where there are many ‘schools of thought’ and little evidence base”.<sup>1</sup>

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<sup>1</sup> Mid Staffordshire NHS Foundation Trust (2013: [21.53]).

- 2.7. Theoretical ethical obligations primarily derive from moral philosophy. Generally, “ethics” – and the related notions of “morals” and “morality” – refers to ideas of the *right* (as opposed to the wrong) and the *good* (as opposed to the bad). There are various schools of ethical thought, which attempt to specify that which is good or right. In doing so, these schools of thought are typically directed towards answering one (or both) of two questions: “What should I do?” and “How should I live (or: Who should I be)?” Some theories hold that the answers to these questions will be *universal*, and therefore apply to everyone, everywhere; however, others suggest that the answers will be *relative* to particular people, places, or times.

#### *What should I do?*

- 2.8. Answers to the question “What should I do?” tend to focus on the *action* a person should (or should not) take. There are two particularly prominent schools of thought, which seek to answer this question. The first emphasises that the obligation is to do that which is one’s *duty*; these are known as deontological accounts of ethics. The second emphasises that the obligation is to do that which will have the best *consequences*; these are known as consequentialist accounts of ethics, as exemplified by utilitarian thinking, which aims at securing the greatest good for the greatest number.

#### *How should I live?*

- 2.9. Answers to the question “How should I live (or: Who should I be)?” tend instead to focus on a person’s *character* and how a person should (or should not) live. Virtue ethics is a prominent approach, according to which people should live in accordance with – and exhibit – particular *virtues*, while avoiding particular vices.
- 2.10. Other moral traditions approach these questions in different ways: for example, some focus on relationships, while others are more community-orientated.

#### *Applied ethics*

- 2.11. There are also more *applied* approaches to ethics, which seek to specify the *particular* theoretical ethical obligations that arise in particular contexts or for particular people. Applied fields of ethics include “bioethics”, which encompasses “healthcare ethics”, which in turn encompasses “medical ethics”.
- 2.12. Within the field of medical ethics, the four principles approach is particularly well-known.<sup>2</sup> This approach – which is also known as “principlism” – was developed in

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<sup>2</sup> Beauchamp and Childress (2019).

the USA and has been adopted by professionals in many settings and countries.<sup>3</sup> [ELJ0002-00100] According to this approach, the aim should be to strike an appropriate balance between four principles:

- 2.12.1. *Respect for autonomy* (self-determination, self-rule): the obligation to respect the decision-making capacities of those persons who are capable of making decisions. Some, such as Gillon in an article from 2003, have suggested that this should be the primary principle in contemporary medical ethics.<sup>4</sup> [ELJ0002-00097] Professional organisations have noted how the principle has indeed gained prominence in recent decades: for example, the British Medical Association (BMA), the doctors' trade union, noted in 1988 that "Society is moving away from paternalism towards partnership" between doctors and patients,<sup>5</sup> [ELJ0002-00158] and in 1993 it asserted the importance of the principle of respect for autonomy, which it saw as underpinning the need to obtain patients' consent.<sup>6</sup> [ELJ0002-00159]
- 2.12.2. *Non-maleficence*: the obligation to avoid causing harm, and therefore to protect and safeguard patients.
- 2.12.3. *Beneficence*: the obligation to provide benefits and to balance benefits against risks.
- 2.12.4. *Justice*: obligations to aim for the fair distribution of benefits and risks. These are principles, which amount to general guides that leave room for the judgment of the individual clinician or a team of clinicians. The authors acknowledge that there may be situations in which the principles conflict. In such situations, they suggest that a balance should be struck between the principles, through a process of "reflective equilibrium". That process involves moving back-and-forth between the principles, background ethical theories (like those described in **2.8** to **2.10**), and particular moral beliefs and judgments, in an effort to achieve coherence between them by bringing them all into balance.

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<sup>3</sup> Huxtable (2013).

<sup>4</sup> Gillon (2003).

<sup>5</sup> British Medical Association (1988: 29).

<sup>6</sup> British Medical Association (1995: 7).

## Professional ethical obligations

- 2.13. We use the phrase “professional ethical obligation(s)” (and related terms) to refer to those ethical obligations that apply to particular professionals. Some such guidance is intended only to apply to particular professionals, for example, to those working in a specific setting or to those undertaking particular tasks or roles. Professionals should be aware of – and heed – any general or specific guidance that is applicable to their practice in the jurisdiction in question; this is the case irrespective of whether (for example) they were trained in another country or culture.<sup>7</sup>
- 2.14. We will primarily refer to professional ethical obligations when addressing questions about what is or was the (professional) ethical position at a given time.
- 2.15. Professional ethical obligations will generally align with legal obligations. Professional ethical obligations may also be informed by theoretical ethical obligations.
- 2.16. Professional ethical obligations will typically be set down in published guidance, which seeks to articulate the ethical standards, behaviours, characteristics, and/or values that should be observed and exhibited by the professionals to whom it applies.<sup>8</sup> [ELJ0002-00101]; [ELJ0002-00136] Such guidance is typically directed towards answering such questions as: “How am I obliged to behave as a professional?”
- 2.17. Distinguishing ethical guidance from other forms of professional guidance is not always straightforward.<sup>9</sup> [ELJ0002-00101]; [ELJ0002-00136] Sometimes guidance is explicitly labelled as “ethical” guidance. On other occasions, guidance is not explicitly so-labelled, but its content may nevertheless be informed by an ethical position(s): for example, clinical guidance might implicitly rest on ethical principle(s) without being overtly labelled “ethical” guidance. We will primarily refer to guidance that is explicitly labelled or described as “ethical” in nature.
- 2.18. Professional ethical guidance will typically be prepared, issued, and/or endorsed by a professional organisation. The various organisations, and the guidance they issue, vary in two important ways:

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<sup>7</sup> See, e.g., the General Medical Council’s website, which states that doctors must hold a licence to practice in the UK, which in turn requires them to register with this regulator and then observe its standards: General Medical Council (2026b).

<sup>8</sup> Huxtable (2020); Smith et al. (2021).

<sup>9</sup> Huxtable (2020); Smith et al. (2021).

- 2.18.1. *Scope*: Some organisations, and the standards they issue, apply to healthcare professionals (generally); others apply only to doctors; others apply only to surgeons; and others apply only to neurosurgeons specifically.
- 2.18.2. *Authority*: Some organisations, and the standards they issue, have authority, while others have influence. Authoritative organisations (and standards) include the regulators, which determine who can practice, and Royal Colleges, which control entry to the specialty (see also **3.17**). Other organisations may have more of an advisory, supportive, or collegial role, but they may nevertheless exert considerable influence, such that their guidance should also be heeded.<sup>10</sup> [ELJ0002-00101]; [ELJ0002-00136]; [ELJ0002-00116] (Please note that key examples are further discussed below (at **3.17**); see also **Table 4**, below.)

### Legal obligations

- 2.19. We use the phrase “legal obligation(s)” (and related terms) to refer to those obligations set down in law.
- 2.20. We will say least about legal obligations, as we anticipate that these will be dealt with in depth elsewhere in the Inquiry.
- 2.21. Legal obligations are often backed by sanctions. Depending on the precise legal wrong, the sanctions may range from providing compensation to imprisonment. Legal obligations therefore tend to provide an answer to the question: “What must I do?”

### Abbreviations

- 2.22. The following abbreviations are used in this report:
- |       |                                                      |
|-------|------------------------------------------------------|
| BMA   | British Medical Association                          |
| BNTRC | British Neurosurgical Trainee Research Collaborative |
| CAG   | Confidentiality Advisory Group                       |
| CCG   | Clinical commissioning group                         |

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<sup>10</sup> Huxtable (2020); Smith et al. (2021); Miola (2006).

|         |                                                                   |
|---------|-------------------------------------------------------------------|
| CCST    | Certificate of Completion of Specialist Training                  |
| CCT     | Certificate of Completion of Training                             |
| CIOMS   | Council for International Organizations of Medical Sciences       |
| CTIMPs  | Clinical Trials of Investigational Medicinal Products             |
| EACME   | European Association of Centres of Medical Ethics                 |
| EANS    | European Association of Neurosurgical Societies                   |
| EPSRC   | Engineering and Physical Sciences Research Council                |
| FRCS    | Fellowship of the Royal College of Surgeons of England            |
| GMC     | General Medical Council                                           |
| HIS     | Healthcare Improvement Scotland                                   |
| HRA     | Health Research Authority                                         |
| ICH     | Global Health Network's International Council for Harmonisation   |
| ICSP    | Intercollegiate Surgical Curriculum Programme                     |
| IMMDS   | Independent Medicines and Medical Devices Safety review           |
| IPAC    | (NICE) Interventional Procedure Advisory Committee                |
| JCIE    | Joint Committee on Intercollegiate Examinations                   |
| JCST    | Joint Committee on Surgical Training                              |
| MDU     | Medical Defence Union                                             |
| MHRA    | Medicines and Healthcare products Regulatory Agency               |
| MIND-IT | Making Informed Decisions Individually and Together in healthcare |
| MPTS    | Medical Practitioners Tribunal Service                            |
| MRC     | Medical Research Council                                          |
| MRCS    | Member of the Royal College of Surgeons                           |
| NICE    | National Institute for Health and Care Excellence                 |
| NIHR    | National Institute of Health Research                             |
| NTNG    | Neuro Theatre Network Group                                       |
| PALS    | Patient Advice and Liaison Service                                |
| PBPP    | Public Benefit and Privacy Panel                                  |

|        |                                                   |
|--------|---------------------------------------------------|
| PMETB  | Postgraduate Medical Education and Training Board |
| PSA    | Professional Standards Authority                  |
| RCS    | Royal College of Surgeons of England              |
| RCSEd  | Royal College of Surgeons of Edinburgh            |
| REC    | Research Ethics Committee                         |
| SBNS   | Society of British Neurological Surgeons          |
| SDM    | Shared decision-making                            |
| SIGN   | Scottish Intercollegiate Guidelines Network       |
| UKNSRN | UK Neurosurgical Research Network                 |
| WFNS   | World Federation of Neurological Societies        |

**Table 2:** *Types of obligations*

| <b>Type of obligation</b>   | <b>Nature and sources</b>                                                                            | <b>Authority and penalties</b>                                                                                                              | <b>Place in report</b>                                                                                                 |
|-----------------------------|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| <b>Theoretical ethical</b>  | Obligations specified by various schools of thought in the <i>academic field</i> of moral philosophy | <i>Lacks any overt authority</i> , but can inform the other types of obligations. Non-compliance may result in (e.g.) negative judgment     | Primarily informs answers to questions about what <i>should be(come)</i> the legal or professional ethical position    |
| <b>Professional ethical</b> | Obligations specified by <i>professional organisations</i>                                           | <i>Has authority</i> or at least influence over those to whom the obligations apply. Non-compliance may lead to removal from the profession | Primarily informs answers to questions about what the (professional) ethical position <i>is or was</i> at a given time |
| <b>Legal</b>                | Obligations specified in <i>law</i>                                                                  | <i>Has authority</i> . Non-compliance may require remedy (e.g., compensation) or lead to punishment (e.g., imprisonment)                    | Features less often, but sometimes provides context to answers                                                         |

## PART B

### GENERAL

#### 3. To what extent does the field of surgical ethics give rise to different considerations from the field of medical ethics more generally?

##### Academic positions on the relationship between surgical and medical ethics

3.1. The academic literature on surgical ethics suggests that different positions may be taken in answer to this question:

3.1.1. The first position holds that surgical ethics does not give rise to different considerations from the field of medical ethics more generally. On this view, surgical ethics essentially involves the *application* of general approaches to (medical) ethics (3.3-3.5);

3.1.2. The second position holds that surgical ethics does give rise to different considerations from the field of medical ethics more generally, as it has distinctive features, which require the *modification* of general approaches to (medical) ethics (3.6-3.7); and/or

3.1.3. The third position holds that surgical ethics does give rise to different considerations from the field of medical ethics more generally, as it has distinctive features, which require the *specification* of particular approaches (3.8-3.16).

3.2. In this section we outline each of these positions, making reference to some of the literature on surgical ethics. Two points should be noted about the literature cited:

3.2.1. Some scholars have suggested that, internationally, there has been (surprisingly) little engagement with surgical ethics in the broad(er) field of medical ethics.<sup>11</sup> [ELJ0002-00072] This is also the case in the UK. **Table 3** compares two basic searches for articles, which were published by authors based in the UK since 1995 and are listed in the medicine database “PubMed”. Row (1) shows the results of a search for articles on surgical ethics; in contrast, row (2) shows the results of a search for articles on palliative care ethics. Despite the relative lack of scholarly

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<sup>11</sup> Agledahl and Pedersen (2024).

engagement with surgical ethics, we believe that there is sufficient evidence available to indicate some themes or patterns.

- 3.2.2. Much of the literature derives from international scholars, and particularly from surgeons and ethicists based in the USA. We note, however, that similar points have been made by UK-based authors.<sup>12</sup>

**Table 3: Comparison of searches for articles**

|   | <b>Search terms:</b><br>UK[Affiliation] and | <b>1995-04</b> | <b>2005-14</b> | <b>2015-24</b> | <b>2025-</b> | <b>Total</b> |
|---|---------------------------------------------|----------------|----------------|----------------|--------------|--------------|
| 1 | ("surg* ethic*")                            | 0              | 33             | 19             | 0            | 52           |
| 2 | (palliat* ethic*)                           | 78             | 202            | 806            | 480          | 1566         |

### *Surgical ethics as the application of general (medical) ethics*

- 3.3. The first position holds that surgical ethics does *not* give rise to different considerations from the field of medical ethics more generally. On this view, surgical ethics involves the *application* of general approaches to (medical) ethics. Indeed, according to Kodner, "Surgeons live and practice an intense form of applied ethics".<sup>13</sup> [ELJ0002-00108]
- 3.4. Some sources on surgical ethics draw on (general) *theoretical ethical obligations* (2.4) and therefore refer to the main schools of ethical thought, which understand ethics in terms of consequences, duties, and/or virtues (2.8-2.10).<sup>14</sup> [ELJ0002-00129]; [ELJ0002-00112] Some authors suggest that surgery requires an "ethics of action",<sup>15</sup> [ELJ0002-00081] so surgeons should focus on consequences and duties (2.8). Other authors instead (or also) emphasise that surgeons need good characters, so they should exhibit particular virtues (2.9),<sup>16</sup> [ELJ0002-00129]; [ELJ0002-00115] such as perseverance, punctuality, fairness, honesty, kindness, and teamwork.<sup>17</sup> [ELJ0002-00081]
- 3.5. Sources on surgical ethics also often refer to areas of *applied ethics*, particularly the four principles approach in medical ethics (2.11-2.12), and the specific obligations that these generate, such as the obligation to ensure that patients provide informed

<sup>12</sup> Hakim et al. (2015).

<sup>13</sup> Kodner (2003 : 952).

<sup>14</sup> Sade (2015: 1); Luc et al. (2022).

<sup>15</sup> Cardenas (2020).

<sup>16</sup> Sade (2015: 2); Jones et al. (2008: 6); McCullough et al. (1998: 5).

<sup>17</sup> Cardenas (2020).

consent.<sup>18</sup> [ELJ0002-00129] [ELJ0002-00115] [ELJ0002-00081] [ELJ0002-00089] [ELJ0002-00084] [ELJ0002-00112]

### *Surgical ethics as the modification of general (medical) ethics*

- 3.6. The second position holds that surgical ethics *does* give rise to different considerations from the field of medical ethics more generally, as it has distinctive features, which require the *modification* of general approaches to (medical) ethics. This position implies that any difference between surgical ethics and the field of (medical) ethics more generally is a matter of degree or emphasis.
- 3.7. Some sources on surgical ethics therefore see the scope of surgical ethics as “the way in which the procedural nature of surgery and its capacity for bodily and psychic damage modify general ethical considerations such as virtues, consequences, rights, justice, and equality”.<sup>19</sup> [ELJ0002-00081] This view, which has been attributed to McCullough et al.,<sup>20</sup> [ELJ0002-00115] essentially holds “that the ethics of surgery is a special case of the general ethics of medicine”.<sup>21</sup> [ELJ0002-00088]

### *Surgical ethics as the specification of particular approaches*

- 3.8. The third position holds that surgical ethics does give rise to different considerations from the field of medical ethics more generally, as it has distinctive features, which require the *specification* of particular approaches, which attend to the particularities of surgery. This position implies that surgical ethics gives rise to different considerations from the field of medical ethics more generally.
- 3.9. Little, who was an Australian surgical oncologist, felt “there is clearly something distinctive about surgery”<sup>22</sup> [ELJ0002-00110]. Various other authors similarly refer to the “distinctive”,<sup>23</sup> [ELJ0002-00111] [ELJ0002-00118] “unique”,<sup>24</sup> [ELJ0002-00089] [ELJ0002-00081] or “special” characteristics of surgery.<sup>25</sup> [ELJ0002-00129] Authors like Ferreres, a surgeon based in Buenos Aires and Washington, suggest

<sup>18</sup> Sade (2015: 2-3); McCullough et al. (1998: 6-9); Jones et al. (2008: 7-9); Cardenas (2020); Ferreres (2019); Cinà and Abouzahr (2025); Luc et al. (2022).

<sup>19</sup> Cardenas (2020: 2).

<sup>20</sup> McCullough et al. (1998).

<sup>21</sup> Ferreres and Angelos (2014).

<sup>22</sup> Little (2002: 184).

<sup>23</sup> Lo (2022); Namm and Krause (2019).

<sup>24</sup> Ferreres (2019: 45); Cardenas (2020).

<sup>25</sup> Sade (2015: 4).

that these different features “necessitate a specialized ethical framework”,<sup>26</sup> [ELJ0002-00090] such that surgical ethics “differentiates itself from the field of medical ethics”.<sup>27</sup> [ELJ0002-00090]

- 3.10. The manual dexterity required of surgeons, along with their use of devices, potentially generate distinctive ethical obligations.<sup>28</sup> [ELJ0002-00129] However, scholars like Ferreres tend to highlight six features of surgery, which they consider to be distinctive and ethically salient:

- 3.10.1. Surgery harms before healing and curing the patient **(3.11)**;
- 3.10.2. The operating room concentrates risk and error **(3.12)**;
- 3.10.3. Surgical decision-making occurs under radical uncertainty **(3.13)**;
- 3.10.4. Surgery carries unique accountability **(3.14)**;
- 3.10.5. The surgical relationship embodies extraordinary intimacy and vulnerability **(3.15)**;
- 3.10.6. Surgery evolves rapidly **(3.16)**.

- 3.11. *Surgery harms before healing and curing the patient.*<sup>29</sup> [ELJ0002-00089] The invasive infliction of harm – via incision or other bodily invasion – is a defining feature of surgery. Indeed, as Agledahl and Pedersen put it, surgeons “inevitably harm as a profession”.<sup>30</sup> [ELJ0002-00072] All medical interventions involve a degree of risk, but surgery carries some distinctive risks, such as the risks inherent in undergoing the operation (including under anaesthetic), scarring, and experiencing post-operative pain.<sup>31</sup> [ELJ0002-00111] Hopefully, though, any harms are not only short-term, but also outweighed by longer-term benefits.<sup>32</sup> [ELJ0002-00081]; [ELJ0002-00090] Ultimately, it is the surgeon’s therapeutic intention which means that their infliction of harm is ethically justified and which also enables them to avoid such legal wrongs as assault or battery.

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<sup>26</sup> Ferreres (2025a: 1).

<sup>27</sup> Ferreres (2025a: 3).

<sup>28</sup> Sade (2015: 6-8).

<sup>29</sup> Ferreres (2019: 45).

<sup>30</sup> Agledahl and Pedersen (2024).

<sup>31</sup> Lo (2022).

<sup>32</sup> Cardenas (2020); Ferreres (2025a: 1).

- 3.12. *The operating room concentrates risk and error.*<sup>33</sup> [ELJ0002-00090] Surgery is characterised by risk and fallibility, with a significant proportion of medical errors reportedly occurring in the operating room.<sup>34</sup> [ELJ0002-00089]
- 3.13. *Surgical decision-making occurs under radical uncertainty.*<sup>35</sup> [ELJ0002-00090] The problem of uncertainty is “magnified” for surgeons.<sup>36</sup> [ELJ0002-00129]; [ELJ0002-00089]; [ELJ0002-00081] Unlike clinicians in some other contexts, surgeons can be required to take immediate action, in circumstances when there is insufficient time to deliberate or gather more complete information.
- 3.14. *Surgery carries unique accountability.*<sup>37</sup> [ELJ0002-00090] Ferreres suggests that a “fierce accountability shapes surgical culture and ethics”.<sup>38</sup> [ELJ0002-00090] Lo notes that operations are neither as predictable nor as standardised as pharmaceutical regimens; instead, patient outcomes significantly depend on the skill, judgment, experience, and confidence of the surgeon.<sup>39</sup> [ELJ0002-00111] As such, an important part of surgical training involves learning about how surgeons assume personal responsibility – and will ultimately be held accountable – for the procedures they perform.<sup>40</sup> [ELJ0002-00072] In their review, Agledahl and Pedersen found that the responsibility of the surgeon featured in many published articles about ethics in the operating room: surgery involves a team, but responsibility tends to lie with the individual surgeon.<sup>41</sup> [ELJ0002-00072] They noted that complications could arise, for example, in situations of overlapping surgery or the introduction of new technologies, which could raise questions about who ultimately has responsibility, including if something goes wrong.<sup>42</sup> [ELJ0002-00072]
- 3.15. *The surgical relationship embodies extraordinary intimacy and vulnerability.*<sup>43</sup> [ELJ0002-00090] Ferreres observes how “The patient literally places their body in the surgeon’s hands, creating a fiduciary relationship of unparalleled trust and responsibility”.<sup>44</sup> [ELJ0002-00090] Others make the same point about the “degree

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<sup>33</sup> Ferreres (2025a: 2).

<sup>34</sup> Ferreres (2019: 45).

<sup>35</sup> Ferreres (2025a: 2).

<sup>36</sup> Sade (2015: 5); Ferreres (2019: 45); Cardenas (2020).

<sup>37</sup> Ferreres (2025a: 2).

<sup>38</sup> Ferreres (2025a: 2).

<sup>39</sup> Lo (2022).

<sup>40</sup> Agledahl and Pedersen (2024).

<sup>41</sup> Agledahl and Pedersen (2024: 11).

<sup>42</sup> Agledahl and Pedersen (2024: 6, 8).

<sup>43</sup> Ferreres (2025a: 2).

<sup>44</sup> Ferreres (2025a: 2).

of intimacy”, “access to physical privacy”,<sup>45</sup> [ELJ0002-00129] and “extreme vulnerability of the patient”,<sup>46</sup> [ELJ0002-00072] which are distinctive features of the surgical encounter.<sup>47</sup> [ELJ0002-00111] Little suggests that these distinctive features are captured by five categories of surgical ethics.<sup>48</sup> [ELJ0002-00110]; [ELJ0002-00089]; [ELJ0002-00090] The first four of these describe the patient’s experiences, while the fifth is more normative, in requiring the surgeon to address the patient’s needs. The five categories described by Little are:

- 3.15.1. *Rescue*: In order to be “rescued”, the patient submits to the skill – and power – of the surgeon;
  - 3.15.2. *Proximity*: The patient-surgeon relationship tends to be intense, intimate, and time-limited;
  - 3.15.3. *Ordeal*: The patient will undergo an extreme, disruptive experience;
  - 3.15.4. *Aftermath*: The patient will live with the – potentially negative – experience and impact of surgery;
  - 3.15.5. *Presence*: The surgeon should recognise that their presence is both a virtue and a duty, which requires them to attend to such needs of the patient as might arise in any or all of the previous four categories. Little suggests that patients “want the surgeon’s presence”, both throughout the process of surgery and in its aftermath; “That presence is at best a real, physical, cognitive and engaged presence; at least a delegated presence in which junior doctors and nursing staff express the surgeon’s engagement and concern”.<sup>49</sup> [ELJ0002-00110]
- 3.16. *Surgery evolves rapidly*. Cardenas has suggested that the rapid evolution of surgery – including the development of innovative procedures and devices, such as robotic surgery – is also a distinctive feature of the field, which means that surgeons “face new and ever more challenging ethical issues”.<sup>50</sup> [ELJ0002-00081] Amongst the examples of new and challenging issues to which Cardenas refers are the provision of information to patients when “the real risks of a new technique may not be known”, training surgeons in new techniques, evaluating outcomes of such

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<sup>45</sup> Sade (2015: 4).

<sup>46</sup> Agledahl and Pedersen (2024).

<sup>47</sup> Lo (2022).

<sup>48</sup> Little (2002). See also: Ferreres (2019: 48); Ferreres (2025a: 2).

<sup>49</sup> Little (2002: 197).

<sup>50</sup> Cardenas (2020).

procedures, and balancing responsibilities to patients and society at large.<sup>51</sup>  
[ELJ0002-00081].

### Professional positions on the relationship between surgical and medical ethics

- 3.17. Turning to professional ethical obligations (**2.13-2.18**), there are various organisations and societies that set down ethical principles, practices, rules, norms, and frameworks (“guidance” or “standards”), which apply to decision-making and practice in the field of surgery. **Table 4** outlines the most relevant standard-setting organisations, including their main roles and functions, their scope, and their authority (see **2.18**).
- 3.17.1. Some of these organisations have *authority* over a surgeon. These primarily comprise the General Medical Council (GMC), which regulates doctors, and the Royal College of Surgeons of England (RCS), the Royal College of Surgeons of Edinburgh (RCSEd), and the Joint Committee on Surgical Training (JCST), as together these control entry to surgery, including neurosurgery.
- 3.17.2. Some of these organisations have *influence* over a neurosurgeon. Influential organisations include the British Medical Association (BMA), which issues guidance to all doctors.
- 3.18. Both the RCS and RCSEd appear to see (professional) surgical ethics as involving the *application* of the more general principles or standards advanced in (professional) medical ethics:
- 3.18.1. The RCS issues *Good Surgical Practice* (most recently in March 2025), which “sets standards for surgeons and is relevant to the wider surgical team”.<sup>52</sup> [ELJ0002-00128] The RCS makes explicit that this document “is not a statutory code or a regulatory document, but rather seeks to exemplify the standards required of all doctors by the GMC in the context of surgery”.<sup>53</sup> [ELJ0002-00128] This guidance does not generally distinguish (professional) surgical ethics from medical ethics, as it adopts the same headings as the GMC’s *Good Medical Practice* “and is the surgical companion to the GMC document”.<sup>54</sup> [ELJ0002-

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<sup>51</sup> Cardenas (2020: 4, 5).

<sup>52</sup> Royal College of Surgeons of England (2025: 2).

<sup>53</sup> Royal College of Surgeons of England (2025: 2).

<sup>54</sup> Royal College of Surgeons of England (2025: 2).

00128] The RCS document had first been issued in 2002, following the publication of the (then) latest edition (2001) of the GMC's *Good Medical Practice*; at that time, there was growing emphasis on standards in healthcare, amidst inquiries into (*inter alia*) paediatric cardiac surgery in Bristol and the retention of organs in different settings nationally.<sup>55</sup> [ELJ0002-00155] The GMC's *Good Medical Practice* had first been published in 1995, when it replaced the so-called "blue book", *Professional Conduct and Discipline: Fitness to Practise*, which had first been issued in 1963.<sup>56</sup> [ELJ0002-00178] From 1979 to 1993, the "blue book" had expanded to include not only information about disciplinary and fitness to practice procedures, but also guidance on expected ethical standards; a 1993 Working Group advised that the material be separated, hence the production of *Good Medical Practice* from 1993 onwards.<sup>57</sup> [ELJ0002-00178]

- 3.18.2. The RCS applies not only to England, but also to Scotland. In addition, the RCSEd has also issued a code of conduct, *Living Our Values* (first issued in January 2024), which "sets out the expected standards of ethics, probity and behaviour expected from the membership of the RCSEd".<sup>58</sup> [ELJ0002-00124] This code specifically refers to the obligation to "adhere to the general principles of conduct and behaviour laid out in our relevant professional regulatory bodies' code of practice".<sup>59</sup> [ELJ0002-00124]

### Conclusion: Surgical ethics as applied, modified, and distinctive

- 3.19. The theoretical and professional literature suggests that surgical ethics involves: (a) the application of general medical ethics; (b) the modification of general medical ethics; and/or (c) the specification of distinctive ethical considerations and obligations, given some of the distinctive features of surgery. All three positions command some support.
- 3.20. We believe that each of these positions plausibly captures an aspect(s) of surgical ethics. We conclude that surgical ethics will sometimes rest on familiar

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<sup>55</sup> Wilson (2014: 236-237).

<sup>56</sup> General Medical Council (2024c).

<sup>57</sup> General Medical Council (2024c).

<sup>58</sup> Royal College of Surgeons of Edinburgh (2024: 4).

<sup>59</sup> Royal College of Surgeons of Edinburgh (2024: 7).

considerations from the field of medical ethics, but will sometimes give rise to considerations that differ from the field of medical ethics more generally.

**4. What training has been provided to surgeons about their ethical obligations (general or particular) in the United Kingdom over the last 40 years? How has that training evolved over that period?**

Background: Formal and informal surgical ethics education

4.1. There appear to be few academic sources that address surgical ethics education. Nemetz et al. noted in 2022 that the topic “has an evolving small body of literature”.<sup>60</sup> [ELJ0002-00119] Those sources advocate the ethical education of surgeons through both formal and informal methods:

4.1.1. *Formal* methods involve the explicit inclusion of ethics in education and training curricula, through various means (e.g., lectures, tutorials, practicals).<sup>61</sup> [ELJ0002-00119] Ferreres asserts that “surgical education must address not just what Bosk called the ‘ethics of technique’ but the ‘technique of ethics’ – the practical skills needed to navigate moral complexity in real time”.<sup>62</sup> [ELJ0002-00090] Echoing some of the topics that arise in neurosurgical ethics (7.11-7.15), Ferreres suggests the following “interconnected domains” as essential components of surgical ethics education: the surgeon-patient relationship; clinical decision-making ethics; professional development; system-level ethics (e.g., resource allocation, justice, advocacy responsibilities); innovation ethics; and end-of-life care.<sup>63</sup> [ELJ0002-00090] Ferreres suggested that such components should be “woven throughout” training, rather than reserved for specific lectures.<sup>64</sup> [ELJ0002-00090]

4.1.2. *Informal* ethics education occurs through what is known as the “hidden curriculum”.<sup>65</sup> [ELJ0002-00119]; [ELJ0002-00090] According to Ferreres, “When residents observe attending surgeons obtaining truly informed consent, acknowledging uncertainty, or admitting error, they

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<sup>60</sup> Nemetz et al. (2022: 147).

<sup>61</sup> Nemetz et al. (2022: 150).

<sup>62</sup> Ferreres (2025a: 16).

<sup>63</sup> Ferreres (2025a: 18).

<sup>64</sup> Ferreres (2025a: 18).

<sup>65</sup> Nemetz et al. (2022: 149); Ferreres (2025a: 16).

learn ethical practice more powerfully than through any lecture”.<sup>66</sup>

[ELJ0002-00090] However, there can be disadvantages to informal education: ethical reasoning might not be made sufficiently explicit,<sup>67</sup> [ELJ0002-00119] and students might learn the wrong lessons from poor role models.

- 4.2. Turning to professional sources, international organisations also call for surgical ethics education, including in neurosurgery specifically. In its 2007 statement on ethics, the WFNS recommended that “We should encourage leaders in medical education, neurosurgical training, and in professional meetings to include discussions and presentations of ethical issues into the syllabi and agendas for their programs”.<sup>68</sup> [ELJ0002-00070\_10].<sup>69</sup> [ELJ0002-00148]

### Becoming a (neuro)surgeon

- 4.3. Turning to the UK position, the RCS website outlines the standard training route for becoming a (neuro)surgeon:<sup>70</sup> [ELJ0002-00063]
- Medical school (undergraduate): 5-6 years
  - Foundation training: 2 years
  - Core surgical training: 2 years
  - Speciality training: approx. 6 years (the Society of British Neurological Surgeons (SBNS) sets out the steps to becoming a neurosurgeon)<sup>71</sup> [ELJ0002-00068]
  - Senior medical appointment (for surgeons, this requires the successful completion of the Fellowship of the Royal College of Surgeons (FRCS) exam, which is “regulated by the Joint Committee on Intercollegiate Examinations (JCIE) for UK residents”).
- 4.4. Informal ethics education is likely to occur throughout all stages of education and training. Formal ethics education is also explicitly incorporated at different stages, with key examples provided below (**4.5-4.19**).

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<sup>66</sup> Ferreres (2025a: 16).

<sup>67</sup> Nemetz et al. (2022: 150).

<sup>68</sup> World Federation of Neurological Societies (2007: [108]).

<sup>69</sup> Westarp et al. (2026).

<sup>70</sup> Royal College of Surgeons of England (2026a).

<sup>71</sup> Society of British Neurological Surgeons (2026).

### Ethics education in Medical school (undergraduate students)

- 4.5. Until 1993, medical ethics education in medical schools was essentially optional and variable in nature and quality<sup>72</sup> [ELJ0002-00060]. In the late 1980s, the Institute of Medical Ethics (a charity dedicated to improving education and debate in medical ethics<sup>73</sup>) [ELJ0002-00103] convened a working party, chaired by Sir Desmond Pond, to review this teaching. The resulting Pond Report published its findings in 1987.<sup>74</sup> Following this, in 1993's *Tomorrow's Doctors*, the GMC formally incorporated ethics into the undergraduate medical curriculum<sup>75</sup> [ELJ0002-00060].
- 4.6. The 2009 edition of *Tomorrow's Doctors* was superseded by *Outcomes for Graduates (Tomorrow's Doctors)* in July 2015<sup>76</sup> [ELJ0002-00028]. The 2009 document had also included standards for the delivery of teaching, learning, and assessment, which were replaced by *Promoting excellence: Standards for medical education and training* in July 2015.
- 4.7. Nowadays, the GMC publishes *Outcomes for Graduates*, which “sets out the knowledge, skills and behaviours that new UK medical graduates must be able to show”,<sup>77</sup> [ELJ0002-00032] along with accompanying guidance for medical schools.<sup>78</sup> [ELJ0002-00096] The first – overarching – outcome makes explicit reference to ethics: “Medical students are tomorrow’s doctors. In accordance with Good medical practice, newly qualified doctors must make the care of patients their first concern, applying their knowledge and skills in a competent, ethical and professional manner and taking responsibility for their own actions in complex and uncertain situations”.<sup>79</sup> [ELJ0002-00096] Thereafter, the document sets out three broad outcomes, the first of which, “Professional values and behaviours”, opens with “Professional and ethical responsibilities”; the document thereafter makes several references to the ethical knowledge and skills expected of newly qualified doctors.<sup>80</sup> [ELJ0002-00096]
- 4.8. The GMC outcomes are complemented and expanded upon by a core curriculum (“core content”) on medical ethics, published by the Institute of Medical Ethics. The first edition of this was published in 1998, with subsequent editions in 2009, and

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<sup>72</sup> Reynolds and Tansey (2007).

<sup>73</sup> Institute of Medical Ethics (2026).

<sup>74</sup> Institute of Medical Ethics (1987).

<sup>75</sup> General Medical Council (1995); Reynolds and Tansey (2007: 66).

<sup>76</sup> General Medical Council (2015b).

<sup>77</sup> General Medical Council (2018a).

<sup>78</sup> General Medical Council (2020b).

<sup>79</sup> General Medical Council (2020b: [1]).

<sup>80</sup> General Medical Council (2020b: [2],[11],[26]).

2019.<sup>81</sup> [ELJ0002-00103] The current edition of the curriculum makes no explicit reference to surgery, but its 12 domains contain numerous topics relevant to surgical practice (e.g., professionalism, decision-making and capacity, medical research).

- 4.9. The RCS has also published a specific national undergraduate curriculum in surgery<sup>82</sup> [ELJ0002-00061]. The RCS notes that the “surgical attachment can provide the clinical environment where the following generic outcomes can be achieved: [...] To behave according to ethical and legal principles”<sup>83</sup> [ELJ0002-00061\_7]. The RCS document focuses particularly on consent. According to the RCS, “The consent process for a surgical operation crystallises elements of ethics, risk, benefit, choice, complications, communication and mental capacity. Emergency surgery, resuscitation discussions, and paediatric surgery consent are also relevant issues”<sup>84</sup> [ELJ0002-00061\_9]. The RCS then notes how, although they cannot themselves obtain consent for procedures, undergraduate students “need a firm understanding of risks, benefits and decision-making, assessing each patient as an individual”<sup>85</sup> [ELJ0002-00061\_9].
- 4.10. The RCS then sets out a syllabus, which comprises 35 “key surgical conditions”, each with specific learning objectives. Condition 29 is “consent for surgery including mental capacity”,<sup>86</sup> [ELJ0002-00061\_14] which comprises 10 specific learning objectives (e.g., explaining the need for informed consent and applying the principles thereof)<sup>87</sup> [ELJ0002-00061\_21].

#### Ethics education in the Foundation programme

- 4.11. Ethics also features in the Foundation programme. The 2021 Foundation Programme Curriculum “divides the role of the doctor into three broad areas: the practicing clinician, the valued healthcare worker and the responsible professional”<sup>88</sup> [ELJ0002-00069]. The third of these outcomes (*inter alia*) “refers to the doctor as a professional with an understanding of the ethical and legal

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<sup>81</sup> Institute of Medical Ethics (2026).

<sup>82</sup> Royal College of Surgeons of England (2015b).

<sup>83</sup> Royal College of Surgeons of England (2015b: 5).

<sup>84</sup> Royal College of Surgeons of England (2015b: 7).

<sup>85</sup> Royal College of Surgeons of England (2015b: 7).

<sup>86</sup> Royal College of Surgeons of England (2015b: 12).

<sup>87</sup> Royal College of Surgeons of England (2015b: 19).

<sup>88</sup> UK Foundation Programme (2021: 2).

framework in which they practice”<sup>89</sup> [ELJ0002-00069]. The UK Foundation Programme website includes curriculum resources for each area/outcome, including materials on ethics and law.<sup>90</sup> [ELJ0002-00142]

- 4.12. The GMC also publishes a generic professional capabilities framework, which informs postgraduate medical education and training<sup>91</sup> [ELJ0002-00031]. The framework includes various references to ethics. The framework is intended to be incorporated into postgraduate curricula, so its content should inform the specialty/specialist curricula discussed below (4.13-4.19).

### Ethics education in core surgical training

- 4.13. The Intercollegiate Surgical Curriculum Programme (ICSP) sets out the core surgical training curriculum, which is currently in the third version (1 August 2025) of the 2021 edition (4 August 2021). Ethics explicitly features in:

- 4.13.1. *Case-based discussion*. This is a learning and assessment method, focused on a patient case, which (*inter alia*) “enables the discussion of the ethical and legal framework of practice”<sup>92</sup> [ELJ0002-00047\_32]
- 4.13.2. *Peri-operative care*. The objective of learning in this area is: “To assess and manage preoperative risk and prepare a patient for theatre, to conduct safe surgery in the operating theatre environment and to provide medical care for the patient in the post-operative period”<sup>93</sup> [ELJ0002-00047\_49]. One of the knowledge areas listed is: “Ethical principles of, and legislative framework for, capacity and consent”<sup>94</sup> [ELJ0002-00047\_49].

### Ethics education in specialty neurosurgical training

- 4.14. The ICSP also sets out specialty training curricula, including the neurosurgery curriculum, which is currently in the third version (3 February 2026) of the 2021 edition (4 August 2021)<sup>95</sup> [ELJ0002-00048].

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<sup>89</sup> UK Foundation Programme (2021: 3).

<sup>90</sup> UK Foundation Programme (2026).

<sup>91</sup> General Medical Council (2017b).

<sup>92</sup> Intercollegiate Surgical Curriculum Programme (2025: 32).

<sup>93</sup> Intercollegiate Surgical Curriculum Programme (2025: 49).

<sup>94</sup> Intercollegiate Surgical Curriculum Programme (2025: 49).

<sup>95</sup> Intercollegiate Surgical Curriculum Programme (2026a).

- 4.15. The training programme is divided into three phases, with phase 1 typically lasting 2 years, phase 2 typically lasting 5 years, and phase 3 typically lasting 1 year<sup>96</sup> [ELJ0002-00048\_6].
- 4.16. As in the core surgical training curriculum (4.13.1), the specialty curriculum refers to case-based discussion as enabling “the discussion of the ethical and legal framework of practice”.<sup>97</sup> [ELJ0002-00048\_34]. Beyond this, ethics explicitly features in various aspects of the specialty curriculum:
- 4.17. Phase 1 includes:
- 4.17.1. *Peri-operative care*, which requires knowledge of “Ethical principles of, and legislative framework for, capacity and consent”<sup>98</sup> [ELJ0002-00048\_56].
- 4.17.2. *Medical ethics*. Here, the objective is “To understand the ethical issues that commonly arise in the management of patients with neurological disorders”<sup>99</sup> [ELJ0002-00048\_64]. The requisite clinical skills comprise “Ability to empathise with and support patients and carers”<sup>100</sup> [ELJ0002-00048\_64]. Knowledge is required of:
- Criteria for the diagnosis of brainstem death;
  - Diagnosis and management of persistent vegetative states;
  - Prognosis in chronic progressive neurological disorders;
  - Professional and statutory framework governing living directives and end-of-life decisions<sup>101</sup> [ELJ0002-00048\_64]
- 4.18. Phase 3 includes:
- 4.18.1. *Neuro-oncology*, where trainees “will be familiar with [...] the ethical, regulatory and practical considerations governing clinical trials in neuro-oncology”<sup>102</sup> [ELJ0002-00048\_112].

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<sup>96</sup> Intercollegiate Surgical Curriculum Programme (2026a: 6).

<sup>97</sup> Intercollegiate Surgical Curriculum Programme (2026a: 34).

<sup>98</sup> Intercollegiate Surgical Curriculum Programme (2026a: 56).

<sup>99</sup> Intercollegiate Surgical Curriculum Programme (2026a: 64).

<sup>100</sup> Intercollegiate Surgical Curriculum Programme (2026a: 64).

<sup>101</sup> Intercollegiate Surgical Curriculum Programme (2026a: 64).

<sup>102</sup> Intercollegiate Surgical Curriculum Programme (2026a: 112).

- 4.18.2. Surgery for mental illness, which requires knowledge of “Ethical and regulatory aspects of surgical treatment of mental illness”<sup>103</sup> [ELJ0002-00048\_124].
- 4.19. Generic:
- 4.19.1. The curriculum also sets out generic requirements shared between surgical specialties, which a trainee must be able to satisfy before they can enter the specialist register. These generic requirements include providing “evidence of having met the relevant requirements for research and scholarship”, which includes “Understanding the basic principles of research governance and how to apply relevant ethical guidelines to research activities”<sup>104</sup> [ELJ0002-00048\_38].
- 5. Please explain the ethical principles which would apply to the concepts of clinical freedom, corporate oversight of clinical practice and professional regulation.**
- 5.1. We interpret this question as asking about the degree of freedom afforded to a surgeon, relative to their obligations to their regulator and/or employer.

#### Academic positions on clinical freedom and its limits

- 5.2. Various academic sources recognise that surgeons have considerable power and freedom, but also that their activities are constrained by obligations to others.
- 5.3. *Surgeons have power and freedom:*
- 5.3.1. Little’s analysis, which others cite with approval,<sup>105</sup> [ELJ0002-00081]; [ELJ0002-00090] recognises that surgeons have power: “Surgery conveys power, the power to enter the body of another by cutting into it. That power is socially endorsed, and may be reinforced by the surgeon’s individual charisma...”.<sup>106</sup> [ELJ0002-00110]
- 5.3.2. Whyte and Wood point to the freedom enjoyed by surgeons as professionals: citing Friedson’s work, they see the “freedom to exercise

<sup>103</sup> Intercollegiate Surgical Curriculum Programme (2026a: 124).

<sup>104</sup> Intercollegiate Surgical Curriculum Programme (2026a: 38).

<sup>105</sup> E.g., Cardenas (2020: 8); Ferreres (2025a: 2).

<sup>106</sup> Little (2002: 185-186).

discretionary judgment” as a key feature of professionalism.<sup>107</sup>  
[ELJ0002-00150]

#### 5.4. *Surgeons owe obligations to their patients:*

5.4.1. Little goes on to note that, “as with all power”, the power enjoyed by surgeons “must be constantly renewed and re-validated. In surgery, that renewal and re-validation is derived from surgery’s *techne* (its technical capabilities), its *episteme* (its knowledge base), and its *phronesis* (practical wisdom or judgement)”.<sup>108</sup> [ELJ0002-00110] Little suggests that this power is in service to – and therefore constrained by – the obligation to “rescue” the patient, which he sees as one of the distinctive aspects of surgical ethics (3.15.1). As Little puts it, “there is always an element of surrender in the surgical relationship”, but this “is a surrender that presupposes rescue”.<sup>109</sup> [ELJ0002-00110]

5.4.2. Frati et al. make similar points, noting that surgery brings various ethical (and legal) responsibilities, including but in addition to the obligation to obtain – and respect the limits of – informed consent: “Surgery is a highly invasive and inherently risky medical treatment, and the surgeon is therefore subject to a very high standard of care and professional conduct. This involves the responsibility to act in accordance with prevailing scientific knowledge, clinical guidelines, and the standard of care accepted at the time, while being patient-centered. Ethical responsibility is also applied, for instance, to the selection of surgical technique: while the surgeon has some therapeutic freedom, this freedom must be exercised with reasoned justification and in the best interest of the patient”.<sup>110</sup> [ELJ0002-00093]

#### 5.5. *Surgeons owe obligations to their employer:*

5.5.1. Whyte and Wood similarly recognise that surgeons owe duties to their patients, but they add that “The surgeon also has duties to his/her employer”.<sup>111</sup> [ELJ0002-00150]

#### 5.6. *Obligations can conflict:*

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<sup>107</sup> Whyte and Wood (2019: 279).

<sup>108</sup> Little (2002: 185-186).

<sup>109</sup> Little (2002: 186).

<sup>110</sup> Frati et al. (2025: 175).

<sup>111</sup> Whyte and Wood (2019: 279).

- 5.6.1. Whyte and Wood note that the duties owed by a surgeon to their patient and their employer can sometimes come into conflict. Citing Friedson's work on professionalism, the authors suggest that duties to patients – "to provide excellent care and to act in the patient's best interests" – tend to have priority, "at least as far as clinical performance and judgment are concerned".<sup>112</sup> [ELJ0002-00150] They further suggest that a surgeon's duty to a patient might sometimes trump their duty to their employer: "professionals must have some freedom to exercise discretionary judgment – even if it may not be in the obvious best interests of the employer".<sup>113</sup> [ELJ0002-00150] But they also recognise that "the customer [the patient] is not always correct" in a professional context.<sup>114</sup> [ELJ0002-00150]
- 5.7. As such, from these theoretical ethical perspectives, a surgeon's power and freedom is constrained by obligations. Surgeons owe obligations to not only patients, but also employers, and these obligations might sometimes come into conflict. However, the academic literature tends to emphasise the obligations owed to patients, e.g., the obligation to rescue (or serve the patient's best interests), the obligation to practice within the limits of the patient's informed consent, and the obligation to possess and retain surgical skills, knowledge, and judgment.

#### Professional positions on clinical freedom and its limits

- 5.8. Professional organisations also recognise that surgeons have considerable power and freedom, but that their activities are constrained by obligations to others.
- 5.9. *Surgeons have power and freedom:*
- 5.9.1. In 2017, Castlen et al published an article on organisational ethics, on behalf of the ethics committees of two international neurosurgical organisations, the WFNS and the EANS.<sup>115</sup> [ELJ0002-00082] Like Little and Whyte and Wood, Castlen et al suggest that "physician autonomy [...] is a tenet of medical professionalism".<sup>116</sup> [ELJ0002-00082] They note the degree of autonomy/freedom and power that has been afforded to doctors: "Physicians have enjoyed and continue to enjoy material and

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<sup>112</sup> Whyte and Wood (2019: 279).

<sup>113</sup> Whyte and Wood (2019: 279).

<sup>114</sup> Whyte and Wood (2019: 279).

<sup>115</sup> Castlen et al. (2017).

<sup>116</sup> Castlen et al. (2017: 423).

nonmaterial benefits, such as relative professional freedom and power, a respected social status, and financial security. Society grants physicians autonomy over their own practice and a monopoly over their expertise...”.<sup>117</sup> [ELJ0002-00082]

#### 5.10. *Surgeons owe obligations to their patients:*

5.10.1. Like Little and Frati et al., Castlen et al also note how, in return for autonomy and power, doctors owe obligations to “provide professional and ethical care”, which (*inter alia*) requires them to acquire knowledge and skills, and “embody the attitude and behaviors expected of them, such as forming relationships with and having a devotion to their patients”.<sup>118</sup> [ELJ0002-00082]

5.10.2. The obligations owed to patients appear in turn to ground the obligations surgeons owe to their regulator, the GMC. As defined by statute, the GMC’s over-arching objective “is the protection of the public”.<sup>119</sup> The GMC further describes its role as being “to support good, safe patient care across the UK”<sup>120</sup> [ELJ0002-00039]. The commitment to patient care runs throughout the GMC’s professional guidance: its central guidance, *Good Medical Practice*, opens with the statement: “Patients must be able to trust medical professionals with their lives and health. To justify that trust you must make the care of patients your first concern...” (see **38.1-38.3**)<sup>121</sup> [ELJ0002-00037\_8]. GMC guidance on raising a concern further conveys how the commitment to patient safety overrides other obligations, including to an employer: “You must not enter into contracts or agreements with your employing or contracting body that seek to prevent you from or restrict you in raising concerns about patient safety. Contracts or agreements are void if they intend to stop an employee from making a protected disclosure”<sup>122</sup> [ELJ0002-00024\_6].

#### 5.11. *Surgeons owe obligations to their employer:*

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<sup>117</sup> Castlen et al. (2017: 422).

<sup>118</sup> Castlen et al. (2017: 422).

<sup>119</sup> Medical Act 1983, s. 1A.

<sup>120</sup> General Medical Council (2026a).

<sup>121</sup> General Medical Council (2024a: 7).

<sup>122</sup> General Medical Council (2012a: [8]).

- 5.11.1. Castlen et al. accept that doctors owe duties to their employers.<sup>123</sup> [ELJ0002-00082]
- 5.11.2. As a general proposition, we suggest that a surgeon will owe duties to their employer(s), as set down in their contract(s) of employment.
- 5.12. *Obligations can conflict:*
- 5.12.1. Like Whyte and Wood, Castlen et al note how doctors' duties to their patients can come into conflict with their duties to their employer, leading "to a conflict of interest in which the physician is forced to weigh the costs of going against the administration with their own duty to help their patients".<sup>124</sup> [ELJ0002-00082] Castlen et al ultimately advocate for upholding the freedom of doctors and allowing for their (continued) self-regulation, but they also call for greater understanding about – and collaboration regarding – the resource pressures that underlie tensions between doctors and employers.
- 5.12.2. The tenor of the sources we have consulted suggest that, in situations of conflict, the surgeon's overriding obligation is to their patient(s). We derive this conclusion principally from the GMC position. The GMC not only empowers the surgeon (enabling them to practice as a surgeon), but also constrains them, and the GMC essentially holds that a surgeon's freedom is ultimately fettered by considerations of patient safety and welfare (see further **Part F, 36-38**).
- 6. In particular, what ethical principles apply to the balancing of patient care and other considerations in the provision of a health service, including but not limited to financial considerations and staff experience/availability? To what extent can ethical principles be subordinated to these more practical considerations?**
- 6.1. We interpret this question as asking how a surgeon should seek to balance their obligations to their patients against their obligations to the health service and, by implication, the wider society.

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<sup>123</sup> Castlen et al. (2017).

<sup>124</sup> Castlen et al. (2017: 422).

### Academic positions on balancing obligations

- 6.2. Considerations germane to the health service and wider society include the availability of resources and experienced staff. These are not only practical considerations, as they also have ethical dimensions.
- 6.3. Scholars recognise that obligations towards individuals can conflict with obligations towards the wider society. Different scholars approach and resolve these conflicts in different ways: some prioritise the individual (**6.4**); others prioritise the collective (**6.5**).
- 6.4. Sometimes priority is given to the *individual patient*.
  - 6.4.1. This tends to be where the emphasis is placed in medical ethics, and in clinical ethics specifically. For example, the four principles approach encompasses the principle of justice, which is concerned with fairness towards members (plural) of the collective (see also **6.5.3**), but some scholars suggest that the individualistic principle of respect for autonomy should be the primary consideration (**2.12.1**).<sup>125</sup> [ELJ0002-00097]
- 6.5. Sometimes priority is given to the *society* (population or collective).
  - 6.5.1. This tends to be where the emphasis is placed in public health ethics. For example, some scholars – and citizens – argue that the protection of the population via vaccination programmes should outweigh any individual objections.<sup>126</sup> [ELJ0002-00138]
  - 6.5.2. There are also ethical schools of thought, which prioritise the collective over the individual: for example, utilitarianism aims to achieve the greatest good for the greatest number (**2.8**).
  - 6.5.3. There is also an extensive theoretical ethical literature on the just distribution of (healthcare) resources (see also **2.10**, **2.12.4**, **7.8.3**, **7.12**, **12**)<sup>127</sup> [ELJ0002-00050]. Much of this literature seeks to articulate a *substantive* account of how scarce resources should be allocated and distributed. In a famous account, Rawls attempts to combine respect for individuals with obligations to the collective.<sup>128</sup> Other scholars focus

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<sup>125</sup> Gillon (2003).

<sup>126</sup> Stead et al (2022).

<sup>127</sup> Lamont and FAVOR (2017).

<sup>128</sup> Rawls (1971).

more on ensuring that the *process* is just or fair, e.g., by ensuring that decision-making is transparent and reasonable.<sup>129</sup> [ELJ0002-00086]

### Professional positions on balancing obligations

- 6.6. GMC guidance refers to obligations to both patients and the wider public. Sometimes the guidance is silent about the possibility of conflict between such obligations (6.7). Elsewhere, the guidance does refer to principles that might help with striking the balance between competing obligations (6.8). Ultimately, however, the general tenor of GMC guidance suggests that, if there is a conflict of obligations, then the balance should fall in favour of protecting the health and safety of patients (6.9).
- 6.7. Sometimes the GMC guidance is silent about the possibility that these sorts of obligations may be in tension or conflict, so it does not refer to, or engage with, ways of balancing the obligations. For example, the duties of a doctor set out in *Good Medical Practice* include the obligation to “Protect and promote the health of patients *and* the public” (emphasis added)<sup>130</sup> [ELJ0002-00037\_8]. Elsewhere in the document, the GMC refers to “Managing resources effectively and sustainably”, where it states: “You must make good use of the resources available to you, and provide the best service possible, taking account of your responsibilities to patients and the wider population”<sup>131</sup> [ELJ0002-00037\_11].
- 6.8. However, there are passages in which the GMC offers some principles for navigating tensions or conflicts:
- 6.8.1. *Using professional judgement.* Near the outset of *Good Medical Practice*, the GMC explains that the document and the standards it contains “isn’t a set of rules. You must use your professional judgement to apply the standards in *Good medical practice* to your day-to-day practice. This means working out which of the professional standards are relevant to the specific circumstances you are facing, and using your knowledge, skills and experience to follow them in that context”<sup>132</sup> [ELJ0002-00037\_5].

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<sup>129</sup> Daniels (2000).

<sup>130</sup> General Medical Council (2024a: 7).

<sup>131</sup> General Medical Council (2024a: [14]).

<sup>132</sup> General Medical Council (2024a: 4).

6.8.2. *Making reasonable and proportionate judgments.* In some passages, the GMC indicates that a principle of proportionality and a standard of reasonableness apply,<sup>133</sup> [ELJ0002-00037\_23]; [ELJ0002-00037\_27] including when working out how to meet obligations to patients, relative to other obligations:

- Guidance on meeting the language and communication needs of patients states that the steps taken “should be proportionate to the circumstances, including the patient’s needs and the seriousness of their condition(s), the urgency of the situation and the availability of resources”<sup>134</sup> [ELJ0002-00037\_15].
- Guidance on meeting the needs of patients with impairments or disabilities states that doctors should “offer reasonable adjustments that are proportionate to the circumstances”<sup>135</sup> [ELJ0002-00037\_15].

6.9. Ultimately, the general tenor of GMC guidance suggests that, if there is a conflict of obligations, then the balance should – or even must – fall in favour of protecting the health and safety of patients, where the emphasis appears to be on the patient that is in front of the doctor. The order of priority is initially apparent from the GMC’s duties of a doctor, set down in *Good Medical Practice*, which opens with the statement: “Patients must be able to trust medical professionals with their lives and health. To justify that trust you must make the care of patients *your first concern...*” (emphasis added)<sup>136</sup> [ELJ0002-00037\_8]. The RCS and WFNS make similar statements (see **38**). This order of priority is replicated elsewhere in *Good Medical Practice*, including in passages which deal specifically with delegating tasks and managing resources:

6.9.1. *Delegating tasks.* The guidance states that the delegating doctor “must be confident” that the person to whom they are delegating “has the necessary knowledge, skills and training to carry out the task” that is being delegated, and that they must be given “clear instructions” and encouraged “to ask questions and seek support or supervision if they need it”.<sup>137</sup> [ELJ0002-00037\_22] The guidance further states that, if you are a doctor who has agreed to take on a task, “but you’re not confident

<sup>133</sup> These principles also feature in the guidance on making formal records (General Medical Council (2024a: [70])) and on professional communication (General Medical Council (2024a: [89])).

<sup>134</sup> General Medical Council (2024a: [32]).

<sup>135</sup> General Medical Council (2024a: [32]).

<sup>136</sup> General Medical Council (2024a: 7).

<sup>137</sup> General Medical Council (2024a: [66]).

you have the necessary knowledge, skills or training to carry it out safely, you must prioritise patient safety and seek help”<sup>138</sup> [ELJ0002-00037\_22].

- 6.9.2. *Managing resources.* The guidance states that “You must give priority to patients based on their clinical need if these decisions are within your power. If inadequate resources, policies, or systems prevent you from doing this – and patient safety or dignity may be seriously compromised as a result – you must follow the guidance in paragraph 75”<sup>139</sup> [ELJ0002-00037\_13]. Paragraph 75 states “You must act promptly if you think that patient safety or dignity is, or may be, seriously compromised” (see **36.2**)<sup>140</sup> [ELJ0002-00037\_24]. The Health and Social Care Act 2008 defines clinical governance responsibilities. Surgeons have professional ethical obligations to report safety issues through established local clinical governance processes. This may include, for example, submitting an incident report for lack of ward staff. Moreover, separate guidance conveys that, in the course of their NHS work, doctors should not initiate discussions about providing private services for NHS patients (see **28.1**).

## The practice of individual surgeons

7. **What are the ethical principles, practices, rules, norms, frameworks and their sources that apply, broadly, to or arise within decision-making and practice in the field of neurosurgery (please note that specific aspects of the ethical context are addressed below)? Please include a consideration of:**
- (a) particular principles and practices that apply to neurosurgery as opposed to other clinical practice or other types of surgery;**
  - (b) the ethical principles and practices that apply when patients are wronged or harmed in their neurosurgery; and**
  - (c) principles and practices as they applied over the relevant period and as they have developed since the relevant period?**

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<sup>138</sup> General Medical Council (2024a: [67]).

<sup>139</sup> General Medical Council (2024a: [20]).

<sup>140</sup> General Medical Council (2024a: [75]).

### Academic positions on the principles and practices that apply to neurosurgery

- 7.1. There are various academic sources (**2.3-2.12**), which advance theoretical ethical positions on decision-making and practice in the field of neurosurgery. Such sources lack overt authority over neurosurgeons, but might sometimes influence practice (e.g., publications that are widely-read and/or are authored by prominent figures). We begin with some of these sources (**7.2-7.10**).
- 7.2. As with the wider field of surgical ethics (**3.1-3.16**), the academic literature on neurosurgical ethics suggests that different positions may be taken on whether neurosurgery gives rise to particular principles or practices:
  - 7.2.1. The first position holds that neurosurgical ethics does *not* give rise to different considerations from the field of surgical ethics (or even medical ethics more generally). On this view, neurosurgical ethics essentially involves the *application* of general approaches to (surgical or medical) ethics (**7.4-7.5**);
  - 7.2.2. The second position holds that neurosurgical ethics does give rise to different considerations from the field of surgical ethics (or even medical ethics more generally), as it has distinctive features, which require the *modification* of general approaches to (surgical or medical) ethics (**7.6-7.8**); and/or
  - 7.2.3. The third position holds that neurosurgical ethics does give rise to different considerations from the field of surgical ethics (or even medical ethics more generally), as it has distinctive features, which require the *specification* of particular approaches (**7.9-7.10**).
- 7.3. In this section we outline each of these positions, making reference to some of the literature on neurosurgical ethics. Similar points to those noted above (**3.2**) also apply here.

### *Neurosurgical ethics as the application of general (surgical or medical) ethics*

- 7.4. The first position holds that neurosurgical ethics does *not* give rise to different considerations from the field of surgical ethics (or even medical ethics more generally). On this view, neurosurgical ethics essentially involves the *application* of general approaches to (surgical or medical) ethics.
- 7.5. Some sources on neurosurgical ethics note how neurosurgery is a diverse field, comprising various (sub)subspecialties, which nevertheless share some ethical

features.<sup>141</sup> [ELJ0002-00130] Some of these features also appear to be shared with surgical ethics more generally: for example, the problem of uncertainty (3.13), the vulnerability and desperation of patients (3.15), and the need for robust informed consent processes (3.5).<sup>142</sup> [ELJ0002-00130]; [ELJ0002-00149] Neurosurgery has also been linked to general approaches to (medical) ethics: e.g., Sedney links the early neurosurgeons to virtue ethics, noting how they role modelled such ideals as excellence, competence, rigour, courage, and patient-centredness.<sup>143</sup> [ELJ0002-00132]

### *Neurosurgical ethics as the modification of general (surgical or medical) ethics*

- 7.6. The second position holds that neurosurgical ethics does give rise to different considerations from the field of surgical ethics (or even medical ethics more generally), as it has distinctive features, which require the *modification* of general approaches to (surgical or medical) ethics. This position implies that any difference between neurosurgical ethics and surgical (or medical) ethics more generally is a matter of degree or emphasis.
- 7.7. Ford and Henderson suggest that “neurosurgical ethics does not constitute an ethic separate from general medical ethics, surgical ethics, or neuroethics”.<sup>144</sup> [ELJ0002-00092] However, they recognise how neurosurgical ethics – and functional neurosurgery specifically – presents “significant unique textures”,<sup>145</sup> [ELJ0002-00092] which “add further detail to some of the issues raised in general surgical ethics”.<sup>146</sup> [ELJ0002-00092]
- 7.8. Examples of neurosurgical features, which invite the adaptation of surgical (or medical) ethics, include:
  - 7.8.1. *Informed consent.* Functional neurosurgery tends to be elective and aimed at correcting problems affecting the central nervous system.<sup>147</sup> [ELJ0002-00092] Such problems can affect how people think, and therefore their capacity to assess risks (including risks of potential psychological impairment or cognitive loss) and make decisions. Some procedures are also performed while the patient is awake: generally, a patient is entitled to withdraw consent, but what should be the position if

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<sup>141</sup> Schroeder (2018: 1-2).

<sup>142</sup> Schroeder (2018); White et al (2024).

<sup>143</sup> Sedney (2020: 96-97).

<sup>144</sup> Ford and Henderson (2004: 213).

<sup>145</sup> Ford and Henderson (2004: 213).

<sup>146</sup> Ford and Henderson (2004: 220).

<sup>147</sup> Ford and Henderson (2004: 220-222).

a patient withdraws consent during a neurosurgical procedure? As such, neurosurgical ethics may necessitate reflection on, and potentially the adaptation of, obligations associated with informed consent (3.5, 13-20) and patient vulnerability (3.15).

- 7.8.2. *Harms, risks, uncertainty, and vulnerability.* Ford and Henderson note that “Neurosurgeons must balance elements of risks and benefits in light of significant uncertainty”.<sup>148</sup> [ELJ0002-00092] Neurosurgery appears to bring several features of surgical ethics into sharp focus (3.11-3.15), such as obligations to avoid or minimise patient harm and to “rescue” the patient.
- 7.8.3. *Justice and equity.* Various authors note how neurosurgery invites particular attention to issues of justice and equity, given the cost to society of developing and delivering these procedures and disparities in access to them.<sup>149</sup> [ELJ0002-00092]; [ELJ0002-00149]
- 7.8.4. *Research and innovation.* According to Ford and Henderson, “The privileged status of the brain, the uncertainty involved in outcomes, and the complexity of cases add significant textures to the ethical concerns of functional neurosurgery”.<sup>150</sup> [ELJ0002-00092] Just as the evolution of surgery can generate distinctive ethical issues (3.16), Ford and Henderson therefore suggest that neurosurgery research can give rise to particular issues, which “cannot be reduced to or solved by impeccable informed consent or some formulaic ethics process”.<sup>151</sup> [ELJ0002-00092] White et al similarly note how concepts associated with research ethics, such as concerns about a “therapeutic misconception”, can be “heightened” in neurosurgery research.<sup>152</sup> [ELJ0002-00149]

### *Neurosurgical ethics as the specification of particular approaches*

- 7.9. The third position holds that neurosurgical ethics does give rise to different considerations from the field of surgical ethics (or even medical ethics more generally), as it has distinctive features, which require the *specification* of particular approaches.

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<sup>148</sup> Ford and Henderson (2004: 223).

<sup>149</sup> Ford and Henderson (2004); White et al (2024: 182-184).

<sup>150</sup> Ford and Henderson (2004: 226).

<sup>151</sup> Ford and Henderson (2004: 226).

<sup>152</sup> White et al (2024: 182).

7.10. Schroeder highlights some distinctive features of neurosurgery, which in turn imply some particular ethical obligations:

- 7.10.1. *Caring beyond technical expertise.* Schroeder observes how the development of the technical aspects of neurosurgery has meant that “the human side of neurosurgery has often been lost or ignored”.<sup>153</sup> [ELJ0002-00130\_1] Schroeder implies that neurosurgeons should be better prepared “to deal with the nonmedical, or at least less medical, parts of caring for their patients”.<sup>154</sup> [ELJ0002-00130\_1]
- 7.10.2. *Dispelling the mystery.* Schroeder sees neurosurgery as a “mystical” area of practice, “where much is unknown or at least unclear to the general public” [ELJ0002-00130\_2] and even other clinicians.<sup>155</sup> [ELJ0002-00130] This implies that more should be done to inform people about neurosurgery, and – by extension – make the field more transparent, accessible, comprehensible, and presumably accountable.
- 7.10.3. *Thinking about brains and selves.* Schroeder notes how neurosurgery may generate distinctive ethical challenges regarding individual identity, since “Neurosurgeons alone have the training and education to operate on the organ [the brain] that constitutes the locus of humankind’s consciousness, emotion, and intelligence”.<sup>156</sup> [ELJ0002-00130\_2]

#### *Topics in neurosurgical ethics*

- 7.11. Some academic sources identify particular topics or areas of decision-making in neurosurgery, which present ethical considerations.
- 7.12. Publications by Ford and Henderson (2004), Morgan et al. (2015), and White et al. (2024) refer to the following topics (listed here alphabetically):
  - 7.12.1. Coma and disorders of consciousness (i.e., the (so-called) vegetative state and the minimally conscious state);<sup>157</sup> [ELJ0002-00117]
  - 7.12.2. Economics and enhancement;<sup>158</sup> [ELJ0002-00092]
  - 7.12.3. Emerging technologies;<sup>159</sup> [ELJ0002-00149]

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<sup>153</sup> Schroeder (2018).

<sup>154</sup> Schroeder (2018).

<sup>155</sup> Schroeder (2018).

<sup>156</sup> Schroeder (2018).

<sup>157</sup> Morgan et al. (2015: 182-187).

<sup>158</sup> Ford and Henderson (2004 : 223).

<sup>159</sup> White et al. (2024: 182).

- 7.12.4. Equity and justice;<sup>160</sup> [ELJ0002-00149]
- 7.12.5. Informed consent and capacity;<sup>161</sup> [ELJ0002-00092]; [ELJ0002-00149]
- 7.12.6. Innovation;<sup>162</sup> [ELJ0002-00092]; [ELJ0002-00149]
- 7.12.7. Organisational ethics;<sup>163</sup> [ELJ0002-00149]
- 7.12.8. Research;<sup>164</sup> [ELJ0002-00092]; [ELJ0002-00149]
- 7.12.9. Risk-benefit.<sup>165</sup> [ELJ0002-00092]
- 7.13. In 2026, the EANS ethico-legal committee published a scoping review of ethical issues in neurosurgery.<sup>166</sup> [ELJ0002-00148] The review examined 13 original research articles, which were published in English or German. The studies all employed a qualitative research design (e.g., questionnaires, interviews, database review). The majority of the studies were published after 2010 and they originated in North America or Europe.
- 7.14. The EANS review found that “Ethical considerations in neurosurgery present a broad variety of topics and patient groups and are therefore difficult to quantify”.<sup>167</sup> [ELJ0002-00148] The review identified “six ethical subcategories”: decision-making (31%); paediatric neurosurgery (23%); neurosurgery in developing countries (15%); artificial intelligence (15%); functional neurosurgery (8%); and patient care (8%). The review further distinguished the studies as respectively focusing on: psychosocial ethical issues (n=7; 53.8%); normative ethical questions (n=4; 30.7%); and professional ethics (n=2; 15.4%).
- 7.15. The EANS review concluded that “Future studies should focus on enhancing ethics training and developing standardized frameworks for ethical analysis improving neurosurgical ethical decision-making”.<sup>168</sup> [ELJ0002-00148]

### Professional guidance on the principles and practices that apply to neurosurgery

- 7.16. Turning to professional ethical obligations (**2.13-2.18**), as noted earlier (**3.17**), there are various organisations and societies that set down ethical principles, practices,

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<sup>160</sup> White et al. (2024: 182).

<sup>161</sup> Ford and Henderson (2004: 220); White et al. (2024: 181).

<sup>162</sup> Ford and Henderson (2004: 224); White et al. (2024: 182).

<sup>163</sup> White et al. (2024: 184).

<sup>164</sup> Ford and Henderson (2004: 224); White et al. (2024: 182).

<sup>165</sup> Ford and Henderson (2004: 222).

<sup>166</sup> Westarp et al. (2026).

<sup>167</sup> Westarp et al. (2026: 3).

<sup>168</sup> Westarp et al. (2026: 1).

rules, norms, and frameworks (“guidance” or “standards”), which apply to decision-making and practice in the field of neurosurgery. **Table 4** outlines the most relevant standard-setting organisations, including their main roles and functions, their scope, and their authority (see **2.18**).

- 7.16.1. Some of these organisations have *authority* over a neurosurgeon. These primarily comprise the General Medical Council (GMC), which regulates doctors, and the Royal College of Surgeons of England (RCS), the Royal College of Surgeons of Edinburgh (RCSEd), and the Joint Committee on Surgical Training (JCST), as together these control entry to surgery, including neurosurgery.
- 7.16.2. Some of these organisations have *influence* over a neurosurgeon. Influential organisations include the British Medical Association (BMA), which issues guidance to all doctors. Particularly pertinent to neurosurgery is the World Federation of Neurosurgical Societies (WFNS), founded in 1955, which has issued ethics guidance. This took the form of a statement of ethics, which was last revised in August 2007,<sup>169</sup> [ELJ0002-00070] and was published in the journal *World Neurosurgery* in 2011.<sup>170</sup> [ELJ0002-00144]
- 7.16.3. In addition to these organisations, there are various other neurosurgery societies globally,<sup>171</sup> [ELJ0002-00073] including several that are specifically relevant to UK-based neurosurgeons. At the continental level is the European Association of Neurosurgical Societies (EANS), which was founded in 1971.<sup>172</sup> At the national level is the Society of British Neurological Surgeons (SBNS), which was founded in 1926.<sup>173</sup> Both of these societies are members of the WFNS. Other relevant UK-specific societies and groups are the British Skull Base Society,<sup>174</sup> the Neuro Theatre Network Group (NTNG),<sup>175</sup> and the UK Neurosurgical Research Network (UKNSRN). There is also the British Neurosurgical Trainees’ Association,<sup>176</sup> and its initiative the British Neurosurgical

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<sup>169</sup> World Federation of Neurosurgical Societies (2007).

<sup>170</sup> Umansky et al (2011).

<sup>171</sup> Araújo et al (2023).

<sup>172</sup> European Association of Neurosurgical Societies (2025).

<sup>173</sup> Society of British Neurosurgical Surgeons (2025).

<sup>174</sup> British Skull Base Society (2025).

<sup>175</sup> Neuro Theatre Network Group (2025).

<sup>176</sup> British Neurosurgical Trainees’ Association (2025).

Trainee Research Collaborative (BNTRC).<sup>177</sup> Broadly, all of these neurosurgery groups and societies aim to facilitate knowledge exchange and networking for the benefit of individual members and their patients. Although, like the WFNS, some of the societies have dedicated ethics committees, none appears to have issued specific ethics guidance.

*Professional guidance that specifically applies to neurosurgery*

- 7.17. The WFNS statement of ethics appears to offer the most specific guidance on the particular principles and practices that apply to neurosurgery, as opposed to other clinical practice or other types of surgery.
- 7.18. The WFNS draws on both theoretical ethical sources and other professional ethical sources:
  - 7.18.1. *Theoretical:* The WFNS statement implicitly draws on theoretical ethical sources, when it recognises how “Relationships between neurosurgeons and their patients, like all patient-doctor relationships, are based on a long-established body of ethical principles developed primarily for the well-being of patients”.<sup>178</sup> [ELJ0002-00070\_1]
  - 7.18.2. *Professional:* The drafters explicitly acknowledge contributions to the WFNS statement from such professional organisations as the EANS and the GMC.
- 7.19. The Introduction to the statement conveys how the guidance is intended “to remind ourselves, and neurosurgeons worldwide, of our fundamental commitments to the patients and communities we serve. These principles are applicable to all neurosurgeons, in private practice as well as academic settings”<sup>179</sup> [ELJ0002-00070\_1]. The Introduction then summarises some of the key principles/obligations contained in the statement:
  - 7.19.1. Avoiding harm, and providing benefit, to patients;
  - 7.19.2. Maintaining the professional competence of neurosurgeons;
  - 7.19.3. Providing individualised care to patients;
  - 7.19.4. Ensuring the ethical independence of neurosurgeons; and
  - 7.19.5. Raising neurosurgery standards worldwide. [ELJ0002-00070\_1]

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<sup>177</sup> British Neurosurgical Trainee Research Collaborative (2025).

<sup>178</sup> World Federation of Neurosurgical Societies (2007: 1).

<sup>179</sup> World Federation of Neurosurgical Societies (2007: 1).

- 7.20. The 2007 version of the statement on the WFNS website thereafter comprises 175 points across 17 pages [ELJ0002-00070\_2-17] (the 2011 version comprises 144 points). Although it is impracticable here to capture all of the depth and detail with the guidance, **Table 5** summarises the main sections/domains and some of the headline principles they contain. We have omitted the section that deals with “Research and clinical trials”, as this topic is addressed elsewhere in this report (45).

*Professional guidance that applies when neurosurgery patients have been harmed*

- 7.21. The WFNS statement offers some specific guidance, which applies when patients are wronged or harmed in their neurosurgery:
- 7.21.1. *Recognition and correction*: The WFNS suggests that neurosurgeons should be trained in, and capable of, recognising and managing complications. This point is made explicit in the section addressing innovation: “Introduction of new practices into clinical practice requires appropriate education and training of surgeons, as well as evaluation of their use of the new technology. The qualifications of those who propose to use the new technology must be carefully assessed. These individuals must have had comprehensive education and experience in the management of the disease process for which the technology is applied, and must acquire the necessary technical skills and competence to recognize and manage any complications resulting from the new technology”<sup>180</sup> [ELJ0002-00070\_15].
- 7.21.2. *Honesty*. If wrongs or harms occur, the WFNS recommends openness: “We should be honest with patients and their families about the reasons for complications, and express our sincere regret when the situation does not go according to plan”<sup>181</sup> [ELJ0002-00070\_4].
- 7.21.3. *Redress*. If wrongs or harms lead to legal proceedings, then the WFNS recommends co-operation when serving as an expert witness: “We should cooperate with lawyers to provide justice to those who may have suffered through medical accidents”<sup>182</sup> [ELJ0002-00070\_9].
- 7.22. Neurosurgeons will also be subject to guidance that applies to surgeons and doctors more generally whenever patients are wronged or harmed. Some of this

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<sup>180</sup> World Federation of Neurosurgical Societies (2007: [153]).

<sup>181</sup> World Federation of Neurosurgical Societies (2007: [42]).

<sup>182</sup> World Federation of Neurosurgical Societies (2007: [96]).

wider guidance specifically concerns candour, which is dealt with in detail elsewhere in this report (see **Part H, 46-48**). Other relevant guidance has been issued by:

- 7.22.1. The General Medical Council (GMC) (**7.23**);
  - 7.22.2. Royal College of Surgeons of England (RCS) (**7.24**); and
  - 7.22.3. Healthcare Improvement Scotland (HIS) (**7.25**).
- 7.23. The GMC's *Good Medical Practice* includes guidance on "Being open when things go wrong"<sup>183</sup> [ELJ0002-00037\_17-18]. Some passages of the GMC guidance state what "must" happen, while others state what "should" happen. The key points and related principles are:
- 7.23.1. *Openness and honesty*: "You must be open and honest with patients if things go wrong". A doctor should "explain fully and promptly what has happened and the likely short-term and long-term effects";
  - 7.23.2. *Apologise*: A doctor should "apologise (apologising does not, of itself, mean that you are admitting legal liability for what's happened)";
  - 7.23.3. *Correction*: A doctor should "put matters right, if possible";
  - 7.23.4. *Reporting and governance*: A doctor should report the incident and co-operate with complaints processes<sup>184</sup> [ELJ0002-00128]
- 7.24. In *Good Surgical Practice*, the RCS provides its own specific guidance on "Being open when things go wrong".<sup>185</sup> [ELJ0002-00128] This draws on the GMC's *Good Medical Practice*. As with the GMC, some passages of the RCS guidance state what "must" happen, while others state what "should" happen. Key points and related principles include:
- 7.24.1. *Openness and honesty*: "Surgeons must be open and honest with patients if things go wrong". In line with the GMC guidance, surgeons should "explain what has happened and the likely short-term and long-term effects";
  - 7.24.2. *Apologise*: In line with the GMC guidance, surgeons "should offer an apology". "[W]here harm is linked to an error, then an apology should

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<sup>183</sup> General Medical Council (2024a: [45]-[47]).

<sup>184</sup> Royal College of Surgeons of England (2025: [2.6]).

<sup>185</sup> Royal College of Surgeons of England (2025: [2.6]).

[...] include an acknowledgement and acceptance of responsibility – this is not an admission of legal liability”;

7.24.3. *Correction*: In line with the GMC guidance, surgeons “should put matters right (if that is possible)...”

7.24.4. *Reporting and governance*: Surgeons should “Report all incidents where significant harm has occurred through the relevant governance processes of your organisation”. They should co-operate with local complaints procedures and “[p]articipate fully in any investigations relating to significant harm, following local guidelines”.<sup>186</sup> [ELJ0002-00128]

7.25. *Healthcare Improvement Scotland (HIS)*: HIS issues guidance to health and social organisations, rather than professionals as such. HIS was established on 1 April 2011 as a public body within the Scottish NHS. HIS publishes a national framework for learning from adverse events through reporting and review; this was first published in 2013, then in revised versions in 2015, 2018, [ELJ0003-00042] and 2025<sup>187</sup> [ELJ0002-00043]. Its framework offers guidance to NHS boards on reviewing and learning from adverse events. Similar to previous iterations, the latest guidance (2025) explains how the review process is explicitly “underpinned by the following principles:

- Care and compassion: The review process should be person centred with patients, families and staff feeling safe throughout.
- Openness and respect: A transparent approach is taken with everyone involved treated with openness, honesty and respect.
- Learning: Identifying, sharing and disseminating learning is a primary focus of the review process.
- Empowerment: Patients, families and staff are supported to ask questions during the review process. Staff are empowered to speak up and raise concerns without the fear of negative repercussions”<sup>188</sup> [ELJ0002-00043\_12].

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<sup>186</sup> Royal College of Surgeons of England (2025: [2.6]).

<sup>187</sup> Healthcare Improvement Scotland (2018); Healthcare Improvement Scotland (2025).

<sup>188</sup> Healthcare Improvement Scotland (2025: 10).

**8. What is the ambit of medical ethics in neurosurgical practice and how do medical ethics interact with the legal obligations of a clinician?**

8.1. There are various ethical obligations applicable to neurosurgeons and neurosurgical practice, the scope and force of which vary (see, generally, **3** and **7**).

8.2. Academic sources set out *theoretical ethical obligations* (see **2.4-2.12**), which may be pertinent to neurosurgical practice.

8.2.1 These sorts of obligations derive from academic sources on either medical ethics generally, or surgical ethics, or neurosurgical ethics specifically (see **3** and **7**).

8.2.2 Academic, theoretical sources do not typically carry any particular authority or force (**2.6**).

8.2.3 However, it is possible that some academic sources might nevertheless exert some influence over neurosurgical practice, e.g., if they have been widely read (see **2.6**). Academic sources have sometimes been cited with approval in courts of law, which implies they might on occasion inform or influence legal obligations.<sup>189</sup>  
[ELJ0002-00133]; [ELJ0002-00080]

8.3. Professional sources convey *professional ethical obligations* (see **2.13-2.18**), which will be pertinent to neurosurgical practice. The precise ambit and force of these obligations varies (see **Table 4**).

8.3.1. Some professional organisations issue ethical obligations that apply to neurosurgeons specifically; others apply to surgeons; and others apply to doctors more generally.

8.3.2. Some of these professional organisations have authority, such that their guidance must be followed. Regulators derive their powers from legal sources; their guidance – and the obligations it contains – has authority over the professionals they regulate. Other organisations, like the Royal Colleges, also have some authority over their members, since they control who enters the particular specialty.

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<sup>189</sup> E.g., Sheldon and Wilkinson (1997), cited in *Re A (Children) (Conjoined Twins: Medical Treatment)* [2001] 2 WLR 480, at 540 and 574; Burrows (2021).

- 8.3.3. Other professional organisations, such as trade unions, may lack overt authority, but they may nevertheless exert influence over their members, e.g., through the guidance they issue.
- 8.4. These different sorts (and sources) of ethical obligations interact with legal obligations in different ways. The interaction(s) can be broadly described in terms of the *authority* and *content* of the respective obligations:
- 8.4.1. *Authority*: The different obligations are essentially arranged in a hierarchy of authority. Legal obligations are the most authoritative, followed by certain types of professional ethical obligation (8.3.2). Beneath these are other types of professional ethical obligation and theoretical ethical obligations, which may be (at most) influential over those to whom they apply.
- 8.4.2. *Content*: Sometimes theoretical, professional, and legal obligations convey the same essential idea. An idea might first be advanced and developed in theoretical sources, before it is adopted by professional and/or legal sources. As such, theoretical ethical obligations may inform the content of professional ethical obligations and/or legal obligations. As Coleridge LCJ once put it, “It would not be correct to say that every moral obligation involves a legal duty; but every legal duty is founded on a moral obligation”.<sup>190</sup> By way of example, the principle of respect for autonomy finds expression in not only theoretical ethical obligations (2.12.1), but also professional and legal obligations, e.g., in relation to informed consent (see further **Part C, 13-20**). Equally, a professional obligation might sometimes influence a legal obligation: e.g., professional guidance on confidentiality has been explicitly endorsed in court as reflective of the legal position.<sup>191</sup> However, legal obligations will take precedence, e.g., if a professional position is found to be out-of-step with the law.<sup>192</sup> As such, professional guidance will usually be based on the applicable legal position and will often make explicit reference thereto.

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<sup>190</sup> *R v Instan* [1893] 1 QB 450.

<sup>191</sup> *W v Egdell* [1990] Ch 359, citing GMC guidance.

<sup>192</sup> E.g., Munby J in *R (on the application of Burke) v General Medical Council* [2005] QB 424 declared parts of the (then) GMC guidance on withholding and withdrawing life-sustaining treatment unlawful. However, this judgment was reversed by the Court of Appeal in *R (on the application of Burke) v General Medical Council* [2006] QB 273.

**9. What bodies had a role to play in the maintenance of ethical standards in the field of neurosurgery over the relevant period and what were their roles? How have the roles of these and other relevant bodies developed in the years since the relevant period?**

9.1. **Table 3** lists the main bodies that had a role to play in the maintenance of ethical standards in the field of neurosurgery over the relevant period. Of particular importance are:

- 9.1.1. The GMC, as this is the statutory regulator for doctors;
- 9.1.2. The RCS and RCSEd, as membership is a pre-requisite for entering specialty training in surgery;
- 9.1.3. The JCST, as this sets the curriculum for surgical training and recommends the certification of surgeons to the GMC;
- 9.1.4. The WFNS, as this has global reach and has issued a statement of neurosurgical ethics.

9.2. The central roles of these bodies appear to have been stable for many decades. However, changes have occurred in recent decades, which primarily concern the GMC and the bodies involved in education. These changes relate to:

- 9.2.1. Oversight of professional regulation (**9.3-9.4**);
- 9.2.2. Revalidation of doctors (**9.5**);
- 9.2.3. Adjudicating on doctors' fitness to practise (**9.6**); and
- 9.2.4. Training surgeons (**9.7-9.11**).

### Professional regulation

9.3. In 2000, GP Harold Shipman was convicted of murdering 15 of his patients. Dame Janet Smith chaired an independent public inquiry, which produced six reports between 2002 and 2005. The fifth of these reports, published in 2004, was critical of the culture in the GMC at the time, finding that it acted more to protect doctors than patients.<sup>193</sup> [ELJ0002-00141] Changes were subsequently made to the system of professional regulation.

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<sup>193</sup> The Shipman Inquiry (2004).

- 9.4. The Council for the Regulation of Healthcare Professionals – now, after several name changes, the Professional Standards Authority (PSA) – was created by the NHS Reform and Health Care Professions Act 2002. The PSA oversees the work of professional regulators, including the GMC, and was established to (*inter alia*) “promote the interests of patients and the public in the performance of functions carried out by the regulatory bodies it oversees”<sup>194</sup> [ELJ0002-00059\_8]

### Revalidation

- 9.5. Revalidation was introduced in 2012. This requires all doctors to “revalidate every 5 years in order to renew their license” to practise<sup>195</sup> [ELJ0002-00059\_19]. Prior to this, there was no formal process of revalidation. The GMC had first proposed such a process in 2000, but “these proposals were eventually diluted to a requirement that all doctors should participate in annual appraisals conducted by their employers, and that employers should issue a statement every five years to confirm the absence of significant concerns”.<sup>196</sup> [ELJ0002-00160]

### Fitness to practise

- 9.6. The fifth report of the Shipman Inquiry also recommended that the GMC no longer adjudicate over the fitness to practise of doctors.<sup>197</sup> [ELJ0002-00141] In June 2012, the Medical Practitioners Tribunal Service (MPTS) was created, which took on the role of adjudication.

### Training surgeons

- 9.7. A House of Commons report has noted “the complexity of medical education” and training<sup>198</sup> [ELJ0002-00059\_10]. Changes have occurred in the relevant period, including in the training of surgeons.
- 9.8. Prior to 1996, higher surgical training lasted 8-12 years. A surgeon would progress through senior house officer, registrar, and senior registrar grades, before becoming

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<sup>194</sup> Pickett (2017: 8).

<sup>195</sup> Pickett (2017: 19).

<sup>196</sup> House of Commons Health Committee (2011: section 2).

<sup>197</sup> The Shipman Inquiry (2004).

<sup>198</sup> Pickett (2017: 10).

a consultant. The process was “firm” based and appointments allegedly relied on the “old-boy network”.<sup>199</sup> [ELJ0002-00078]

- 9.9. On 12 January 1996, an order (statutory instrument) came into force, which gave effect to EU directives on the harmonisation of medical training.<sup>200</sup> The order established the Specialist Training Authority of the medical royal colleges. Higher surgical training was now structured and time-limited (to six years), with surgeons moving from specialist (later specialty) registrar to consultant, following the award of a Certificate of Completion of Specialist Training (CCST).<sup>201</sup> [ELJ0002-00078]
- 9.10. In January 2004, changes were made to the final qualifying examinations. The new Intercollegiate Member of the Royal College of Surgeons (MRCS) replaced the old Fellow of The Royal College of Surgeons of England (FRCS), which had been the initial qualifying diploma. The new final FRCS is an exit examination, which is “mandatory for the award of a Certificate of Completion of Training (CCT) and entry onto the specialist register”.<sup>202</sup> [ELJ0002-00078]
- 9.11. An order in 2005 abolished the Specialist Training Authority, “replaced the CCST with the CCT and formed the independent Postgraduate Medical Education and Training Board (PMETB)”.<sup>203</sup> [ELJ0002-00078] The latter was then merged with the GMC following a third order in 2010.

**10. What are the ethical principles and factors that should, in your view, inform decision making by central government, NHS bodies and other relevant organisations with responsibilities towards the maintenance of standards in patient care in the NHS?**

- 10.1. This is a significant question, which potentially invites reflection on such matters as the nature and scope of democratic governance and legitimacy. Such matters lie beyond our specific areas of expertise (see **1.2-1.4**). We can, however, point to some sources, which set out some of the (substantive and procedural) ethical principles and factors that should inform decision-making:

10.1.1. NHS Constitution (England) (**10.2-10.5**);

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<sup>199</sup> Bolwell (2010: 98).

<sup>200</sup> The date on which the European Specialist Medical Qualifications Order 1995 came into force.

<sup>201</sup> Bolwell (2010: 98).

<sup>202</sup> Bolwell (2010: 98).

<sup>203</sup> Bolwell (2010: 99).

- 10.1.2. Charter of Patient Rights and Responsibilities (Scotland) (**10.6-10.8**);  
and
- 10.1.3. Principles from professional ethical guidance (England and Wales)  
(**10.9-10.10**).

### NHS Constitution (England)

- 10.2. There are ethical values – and associated standards – enshrined in the NHS Constitution for England<sup>204</sup> [ELJ0002-00015]. Central government and NHS bodies in England should at least honour these commitments because there is a legal obligation to do so.<sup>205</sup>
- 10.3. The NHS Constitution was published in March 2012 and last updated in August 2023<sup>206</sup> [ELJ0002-00015]. The Constitution states seven principles that guide the NHS:
  - 10.3.1. The NHS provides a comprehensive service, available to all;
  - 10.3.2. Access to NHS services is based on clinical need, not an individual's ability to pay;
  - 10.3.3. The NHS aspires to the highest standards of excellence and professionalism;
  - 10.3.4. The patient will be at the heart of everything the NHS does;
  - 10.3.5. The NHS works across organisational boundaries;
  - 10.3.6. The NHS is committed to providing best value for taxpayers' money;
  - 10.3.7. The NHS is accountable to the public, communities and patients that it serves.
- 10.4. The Constitution also provides a core set of six NHS values, which – in line with principles of democracy and inclusivity – were co-developed with patients, public, and healthcare staff:
  - 10.4.1. Working together for patients;
  - 10.4.2. Respect and dignity;

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<sup>204</sup> Department of Health and Social Care (2023).

<sup>205</sup> Health Act 2009.

<sup>206</sup> Department of Health and Social Care (2023).

- 10.4.3. Commitment to quality of care;
  - 10.4.4. Compassion;
  - 10.4.5. Improving lives;
  - 10.4.6. Everyone counts.
- 10.5. As the Francis report stated in 2013, “it can be accepted that the Constitution appears to capture most of the matters many people would consider to be essential to a healthy NHS culture”.<sup>207</sup> [ELJ0002-00051\_67] The Francis report nevertheless noted that more could be done to give effect to the principles and values enshrined in the Constitution.<sup>208</sup> [ELJ0002-00051\_69-70]

### Charter of Patient Rights and Responsibilities (Scotland)

- 10.6. The NHS Constitution does not apply to Scotland. However, similar principles and values are captured in the Charter of Patient Rights and Responsibilities. As with the NHS Constitution in England, there is a legal obligation for relevant bodies in Scotland to honour these commitments.<sup>209</sup> The Explanatory Notes to the Act explained how it neither generated any new rights, nor amended any existing rights;<sup>210</sup> [ELJ0002-00161\_1] instead, it essentially formalised existing rights, which had been present in such standards as NHS Scotland’s *Patient Focus and Public Involvement* framework (2001).<sup>211</sup> [ELJ0002-00162]
- 10.7. The first edition of the Charter<sup>212</sup> [ELJ0002-00057] which was published in September 2012, set down the following patient rights and responsibilities:
- 10.7.1. *Access*: rights when using NHS services in Scotland;
  - 10.7.2. *Communication and participation*: the right to be informed, and involved, in decisions about health care and services;
  - 10.7.3. *Confidentiality*: the right for personal health information to be kept secure and confidential;
  - 10.7.4. *Respect*: the right to be treated with dignity and respect;
  - 10.7.5. *Safety*: the right to safe and effective care;

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<sup>207</sup> Mid Staffordshire NHS Foundation Trust (2013, [21.40]).

<sup>208</sup> E.g., Mid Staffordshire NHS Foundation Trust (2013, [21.46-47]).

<sup>209</sup> Patient Rights (Scotland) Act 2011.

<sup>210</sup> Patient Rights (Scotland) Act 2011, Explanatory Notes, Section 1, [9].

<sup>211</sup> NHS Scotland (2001).

<sup>212</sup> NHS Scotland (2012).

- 10.7.6. *Feedback and complaints*: the right to have a say about care and have any concerns and complaints dealt with.
- 10.8. The revised edition of the Charter,<sup>213</sup> [ELJ0002-00120] which was published in June 2022, set down patient rights and responsibilities regarding:
  - 10.8.1. Accessing and using NHS services in Scotland;
  - 10.8.2. Communication and involving patients;
  - 10.8.3. Privacy and confidentiality;
  - 10.8.4. Feedback and complaints.

#### Principles from professional ethical guidance (England and Wales)

- 10.9. There are various sources of professional ethical obligations, such as guidance documents issued by a range of professional organisations (**2.13-2.18**), which set down some broadly comparable values and standards to those noted above (**10.2.-10.8**).
- 10.10. A prominent recent example is the guidance issued by various professional organisations in England and Wales in response to the Covid-19 pandemic.<sup>214</sup> [ELJ0002-00136] These documents set down such (overlapping) principles to guide decision-making as:
  - 10.10.1. *Respect*, which requires attention to rights, wishes, feelings, and choices of the individual;
  - 10.10.2. *Fairness*, which requires that people are treated fairly and equally, that processes are fair, and that decision-making is consistent;
  - 10.10.3. *Minimising harm*, which requires efforts to reduce harms to individuals and groups;
  - 10.10.4. *Reciprocity*, which means supporting those who take on increased burdens;
  - 10.10.5. *Proportionality*, which requires different benefits and risks to be balanced;

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<sup>213</sup> NHS Scotland (2022).

<sup>214</sup> Smith et al (2021).

- 10.10.6. *Flexibility*, which requires an ability and willingness to adapt to changing circumstances;
- 10.10.7. *Working together*, which requires support for and co-operation with others;
- 10.10.8. *Inclusiveness*, which requires informing and involving people in decisions that affect them;
- 10.10.9. *Communication*, which requires consultation and discussion;
- 10.10.10. *Transparency*, which requires openness on the part of individuals and organisations;
- 10.10.11. *Reasonableness*, which requires decisions to be based on appropriate processes and justifications, including the use of appropriate evidence;
- 10.10.12. *Responsibility*, which requires individuals and organisations to fulfil their roles responsibly;
- 10.10.13. *Accountability*, which requires individuals and organisations to account for how and which decisions are made.

## **11. How do the ethical obligations of individual surgeons sit alongside and intersect with obligations of such organisations in the maintenance of high standards of patient care?**

- 11.1. The obligations of individual surgeons and of government, NHS, and related organisations are designed to be complementary. A key shared goal is that of patient safety and quality care (see, e.g., **5.10.2, 6.9, 36.2, 38**)<sup>215</sup> [ELJ0002-00037]; [ELJ0002-000128] Both individuals and organisations, for example, must work toward fostering a culture of honesty and openness, especially regarding reporting and learning from errors (see **Part F, 36-44; Part H, 46-48**).
- 11.2. Generally speaking, surgeons hold direct responsibility and accountability for patient care; however, organisations such as NHS Trusts (England) and Health Boards (Scotland) hold responsibility for creating the environment that enables that care, including providing monitoring systems and resources. This is done through frameworks for clinical governance.

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<sup>215</sup> E.g., General Medical Council (2024a); Royal College of Surgeons of England (2025).

11.3. NHS Scotland has established an integrated clinical and care governance framework designed to support collaborative health and social care partnerships, as well as Integrated Joint Boards, i.e., Health Boards and Local Authorities, which have come together to provide integrated health and social care. The framework published in 2015 provides “guidance on the key elements and principles to be reflected in local clinical and care governance of integrated health and social care arrangements”<sup>216</sup> [ELJ0002-00065]. The framework includes “Five Key Principles of Clinical and Care Governance”:

- “1. Clearly defined governance functions and roles are performed effectively.
2. Values of openness and accountability are promoted and demonstrated through actions.
3. Informed and transparent decisions are taken to ensure continuous quality improvement.
4. Staff are supported and developed.
5. All actions are focused on the provision of high quality, safe, effective and person-centred services”<sup>217</sup> [ELJ0002-00065].

11.4. Clinical governance sits alongside a larger framework for good governance as a whole, across NHS services, i.e., the NHS *Blueprint for good governance*<sup>218</sup> [ELJ0002-00066]. Healthcare Improvement Scotland (HIS) has developed clinical governance standards for Scotland, which were published in February 2026<sup>219</sup> [ELJ0002-00044] [ELJ0002-00163]

11.5. Surgeons are required to take part in regular clinical governance meetings, and expected to report any clinical errors or near misses in an open and honest manner (see **Part F, 36-44; Part H, 46-48**)<sup>220</sup> [ELJ0002-00064].

11.6. The RCS also has guidance on the “difference between the duty of individuals and the duty of organisations” in their specific guidance on candour (see **Part H, 46-48**):

“The statutory duty [of candour] is a duty on health providers. However, individual doctors and surgeons are relied on to discharge it on behalf of their organisations, and therefore need to have a clear understanding of the differences between the

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<sup>216</sup> Scottish Government (2015). This framework is part of statutory guidance on the Public Bodies (Joint Working) (Scotland) Act 2014.

<sup>217</sup> Scottish Government (2015).

<sup>218</sup> Scottish Government (2019).

<sup>219</sup> Healthcare Improvement Scotland (2025); Healthcare Improvement Scotland (2026).

<sup>220</sup> Royal College of Surgeons of England (2026b).

common professional duty and the statutory duty for organisations. The organisational duty requires health providers to act in an open and transparent way towards patients. It includes all aspects of the professional duty of candour for individual doctors as described in the previous section. In addition, however, providers must also undertake the following actions when the threshold of a 'notifiable safety incident' has been reached:

- Carry out a thorough investigation into the causes of the incident and share relevant details with the patient.
- Provide an apology in writing, following the verbal apology in person.
- Provide reasonable support to the patient in relation to the incident.
- Establish a formal and defined process of harm disclosure as part of the provider's clinical governance processes".<sup>221</sup> [ELJ0002-00127]

## **12. How should the ethical requirements of patient care and financial considerations, including the cost of treatment and the maintenance of a particular medical service be balanced against each other by health boards and by individual practitioners? Who should be involved in maintaining that balance?**

12.1. In seeking to answer this question about the ethical balance to be struck between patient care and financial considerations, we consider:

- 12.1.1. How decisions are currently made and by whom (**12.2-12.7**); and
- 12.1.2. How decisions should be made and by whom (**12.8-12.9**).

### How decisions are currently made and by whom

12.2. Various decision-makers are currently involved in maintaining the balance between the ethical requirements of patient care and financial considerations. Key examples include:

- 12.2.1. At a national level in Scotland, the funding for the NHS is determined by the Scottish Government. Funding to NHS Boards is distributed using

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<sup>221</sup> Royal College of Surgeons of England (2015a: 7).

- the NHS Scotland Resource Allocation Committee formula (“NRAC formula”);
- 12.2.2. In Scotland, Integration Joint Boards (the equivalent of English Integrated Care Boards) allocate budgets;
  - 12.2.3. NHS directorates have a role in allocating broader costs, e.g., staffing, new equipment, and distribution of funds between specialties;
  - 12.2.4. In Scotland and England, the Scottish Intercollegiate Guidelines Network (SIGN) and National Institute for Health and Care Excellence (NICE) (respectively) provide guidance on cost-effective treatments. This guidance is made to sit alongside the GMC’s ethical standards for doctors. The Scottish Medicines Consortium (part of Healthcare Improvement Scotland) review new medicines licenced by the Medicines and Healthcare products Regulatory Agency (MHRA). Part of their review remit is deciding whether a particular medicine provides value for money;<sup>222</sup> [ELJ0002-00131] and
  - 12.2.5. Clinicians. In its 2012 guidance on leadership, the GMC states that all doctors “should be willing to demonstrate leadership in managing and using resources effectively. This means that you should be prepared to contribute to discussions and decisions about: (a) allocating resources and setting priorities in any organisation in which you work; (b) commissioning services for the wider population of patients”.<sup>223</sup> [ELJ0002-00025\_16]
- 12.3. Generally, principles for balancing patient care and financial considerations may be seen across guidance and policies in the system. Various guidance and policies refer to such principles as: equity; fairness; value (for money); transparency; and inclusiveness (see **10**).
- 12.4. More specific guidance also exists on how an ethical balance can be struck between patient care and financial considerations. Key examples include guidance from the GMC (**12.5**), a statement of the principles adopted by NICE (**12.6**), and NHS Scotland’s Charter of Patient Rights and Responsibilities (**12.7**).

### *GMC guidance*

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<sup>222</sup> Scottish Medicines Consortium (2026).

<sup>223</sup> General Medical Council (2012b: [79]).

- 12.5. The GMC's 2012 guidance on leadership contains specific guidance on allocating resources:
- 12.5.1. The guidance recognises the possibility of tension between patient care and financial considerations: "All medical professionals must make the care of patients their first concern. However, the treatment options that can be offered to patients may be affected by limits on resources";<sup>224</sup> [ELJ0002-00025\_17]
- 12.5.2. The guidance then offers four principles, which "must" underpin "decisions about using resources":
- "1. Provide the best service possible within the resources available, taking account of your responsibilities towards your patients and the wider population.
  2. Be familiar with any local and national policies that set out agreed criteria for access to a particular treatment.
  3. Make sure that decisions about setting priorities that affect patients are fair and based on clinical need and the likely effectiveness of treatments, and are not based on factors that may introduce discriminatory access to care.
  4. Be open and honest with patients and the rest of the healthcare team about the decision-making process and the criteria for setting priorities in individual cases".<sup>225</sup>[ELJ0002-00025\_17]
- 12.5.3. The guidance adds that doctors should involve colleagues in discussions about resource allocation and, if disputes arise, should discuss options "with, for example, patients, the healthcare team, other colleagues (including other health and social care professionals) and managers. You should be open and honest with patients when resource constraints may affect the treatment options available".<sup>226</sup> [ELJ0002-00025\_17]

### *NICE principles*

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<sup>224</sup> General Medical Council (2012b: [84]).

<sup>225</sup> General Medical Council (2012b: [85]).

<sup>226</sup> General Medical Council (2012b: [86]).

12.6. NICE has published principles, which “focus on the morals, ethics and values that underpin our recommendations”.<sup>227</sup> [ELJ0002-00054]

12.6.1. NICE recognises the possibility of tension between patient care and financial considerations: “When making decisions, NICE and our committees strive to balance the need to achieve the most overall benefit for the greatest number of people, with the need to ensure fairness and respect for individual choice”;<sup>228</sup> [ELJ0002-00054\_1]

12.6.2. NICE states that its principles for producing guidance “are based in part on the following moral principles:

- People have the right to make informed choices about the care they receive. But not everyone has the ability to make their own choices, and not everything people might want will necessarily be available.
- Every intervention has the potential to cause harm and may not always benefit everyone. So it is important consider the balance of benefits and harms when deciding whether an intervention is appropriate.
- Resources need to be allocated appropriately and fairly. They must provide the best outcomes for the finite resources available while balancing the needs of the overall population and of specific groups”.<sup>229</sup> [ELJ0002-00054\_2]

#### *NHS Scotland Charter of Patient Rights and Responsibilities*

12.7. The 2022 version of NHS Scotland’s Charter of Patient Rights and Responsibilities (10.6-10.8) states that the system will “distribute available resources to where they will deliver best value for the people we care for and for the health and care system”.<sup>230</sup> [ELJ0002-00120] It notes how the “local health board is responsible for assessing the local community’s health needs and deciding how best to use its resources to meet those needs. The board provides opportunities for communities, the public, service users and NHS staff to influence decision-making”.<sup>231</sup> [ELJ0002-00120]

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<sup>227</sup> National Institute for Health and Care Excellence (2026a).

<sup>228</sup> National Institute for Health and Care Excellence (2026a).

<sup>229</sup> National Institute for Health and Care Excellence (2026a).

<sup>230</sup> NHS Scotland (2022: 5).

<sup>231</sup> NHS Scotland (2022: 17).

### How decisions should be made and by whom

- 12.8. Deciding how an ethical balance should be struck between patient care and financial considerations, and who should do so, is a significant question. As noted above (**6, esp. 6.5.3**), there is an extensive theoretical ethical literature on the just distribution of (healthcare) resources.
- 12.9. Mindful that this is a very difficult question to answer, we make two observations:
  - 12.9.1. Even in the absence of agreement about the most (substantively) ethical approach to allocating resources, efforts should be made to ensure that *processes* are fair, reasonable, and transparent;
  - 12.9.2. As some existing guidance recognises (**10.10.8, 12.5.3, 12.7**), such processes should incorporate mechanisms to *include* the views of diverse stakeholders, including patients (spurred by efforts to ensure that there is “no decision about me without me”: see further **21.6.5, 21.9.2**).

**Table 4: Professional organisations**

| Issuing organisation          | Scope   | Role                                                                                                                                                                                                                                                                                                        | Authority                                                                                                                                                                                                                                                                                                                                                           | Examples of ethical guidance                                                                                                                                                                                                                                                                                                                                                             |
|-------------------------------|---------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| General Medical Council (GMC) | Doctors | <p>Statutory regulator for doctors.</p> <p>Functions include:</p> <ul style="list-style-type: none"> <li>• setting standards;</li> <li>• maintaining the medical register;</li> <li>• educating and revalidating doctors; and</li> <li>• taking action when a doctor departs from the standards.</li> </ul> | <p>Authority: Determines who is entitled to (continue to) practice as a doctor.</p> <p>Note: Current GMC guidance uses the terms “must” and “should” in the ways quoted below. We have reflected their use of these terms in our answers:</p> <p>“‘You must’ is used for a legal or ethical duty you’re expected to meet (or be able to justify why you didn’t)</p> | <ul style="list-style-type: none"> <li>• Good medical practice (2024)<sup>233</sup> [ELJ0002-00037]</li> <li>• Decision making and consent (2020)<sup>234</sup> [ELJ0002-00034]</li> <li>• Raising and acting on concerns about patient safety (2012)<sup>235</sup> [ELJ0002-00024]</li> <li>• Openness and honesty when things go wrong (2015)<sup>236</sup> [ELJ0002-00027]</li> </ul> |

<sup>233</sup> General Medical Council (2024a).

<sup>234</sup> General Medical Council (2020a).

<sup>235</sup> General Medical Council (2012a).

<sup>236</sup> General Medical Council (2015a).

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|---------------------------------------------------------------------------------------------|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                             |          |                                                                                                                                                                                                                                                                                                                               | 'You should' is used for duties or principles that either: may not apply to you or to the situation you're currently in, or you may not be able to comply with because of factors outside your control." <sup>232</sup> [ELJ0002-00037_6] |                                                                                                                                                                                                                                                                  |
| Royal College of Surgeons of England (RCS) & Royal College of Surgeons of Edinburgh (RCSEd) | Surgeons | <p>Professional organisation of surgeons. RCS and RCSEd respectively focus on England and Scotland, but sometimes guidance co-produced.</p> <p>Functions include:</p> <ul style="list-style-type: none"> <li>• maintaining standards;</li> <li>• educating surgeons; and</li> <li>• influencing healthcare policy.</li> </ul> | Authority: Membership is a pre-requisite for entering specialty training in surgery.                                                                                                                                                      | <ul style="list-style-type: none"> <li>• RCS, Good Surgical Practice (2025)<sup>237</sup> [ELJ0002-00128]</li> <li>• RCS, Duty of candour (2015)<sup>238</sup> [ELJ0002-00127]</li> <li>• RCSEd, Code of Conduct (2024)<sup>239</sup> [ELJ0002-00124]</li> </ul> |

<sup>232</sup> General Medical Council (2024a: 5).

<sup>237</sup> Royal College of Surgeons of England (2025).

<sup>238</sup> Royal College of Surgeons of England (2015a).

<sup>239</sup> Royal College of Surgeons of Edinburgh (2024).

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|---------------------------------------------|----------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                             |          |                                                                                                                                                                                                                                                                                            |                                                                                                        | <ul style="list-style-type: none"> <li>• RCSEd, Our values<sup>240</sup> [ELJ0002-00125]</li> </ul>                                                                                                                                                                  |
| Joint Committee on Surgical Training (JCST) | Surgeons | Advises the four Royal Colleges of the UK and Ireland on surgical training and assessment. Comprises Specialty Advisory Committees (SAC), including one on neurosurgery, and the Intercollegiate Surgical Curriculum Programme (ISCP).                                                     | Authority: Trainees must be enrolled with a SAC, which then recommends their certification to the GMC. | <ul style="list-style-type: none"> <li>• ISCP, Neurosurgery Curriculum (2021/2026<sup>241</sup>) [ELJ0002-00104]</li> </ul>                                                                                                                                          |
| British Medical Association (BMA)           | Doctors  | <p>Trade union for doctors.</p> <p>Functions include:</p> <ul style="list-style-type: none"> <li>• representing, supporting, and negotiating on behalf of doctors;</li> <li>• lobbying and campaigning on issues affecting medical profession; and</li> <li>• providing advice.</li> </ul> | Influence: Issues ethics guidance and toolkits.                                                        | <ul style="list-style-type: none"> <li>• BMA core ethics guidance (2025)<sup>242</sup> [ELJ0002-00005]</li> <li>• Doctor patient relationship (2025)<sup>243</sup> [ELJ0002-00003]</li> <li>• Consent and refusal by adults with decision-making capacity</li> </ul> |

<sup>240</sup> Royal College of Surgeons of Edinburgh (2026a).

<sup>241</sup> Intercollegiate Surgical Curriculum Programme (2026). A summary of changes is provided at: Intercollegiate Surgical Curriculum Programme (2026b).

<sup>242</sup> British Medical Association (2025c).

<sup>243</sup> British Medical Association (2025a).

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|-------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                   |               |                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                  | <p>(2025)<sup>244</sup> [ELJ0002-00004]</p> <ul style="list-style-type: none"> <li>• Transparency for doctors with competing interests (2024)<sup>245</sup> [ELJ0002-00004]</li> </ul> |
| World Federation of Neurosurgical Societies (WFNS) <sup>246</sup> | Neurosurgeons | Aims to work together with its neurosurgical member societies to improve worldwide neurosurgical care, training, and research to benefit neurosurgical patients. WFNS envisions a world where safe, timely and high-quality neurosurgical care is accessible to all. | Influence: Comprises 5 continental neurosurgical societies and 119 national neurosurgical societies, representing over 49,000 neurosurgeons worldwide. The Society of British Neurological Surgeons (SBNS) is a member organisation, which has >1,000 members (NHS figures suggest that, in 2021, there were 362 | <ul style="list-style-type: none"> <li>• Statement of ethics (2007)<sup>248</sup> [ELJ0002-00070]</li> </ul>                                                                           |

<sup>244</sup> British Medical Association (2025b).

<sup>245</sup> British Medical Association (2024).

<sup>246</sup> World Federation of Neurosurgical Societies (2025).

<sup>248</sup> World Federation of Neurosurgical Societies (2007).

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|--|--|--|------------------------------------------------------------------------------|--|
|  |  |  | consultant neurosurgeons<br>in England <sup>247</sup> ). [ELJ0002-<br>00055] |  |
|--|--|--|------------------------------------------------------------------------------|--|

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<sup>247</sup> NHS (2026).

**Table 5: WFNS Statement on ethics**

| Domain                                                                                   | Key principles/obligations                                                                                                                                                                                                                                                                                                                                                                                                                        | Selected quotations                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Good Medical Practice – The Standard of Care</b><br>([1]-[18]) [ELJ0002-00070_2-3]    | <ul style="list-style-type: none"> <li>▪ Maintain a high level of professional competence;</li> <li>▪ Recognise (and work within) limits of competence;</li> <li>▪ Undertake careful assessments of patients;</li> <li>▪ Ensure a favourable risk/benefit balance;</li> <li>▪ Work well with colleagues;</li> <li>▪ Ensure continuity of care;</li> <li>▪ Support and oversee junior colleagues;</li> <li>▪ Maintain accurate records.</li> </ul> | <ul style="list-style-type: none"> <li>▪ “We must avoid serving as the surgeon of last resort for a desperate patient seeking surgical intervention that has been rejected by many of our peers, and that may not help the patient or stop the advance of disease”;</li> <li>▪ “When patient care may be compromised by inadequate facilities or equipment, lack of reimbursement for important medical services, or shortages of medical and support staff, neurosurgeons should address the issues to the best of their ability”;</li> <li>▪ “We should keep clear, up to date, detailed, and accurate clinical records, with full descriptions of [...] significant medical events...”</li> </ul> |
| <b>Relationships with Patients and Family Members</b> ([19]-[53])<br>[ELJ0002-00070_3-5] | <ul style="list-style-type: none"> <li>▪ Provide care at standards of best practice;</li> <li>▪ Treat patients, families, colleagues with dignity and respect;</li> <li>▪ Provide access to records and second opinions;</li> </ul>                                                                                                                                                                                                               | <ul style="list-style-type: none"> <li>▪ “We should treat patients even at the cost of personal sacrifice and legitimate self interest”;</li> <li>▪ “Neurosurgeons should be willing to provide patients with clear information, and discuss fully the benefits, risks, and costs of appropriate treatment alternatives using language that allows them to understand the issues at hand”;</li> </ul>                                                                                                                                                                                                                                                                                                |

|                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                       | <ul style="list-style-type: none"> <li>▪ Provide guidance to patients, but enable their participation and informed consent;</li> <li>▪ Prevent personal beliefs from prejudicing care;</li> <li>▪ Communicate appropriately;</li> <li>▪ Provide clear, honest, and accurate information, tailored to the individual;</li> <li>▪ Respect patient privacy and confidentiality.</li> </ul>                   | <ul style="list-style-type: none"> <li>▪ “We must weigh our decisions on what information to disclose and how to present that information, with consideration for cultural mores and values, as well as the makeup of individual patients. This becomes particularly important when we are treating patients with malignant diseases, and they wish to discuss their prognosis”;</li> <li>▪ “We should be honest with patients and their families about the reasons for complications, and express our sincere regret when the situation does not go according to plan”;</li> </ul>                                                                  |
| <b>Standards of Personal and Professional Life</b><br>([54]-[73]) [ELJ0002-00070_6-7] | <ul style="list-style-type: none"> <li>▪ Act fairly and honestly;</li> <li>▪ Avoid overwork or habits that impair competence;</li> <li>▪ Communicate with, and behave respectfully towards, colleagues;</li> <li>▪ Protect patients, including from colleagues’ harmful behaviour;</li> <li>▪ Manage financial interests appropriately, e.g., clearly communicating fees and terms to patients</li> </ul> | <ul style="list-style-type: none"> <li>▪ “The neurosurgeon’s self-interest is subordinate to patient care. Patient referrals, the choice of procedure, and the use [of] devices or surgical aids must never be affected by personal financial benefit”;</li> <li>▪ “If there is reason to believe the actions of a colleague are endangering patients, we have a duty to make every effort to persuade that colleague to change his or her practice. If this approach fails, we must act to protect patients from risk when there is good reason to believe the ability of a colleague to provide a high standard of care is compromised”</li> </ul> |

|                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                               |
|-------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Medico-Legal Responsibilities</b><br>([74]-[94]) [ELJ0002-00070_7-9]                         | <p>Generally, honour legal boundaries and understand specific legal obligations and standards associated with:</p> <ul style="list-style-type: none"> <li>▪ Establishing patient capacity/competence to make decisions;</li> <li>▪ The information to provide to competent patients;</li> <li>▪ The treatment of incompetent and psychiatric patients, and children;</li> <li>▪ End-of-life care, including advance decision-making, and the provision, withholding and withdrawing of treatment.</li> </ul> | <ul style="list-style-type: none"> <li>▪ “We may describe risks and benefits as cited in the world literature, but we must also describe our own experience and results with the patients we treat when requested”</li> </ul> |
| <b>Participation as an Expert Witness in Legal Proceedings</b><br>([95]-[98]) [ELJ0002-00070_9] | <ul style="list-style-type: none"> <li>▪ Protect patient confidentiality;</li> <li>▪ Co-operate with lawyers to provide justice;</li> <li>▪ Maintain a fair and unbiased position.</li> </ul>                                                                                                                                                                                                                                                                                                                | <ul style="list-style-type: none"> <li>▪ “We should cooperate with lawyers to provide justice to those who may have suffered through medical accidents”</li> </ul>                                                            |
| <b>Teaching &amp; Training</b><br>([99]-[109]) [ELJ0002-00070_9-10]                             | <ul style="list-style-type: none"> <li>▪ Teach students and juniors;</li> <li>▪ Respect patients while teaching;</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                  | <ul style="list-style-type: none"> <li>▪ “We should encourage leaders in medical education, neurosurgical training, and in professional meetings to include</li> </ul>                                                        |

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|                                                                                                              | <ul style="list-style-type: none"> <li>▪ Provide students and juniors with experience, support, and (accurate) assessment.</li> </ul>                                                                                                               | discussions and presentations of ethical issues into the syllabi and agendas for their programs”                                                                      |
| <b>Integrating the Principles of Evidence-Based Medicine (EBM)</b><br>([110]-[113])<br>[ELJ0002-00070_10-11] | <ul style="list-style-type: none"> <li>▪ Include EBM within training;</li> <li>▪ Use EBM within patient care, when feasible and appropriate;</li> <li>▪ Design collaborative research programmes, which use EBM to support patient care.</li> </ul> | <ul style="list-style-type: none"> <li>▪ “When feasible and appropriate, the EBM process should be brought to bear on the care of individual patients”</li> </ul>     |
| <b>Conflicts of Interest in Research &amp; Clinical Practice</b><br>([141]-[150])<br>[ELJ0002-00070-14-15]   | <ul style="list-style-type: none"> <li>▪ Conflicts of interest should be disclosed;</li> <li>▪ Work to avoid bias and ensure the independence of research, conferences, publications.</li> </ul>                                                    | <ul style="list-style-type: none"> <li>▪ “We must work to ensure the independence of our scientific conferences and publications”</li> </ul>                          |
| <b>New Procedures, Materials, and Devices</b> ([151]-[155])<br>[ELJ0002-00070_15]                            | <ul style="list-style-type: none"> <li>▪ Carefully assess the safety, efficacy, and value for patients of innovative procedures (etc.);</li> <li>▪ Publish results, including the negative;</li> </ul>                                              | <ul style="list-style-type: none"> <li>▪ “Outcomes from the new practices should be monitored, especially during the early period following introduction”.</li> </ul> |

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|                                                                                                                     | <ul style="list-style-type: none"> <li>▪ Train surgeons in new procedures (etc.) and evaluate their use;</li> <li>▪ Monitor outcomes.</li> </ul>                                           |                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Tissue and Organ Transplantation</b><br>([156]-[159])<br>[ELJ0002-00070_16]                                      | <ul style="list-style-type: none"> <li>▪ Restrict transplantation to specialist settings;</li> <li>▪ Observe applicable laws and customs, e.g., regarding brain death, consent.</li> </ul> | <ul style="list-style-type: none"> <li>▪ “Although tissue transplantation has only a limited place in neurosurgical practice, this may change with time. Transplantation should only be undertaken in specialized centers with the facilities to provide the treatment and evaluate results. All national laws and professional regulations must be respected”</li> </ul> |
| <b>Advertising and Publicity</b> ([160]-[172])<br>[ELJ0002-00070_16-17]                                             | <ul style="list-style-type: none"> <li>▪ Adverts should be accurate</li> </ul>                                                                                                             | <ul style="list-style-type: none"> <li>▪ “Publicity should primarily serve the interests of patients, rather than physicians”</li> </ul>                                                                                                                                                                                                                                  |
| <b>Narrowing the Gap – Neurosurgery in the Developed &amp; Developing World</b><br>([173]-[175])<br>[ELJ0002-00017] | <ul style="list-style-type: none"> <li>▪ Neurosurgeons should support and educate colleagues globally to improve standards</li> </ul>                                                      | <ul style="list-style-type: none"> <li>▪ “Neurosurgeons in the developed world have a moral and social obligation to help their peers in the developing world to gain theoretical and practical knowledge that will enable them to improve the standard of care in all nations of the world”</li> </ul>                                                                   |

## PART C

### INFORMED CONSENT

#### 13. What are the principles of informed consent in the field of neurosurgery?

- 13.1. Although guidance from professional organisations has long conveyed the importance of obtaining consent from the patient, the clearest and most authoritative statements of the relevant principles appear to have emerged in the 1990s (see **13.12ff**, below).

#### Professional guidance from influential organisations (1960s-1990s)

- 13.2. Prior to the 1990s, relevant pointers could be found in guidance issued by such organisations as the Medical Defence Union (MDU), which provides professional indemnity, advice, and support to doctors, and the doctors' trade union, the BMA.
- 13.3. In 1962, the MDU issued *Consent to Operative Treatment*. This explained the legal background to consent, and specifically the risk that a procedure performed without valid consent might amount to assault. The guidance addressed the form of consent: consent could be express or implied, and oral or written.<sup>249</sup> [ELJ0002-00164] In this regard, the guidance stated a preference for consent to be explicit, written, and specific (as opposed to “universal”), to which end it included example consent forms.<sup>250</sup> [ELJ0002-164] The guidance further conveyed how consent “must be fully and freely given”.<sup>251</sup> [ELJ0002-00164] The patient should be informed, by an appropriately informed person, about the nature and effect of the operation, and any “special risks” should also be explained – although a therapeutic exception was noted, according to which information might sometimes be withheld in the interests of the patient.<sup>252</sup> [ELJ0002-00164] The document went on to note some exceptions to the need for consent, such as in emergencies or when dealing with an unconscious patient.<sup>253</sup> [ELJ0002-00164]
- 13.4. Subsequent editions of the MDU guidance over the following decade did not deviate substantially from the 1962 guidance, although they sometimes incorporated additional guidance on specific scenarios. Although the 1966 guidance, now entitled

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<sup>249</sup> Medical Defence Union (1962: 3).

<sup>250</sup> Medical Defence Union (1962: 4).

<sup>251</sup> Medical Defence Union (1962: 3).

<sup>252</sup> Medical Defence Union (1962: 3).

<sup>253</sup> Medical Defence Union (1962: 5).

*Consent to Treatment*,<sup>254</sup> [ELJ0002-00165] appeared to add little to the 1962 iteration, the 1968 guidance expanded on consent in relation to (non-therapeutic) research.<sup>255</sup> [ELJ0002-00166] The 1971 edition added further considerations around maternity and termination of pregnancy,<sup>256</sup> [ELJ0002-00167] and reiterated the organisation's opposition to the use of multipurpose consent forms.<sup>257</sup> [ELJ0002-00167]

- 13.5. The BMA's guidance on consent expanded during the 1970s and 1980s. The word "consent" featured 44 times in its 1970 document *Medical Ethics*, in which it was discussed in relation to specific contexts (such as research and sterilisation), rather than as a general concept.<sup>258</sup> [ELJ0002-00168] The references increased to 54 in the 1974 edition,<sup>259</sup> [ELJ0002-00169] and then to 99 in the 1980 edition,<sup>260</sup> [ELJ0002-00170] and 109 in the 1981 edition.<sup>261</sup> [ELJ0002-00171] By 1980, consent was being included as a discrete index entry and the guidance provided a fuller treatment of the general concept, including the need for consent to be freely given by a patient who understands what is being proposed.<sup>262</sup> [ELJ0002-00170]
- 13.6. By 1988, consent merited its own chapter in the BMA's *Philosophy and Practice of Medical Ethics*.<sup>263</sup> [ELJ0002-00158] Familiar points were made, for example, about oral as opposed to written consent, express as opposed to implied consent, and exceptional situations, such as those involving children or people with mental disorders.<sup>264</sup> [ELJ0002-00158] As with previous guidance, this book noted the *legal* importance of obtaining a valid consent, but it also went beyond this to emphasise the *ethical* importance of doing so, which it linked to respect for patient autonomy (2.12.1): "It is important to remember that a doctor's legal obligations are much less than his [sic] moral obligations. The legal minimum is not necessarily ethical".<sup>265</sup> [ELJ0002-00158]
- 13.7. The legal dimensions were nevertheless expanded upon in a 1992 book from the BMA, which (according to its back cover) sought to offer a "practical guide to the

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<sup>254</sup> Medical Defence Union (1966).

<sup>255</sup> Medical Defence Union (1968: 9).

<sup>256</sup> Medical Defence Union (1971: 5).

<sup>257</sup> Medical Defence Union (1971: 4).

<sup>258</sup> British Medical Association (1970).

<sup>259</sup> British Medical Association (1974).

<sup>260</sup> British Medical Association (1980).

<sup>261</sup> British Medical Association (1981).

<sup>262</sup> British Medical Association (1980: 12ff).

<sup>263</sup> British Medical Association (1988).

<sup>264</sup> British Medical Association (1988: 33).

<sup>265</sup> British Medical Association (1988: 30).

law as it affects doctors”.<sup>266</sup> [ELJ0002-00172] This document expanded upon (now) familiar points about a consent form providing evidence of consent (rather than constituting consent itself), the need to inform patients about the proposed procedure and why it is being proposed, and how consent operates in specific scenarios (such as research or organ transplantation).<sup>267</sup> [ELJ0002-00172]

- 13.8. The BMA further expanded on consent in its 1993 book, *Medical Ethics Today*.<sup>268</sup> [ELJ0002-00159] Here, the links between autonomy and consent were restated, in line with the spirit of the World Medical Association's Declaration of Lisbon (1981), which held that “the patient has the right to accept or to refuse treatment after receiving adequate information”.<sup>269</sup> [ELJ0002-00159] In addition to observations about the importance of effective communication,<sup>270</sup> [ELJ0002-00159] and the duration of consent,<sup>271</sup> [ELJ0002-00159] the book reiterated familiar points about the form of consent (explicit or implicit), the status of consent forms (as evidence of consent), and the particular considerations pertaining to children and patients who lack capacity.<sup>272</sup> [ELJ0002-00159]
- 13.9. The BMA's 1993 book also expanded on a point that had been made in the 1992 book: “Good practice”, the 1993 book noted, “is not necessarily interchangeable with the legal minimum”.<sup>273</sup> [ELJ0002-00159] Here, the BMA commended a view that had been advanced by Lord Scarman in a (then) leading judgment,<sup>274</sup> which it suggested was “held by many to encapsulate the true ethical position”.<sup>275</sup> [ELJ0002-00159] On this view, “ideally, the doctor should inform the patient about any risks inherent in the treatment which might be particularly important to that patient as well as explaining the risks and benefits of alternatives and of non-treatment”.<sup>276</sup> [ELJ0002-00159]
- 13.10. The BMA's 1993 text also addressed the prospect of exceeding consent: “consent is valid insofar as it applies to the precise treatment in question, or at least to acts of a substantially similar nature. When a patient agrees to a particular operation, the surgeon is not justified to depart from instructions and perform a different one. The

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<sup>266</sup> British Medical Association (1992).

<sup>267</sup> British Medical Association (1992: 1-3).

<sup>268</sup> British Medical Association (1995).

<sup>269</sup> British Medical Association (1995: 10).

<sup>270</sup> British Medical Association (1995: 8).

<sup>271</sup> British Medical Association (1995: 11).

<sup>272</sup> British Medical Association (1995: 7, 9).

<sup>273</sup> British Medical Association (1995: 10).

<sup>274</sup> *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871.

<sup>275</sup> British Medical Association (1995: 10).

<sup>276</sup> British Medical Association (1995: 11).

only time when doctors are justified in proceeding without prior authority is when it is necessary to do so to save the life or preserve the health of the patient and it is not possible to obtain that person's consent but the doctor has no convincing evidence that the patient would object".<sup>277</sup> [ELJ0002-00159]

- 13.11. The BMA's 1993 book then concluded by summarising some of the key principles: "Decisions about health care should be made by the individual, with advice and information from the doctor. In order to be valid, patient consent must be informed, voluntary and competent... Consent is a process, not an event, and it is important that there be continuing discussion".<sup>278</sup> [ELJ0002-00159]

#### Professional guidance from authoritative organisations (1990s+)

- 13.12. The MDU and BMA have therefore long referred to consent and its key principles. But while these organisations may have *influence* over the practices of their members (3.17), neither the MDU nor the BMA issue *authoritative* guidance as such, which can be considered strictly binding on all doctors. The GMC and Government departments can, however, issue such guidance.
- 13.13. In 1992, NHS in Scotland issued *A guide to consent to examination, investigation, treatment or operation*, which complemented guidance from the Department of Health, and was intended to ensure consistency across the UK. In addition to again providing some model consent forms, this guidance echoed and expanded upon many points that had been made in the preceding documents, including about: the legal background; the distinction between express and implied consent;<sup>279</sup> [ELJ0002-00173] the fact that a consent form provides only evidence of consent;<sup>280</sup> [ELJ0002-00173] the obligation to inform the patient;<sup>281</sup> [ELJ0002-00173] the obligation to advise patients about one's recommendations, and clearly convey information that is itself clear;<sup>282</sup> [ELJ0002-00173] the need to take particular care with some patients (e.g., those who are distressed or who have potential barriers to communication);<sup>283</sup> [ELJ0002-00173] and the obligation to inform patients about substantial or unusual risks.<sup>284</sup> [ELJ0002-00173]

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<sup>277</sup> British Medical Association (1995: 12).

<sup>278</sup> British Medical Association (1995: 33, 34).

<sup>279</sup> The Scottish Office (1992: chapter 2, [5]).

<sup>280</sup> The Scottish Office (1992: chapter 2, [8]).

<sup>281</sup> The Scottish Office (1992: chapter 1, [2]).

<sup>282</sup> The Scottish Office (1992: chapter 2, [1]).

<sup>283</sup> The Scottish Office (1992: chapter 2, [2]).

<sup>284</sup> The Scottish Office (1992: chapter 2, [4]).

- 13.14. Like the BMA in 1993, the NHS in Scotland guidance also addressed the prospect of exceeding consent: “Consent given for one procedure does not give any automatic right to undertake any other procedure. A health professional may, however, carry out further procedures if the circumstances are such that a patient’s consent cannot reasonably be requested and provided the further procedure is immediately necessary and the patient has not previously indicated that the further procedure would be unacceptable”.<sup>285</sup> [ELJ0002-00173]
- 13.15. Around this time, the GMC also began to issue more detailed guidance on consent. Aspects of the principles we have today appeared in the first edition of the GMC guidance in 1995 (i.e., giving patients the information they request or need to know, in a way they can understand, which was then framed as “maintaining trust”).<sup>286</sup> [ELJ0002-00016\_6] Consent (with regards to treatment) was first mentioned explicitly in the 1998 guidance, where it was noted that doctors should “give patients the information they ask for or need about their condition, its treatment and prognosis.....[and] be satisfied that, wherever possible, the patient has understood what is proposed, and consents to it, before you provide treatment or investigate a patient’s condition”.<sup>287</sup> [ELJ0002-00018\_7-8]
- 13.16. Detailed guidance on the principles of consent was first provided by the GMC in their subsequent 1998 supplementary guidance on *Seeking patients’ consent: The ethical considerations*.<sup>288</sup> [ELJ0002-00019] In this, most of the principles of consent we have in contemporary guidance were written in detail, including: providing sufficient information; continuing dialogue between clinician and patients regarding their treatment (including reviewing consent); presenting information in a way patients can understand; ensuring voluntary decision-making; and principles relating to capacity, consent to research, and considering the different ways in which consent can be given (i.e., orally, in writing, or implied).
- 13.17. The latter guidance was withdrawn in 2008, and replaced with *Consent: patients and doctors making decisions together* (withdrawn 2020).<sup>289</sup> [ELJ0002-00021] This guidance contained distinct principles in some detail, but overarchingly stated that clinicians must: “a) listen to patients and respect their views about their health; b) discuss with patients what their diagnosis, prognosis, treatment and care involve; c) share with patients the information they want or need in order to make decisions; d)

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<sup>285</sup> The Scottish Office (1992: chapter 2, [9]).

<sup>286</sup> General Medical Council (1995a: [11]).

<sup>287</sup> General Medical Council (1998a: [12]).

<sup>288</sup> General Medical Council (1998b).

<sup>289</sup> General Medical Council (2008).

maximise patients' opportunities, and their ability, to make decisions for themselves; e) respect patients' decisions".<sup>290</sup> [ELJ0002-00021\_6] The revised guidance not only took account of legal developments since 1998, but also appeared to place further emphasis on doctors working in partnership with patients. However, some commentators considered this 2008 guidance to be a step backwards, as (in their opinion) doctors were "now required to tell their patients less than they were in 1998 when the last guidance was produced".<sup>291</sup> [ELJ0002-00174] These authors felt that the 1998 guidance had gone further than the law, in its emphasis on communication with the individual patient and what a doctor *must* do or say. In contrast, they argued that the 2008 guidance, with its emphasis on the percentage of risks and what doctors *should* do or say, did not go as far beyond the legal requirements as the 1998 guidance.<sup>292</sup> [ELJ0002-00174]

- 13.18. The next available guidance on principles of consent is the currently available guidance, which was published in 2020. [ELJ0002-00034] Current GMC guidance does not set out exact procedures for gaining informed consent; instead, it highlights the patient as the central focus, i.e., a patient-centred approach. This patient-focused approach supports tailoring communication and consent to each patient's needs and preferences, helping to create a more personalised and effective healthcare experience. It therefore prioritises patient understanding of treatment options, encourages questions, and supports informed decision-making. The current principles of informed consent are detailed in the GMC guidance *Decision-Making and Consent* (2020):

- "1. All patients have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able.
2. Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient.
3. All patients have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it.
4. Medical professionals must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action.

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<sup>290</sup> General Medical Council (2008: [2]).

<sup>291</sup> Fovargue and Miola (2010: 494).

<sup>292</sup> Fovargue and Miola (2010).

5. Medical professionals must start from the presumption that all adult patients have capacity to make decisions about their treatment and care. A patient can only be judged to lack capacity to make a specific decision at a specific time, and only after assessment in line with legal requirements.

6. The choice of treatment or care for patients who lack capacity must be of overall benefit to them, and decisions should be made in consultation with those who are close to them or advocating for them.

7. Patients whose right to consent is affected by law should be supported to be involved in the decision-making process, and to exercise choice if possible”.<sup>293</sup>

[ELJ0002-00034\_6-7]

### Professional guidance from the Royal College of Surgeons

13.19. The 2002 edition of *Good Surgical Practice* made reference to principles laid out in the 2001 edition of the GMC’s *Good Medical Practice*, which were judged to be particularly relevant to surgeons. The guidance stated that “Obtaining consent involves a dialogue between surgeon and patient which leads to the signing of the consent form”.<sup>294</sup> [ELJ0002-00180] Amongst other points, the guidance conveyed that surgeons should:

“ensure that patients, including children, are given information about the treatment proposed, any alternatives and the main risks, side effects and complications when the decision to operate is made. The consequences of non-operative alternatives should also be explained;

provide time for patients and their supporter(s) to discuss the proposed procedure and provide an opportunity for the patient to make a fully informed and unharassed decision to agree to the treatment suggested and to indicate by signature their willingness to proceed;

carefully consider any ‘advance statement’ (living will) that the patient may have written;

give the patient the opportunity to indicate any procedure they do not wish to be carried out”.<sup>295</sup> [ELJ0002-00180]

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<sup>293</sup> General Medical Council (2020a: 5-6).

<sup>294</sup> Royal College of Surgeons of England (2002: [4.1]).

<sup>295</sup> Royal College of Surgeons of England (2002: [4.1]).

- 13.20. The importance of obtaining consent was also conveyed elsewhere in the 2002 guidance, for example, in a section devoted to new techniques, which required surgeons to “ensure that patients and their supporters know when a technique is new before seeking consent and that all the established alternatives are fully explained prior to recording their agreement to proceed”.<sup>296</sup> [ELJ0002-00180]
- 13.21. The 2014 edition of *Good Surgical Practice* retained the wording about consent to new procedures.<sup>297</sup> [ELJ0002-00181] The section on consent now opened with the observation that, “Before surgery, surgeons should strive to have an honest and sensitive discussion with patients about their options for treatment that leads to informed and deliberate consent”.<sup>298</sup> [ELJ0002-00181] Again, surgeons were reminded to observe the GMC standards of *Good Medical Practice*, and the guidance further made such points as:
- “Recognise that seeking consent for surgical intervention is not merely the signing of a form. It is the process of providing the information that enables the patient to make a decision to undergo a specific treatment. Consent should be considered informed decision making, or informed request. It requires time, patience and clarity of explanation; [...]
- Ensure that consent is obtained either by the person who is providing the treatment or by someone who is actively involved in the provision of treatment. The person obtaining consent should have clear knowledge of the procedure and the potential risks and complications;
- Obtain the patient's consent prior to surgery and ensure that the patient has sufficient time and information to make an informed decision. The specific timing and duration of the discussion should take into account the complexity and risks of the proposed procedure. A patient's consent should not be taken in the anaesthetic room”.<sup>299</sup> [ELJ0002-00181]
- 13.22. The guidance also specified some of the information about “the procedure and its implications” that should be disclosed:
- “The patient's diagnosis and prognosis;
- Options for treatment, including non-operative care and no treatment;

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<sup>296</sup> Royal College of Surgeons of England (2002: [2.3]).

<sup>297</sup> Royal College of Surgeons of England (2014: 20).

<sup>298</sup> Royal College of Surgeons of England (2014: [3.5]).

<sup>299</sup> Royal College of Surgeons of England (2014: [3.5.1]).

The purpose and expected benefit of the treatment;

The likelihood of success;

The clinicians involved in their treatment;

The risks inherent in the procedure, however small the possibility of their occurrence, side effects and complications. The consequences of non-operative alternatives should also be explained;

Potential follow up treatment".<sup>300</sup> [ELJ0002-00181]

- 13.23. The RCS' current guidance on consent in *Good Surgical Practice* closely resembles the principles laid out in *Good Medical Practice*. It provides some additional detail specific to surgery, e.g., that consent should be obtained prior to surgery (and not taken in the anaesthetic room).<sup>301</sup> [ELJ0002-00128]

- 13.24. The RCS has also published supplementary guidance on consent, in 2016,<sup>302</sup> [ELJ0002-00179] and most recently in 2018.<sup>303</sup> [ELJ0002-00062] The latest iteration of this guidance provides principles of consent tailored to a surgical context (these only apply to elective situations):

"The aim of the discussion about consent is to give the patient the information they need to make a decision about what treatment or procedure (if any) they want.

The discussion has to be tailored to the individual patient. This requires time to get to know the patient well enough to understand their views and values.

All reasonable treatment options, along with their implications, should be explained to the patient.

Material risks for each option should be discussed with the patient. The test of materiality is twofold: whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would likely attach significance to it.

Consent should be written and recorded. If the patient has made a decision, the consent form should be signed at the end of the discussion. The signed form is part

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<sup>300</sup> Royal College of Surgeons of England (2014: [3.5.1]).

<sup>301</sup> Royal College of Surgeons of England (2025: [2.4.5]).

<sup>302</sup> Royal College of Surgeons of England (2016).

<sup>303</sup> Royal College of Surgeons of England (2018).

of the evidence that the discussion has taken place, but provides no meaningful information about the quality of the discussion.

In addition to the consent form, a record of the discussion (including contemporaneous documentation of the key points of the discussion, hard copies or web links of any further information provided to the patient, and the patient's decision) should be included in the patient's case notes. This is important even if the patient chooses not to undergo treatment".<sup>304</sup> [ELJ0002-00062\_3]

**(a) What information about risks, benefits or alternatives ought to be disclosed?**

- 13.25. The earliest iteration of GMC guidance (1995) does not explicitly mention the disclosure of risks or benefits, but this may reasonably be read into the requirement that clinicians must "give patients the information they ask for or need about their condition, its treatment and prognosis".<sup>305</sup> [ELJ0002-00016\_6]
- 13.26. Providing information about the risks associated with the treatment or procedure is a core feature of "providing sufficient information" in the 1998 GMC guidance on consent,<sup>306</sup> [ELJ0002-00019\_2] including "an explanation of any risks to which they [the patient] may attach particular significance".<sup>307</sup> [ELJ0002-00019\_3] It notes, for example, that a clinician may need to give the patient more information for a procedure with a "high risk of failure or adverse side effects".<sup>308</sup> [ELJ0002-00019\_2] Likewise, it includes likely benefits and the probabilities of success as information patients may want to know.<sup>309</sup> [ELJ0002-00019\_2] It refers several times to letting patients know about the treatment options available to them (including the option not to treat).<sup>310</sup> [ELJ0002-00019\_2-3, 4-5]
- 13.27. The 2008 GMC guidance on consent (withdrawn in 2020) provided detail on discussing side effects, complications and other risks. It detailed that risks could take a number of forms, but these would usually be: "side effects, complications, [or] failure of an intervention to achieve the desired aim".<sup>311</sup> [ELJ0002-00021\_16] It gives no specific list of types of information to be given regarding risks and instead

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<sup>304</sup> Royal College of Surgeons of England (2018: 4).

<sup>305</sup> General Medical Council (1995a: 11).

<sup>306</sup> General Medical Council (1998b: 4).

<sup>307</sup> General Medical Council (1998b: [6]).

<sup>308</sup> General Medical Council (1998b: [4]).

<sup>309</sup> General Medical Council (1998b: [5]).

<sup>310</sup> General Medical Council (1998b: [4]-[5], [13]).

<sup>311</sup> General Medical Council (2008: [29]).

emphasises that the latter will differ depending on context. For example, it notes that the types and amount of information that should be shared will depend on the individual and “what they want or need to know”.<sup>312</sup>[ELJ0002-00021\_16]

- 13.28. As noted above, one of the key principles of the 2018 RCS guidance on consent is that the “material risks for each option should be discussed with the patient”.<sup>313</sup> [ELJ0002-00062\_3] It goes on to state that “Different options for treatment, including the option of no treatment, should be presented side by side and the benefits and material risks should be given objectively”.<sup>314</sup> [ELJ0002-00062\_4] Noting that there has been a marked shift to a patient-centred approach to decisions about care, the guidance goes on to describe doctors’ duty to warn patients of a material risk, following the court decision in *Montgomery*:<sup>315</sup> “What constitutes a material risk will vary from patient to patient. Therefore consent has to be patient-specific. The new test for materiality is ‘whether, in the circumstances of the particular case, a reasonable person in the patient’s position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would likely attach significance to it’. The judges pointed out that it is not sufficient to ask the patient if they want to know anything else, as patients cannot be expected to know what they do not know about their condition or treatment options”.<sup>316</sup> [ELJ0002-00062\_6]
- 13.29. Current GMC guidance on decision-making and consent (2020) also clearly states that potential benefits or risks should be communicated to patients.<sup>317</sup> [ELJ0002-00034\_9] It goes further than previous guidance to frame risk as ‘risk of harm’, defined as ‘any potential negative outcome, including a side- effect or complication.’<sup>318</sup> [ELJ0002-00034\_9] The guidance also provides new detail on discussing benefits and harms, and states that clinicians should usually include the following information when doing so:
- “a. Recognised risks of harm that you believe anyone in the patient’s position would want to know. You’ll know these already from your professional knowledge and experience.

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<sup>312</sup> General Medical Council (2008: [28]).

<sup>313</sup> Royal College of Surgeons of England (2018: 1).

<sup>314</sup> Royal College of Surgeons of England (2018: [2.3]).

<sup>315</sup> *Montgomery (Appellant) v Lanarkshire Health Board (Respondent)* [2015] UKSC 11.

<sup>316</sup> Royal College of Surgeons of England (2018: [4.3]).

<sup>317</sup> General Medical Council (2020a: [10]).

<sup>318</sup> General Medical Council (2020a: [10e]).

b. The effect of the patient's individual clinical circumstances on the probability of a benefit or harm occurring. If you know the patient's medical history, you'll know some of what you need to share already, but the dialogue could reveal more.

c. Risks of harm and potential benefits that the patient would consider significant for any reason. These will be revealed during your discussion with the patient about what matters to them.

d. Any risk of serious harm, however unlikely it is to occur. This is likely to be easier to discuss in advance if possible...

e. Expected harms, including common side effects and what to do if they occur".<sup>319</sup> [ELJ0002-00034\_11]

- 13.30. As noted above (**13.18**), providing information on alternatives is now explicitly contained in the "seven principles of decision making and consent", in principle four.

**(b) What are the categories of information that a person would need to know and understand in order to give consent to surgical treatment?**

- 13.31. As noted above, the categories of information that a patient would need to know and understand in order to give consent to surgical treatment has long been held to vary greatly depending on the treatment context, and the patient themselves. Since the GMC's first edition of *Good Medical Practice* in 1995, it has been clear that clinicians *must* "give patients the information they ask for or need about their condition, its treatment and prognosis".<sup>320</sup> [ELJ0002-00016\_6] From 1998 onwards this was expanded in GMC guidance, with emphasis on the amount of information given to the patient depending on context, such as the condition, the complexity of treatment, the risks, and the patient's views/wishes.
- 13.32. In the 1998 GMC guidance on consent, the information that a patient "may want or ought to know" included:
- "details of the diagnosis, and prognosis, and the likely prognosis if the condition is left untreated;
  - uncertainties about the diagnosis including options for further investigation prior to treatment;

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<sup>319</sup> General Medical Council (2020a: [23]).

<sup>320</sup> General Medical Council (1995a: [11]).

- options for treatment or management of the condition, including the option not to treat;
- the purpose of a proposed investigation or treatment; details of the procedures or
- therapies involved, including subsidiary treatment such as methods of pain relief;
- how the patient should prepare for the procedure; and details of what the patient might experience during or after the procedure including common and serious side effects;
- for each option, explanations of the likely benefits and the probabilities of success; and discussion of any serious or frequently occurring risks, and of any lifestyle changes which may be caused by, or necessitated by, the treatment;
- advice about whether a proposed treatment is experimental;
- how and when the patient's condition and any side effects will be monitored or re-assessed;
- the name of the doctor who will have overall responsibility for the treatment and, where appropriate, names of the senior members of his or her team;
- whether doctors in training will be involved, and the extent to which students may be involved in an investigation or treatment;
- a reminder that patients can change their minds about a decision at any time;
- a reminder that patients have a right to seek a second opinion;
- where applicable, details of costs or charges which the patient may have to meet".<sup>321</sup> [ELJ0002-00019\_2-3]

13.33. The 2008-2020 guidance stated that clinicians "must" give patients the information they want or need about:

- "a. the diagnosis and prognosis
- b. any uncertainties about the diagnosis or prognosis, including options for further investigations
- c. options for treating or managing the condition, including the option not to treat
- d. the purpose of any proposed investigation or treatment and what it will involve

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<sup>321</sup> General Medical Council (1998b: [5]).

- e. the potential benefits, risks and burdens, and the likelihood of success, for each option; this should include information, if organisation or doctor is chosen to provide care
- f. whether a proposed investigation or treatment is part of a research programme or is an innovative treatment designed specifically for their benefit
- g. the people who will be mainly responsible for and involved in their care, what their roles are, and to what extent students may be involved
- h. their right to refuse to take part in teaching or research
- i. their right to seek a second opinion
- j. any bills they will have to pay
- k any conflicts of interest that you, or your organisation, may have
- l. any treatments that you believe have greater potential benefit for the patient than those you or your organisation can offer".<sup>322</sup> [ELJ0002-00021\_10]

13.34. The 2018 RCS guidance details the categories of information that surgeons should communicate to their patients, as follows:

- "The patient's diagnosis and prognosis
- The right of the patient to refuse treatment and make their own decisions about their care
- Alternative options for treatment, including non-operative care and no treatment
- Advice on lifestyle that may moderate the disease process
- The purpose and expected benefit of the treatment
- The nature of the treatment (what it involves)
- The likelihood of success
- The clinicians involved in their treatment
- Potential follow-up treatment
- The material risks inherent in the procedure and in the alternative options discussed [...]

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<sup>322</sup> General Medical Council (2008: [9]).

- For private patients, costs of treatment and potential future costs in the event of complications”.<sup>323</sup> [ELJ0002-00062\_5]
- 13.35. The guidance also notes that surgeons should make patients aware of national guidance on treatment choices (in Scotland, the Scottish Intercollegiate Guidelines Network). Surgeons should also explain, if their treatment is not in keeping with current guidelines, why this is the case.<sup>324</sup> [ELJ0002-00062\_5]
- 13.36. Importantly, the legal landscape and requirements for providing information to patients changed with the landmark *Montgomery* ruling in 2015.<sup>325</sup> Older professional guidance had recognised that there may be some scope for a “therapeutic exception” (see **13.3**), on which – in the wake of *Montgomery* – the 2018 RCS guidance on consent then noted: “The traditional concept of the therapeutic exception (sometimes referred to as therapeutic privilege) describes the situation in which a doctor may claim exemption from the duty to provide certain information to a patient if the doctor deems that this might cause the patient psychological harm to a degree which outweighs the benefits of informing them. The possibility of this exception presents significant legal difficulties for doctors. The Supreme Court in the *Montgomery* case made clear that the therapeutic exception should only be used in rare cases. Litigation is a likely consequence of the use of the therapeutic exception and surgeons should ensure that, if they use it at all, their reasons should be documented at the time. Where contentious issues are involved, legal advice should be sought”.<sup>326</sup> [ELJ0002-00062\_5]
- 13.37. The current GMC guidance on decision-making and consent (2020) also emphasises that clinicians should not rely on assumptions when deciding what information a patient might need or find significant.<sup>327</sup> [ELJ0002-00034\_9] Importantly, they must give patients the information they want or need to make a decision, which usually includes:
- “a. diagnosis and prognosis
  - b. uncertainties about the diagnosis or prognosis, including options for further investigation. [...]

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<sup>323</sup> Royal College of Surgeons of England (2018: [4.1]).

<sup>324</sup> Royal College of Surgeons of England (2018: [4.1]).

<sup>325</sup> *Montgomery (Appellant) v Lanarkshire Health Board (Respondent)* [2015] UKSC 11.

<sup>326</sup> Royal College of Surgeons of England (2018: [4.2]).

<sup>327</sup> General Medical Council (2020a: [12]).

- c. options for treating or managing the condition, including the option to take no action
- d. the nature of each option, what would be involved, and the desired outcome
- e. the potential benefits, risks of harm, uncertainties about and likelihood of success for each option, including the option to take no action.

By 'harm' we mean any potential negative outcome, including a side effect or complication".<sup>328</sup> [ELJ0002-00034\_8]

13.38. The current GMC guidance also goes on to list other examples which may be relevant, depending on the patient:

- "a. whether an option is an innovative treatment designed specifically for their benefit
- b. whether there is a time limit on making their decision and what the implications of delaying might be
- c. the names and roles of key people who will be involved in their care, and who they can contact (and how) if they have questions or concerns
- d. their right to refuse to take part in teaching or research
- e. their right to seek a second opinion
- f. any bills they will have to pay
- g. any conflicts of interest that you or your organisation may have
- h. any treatments that you believe have greater potential benefit for the patient than those you or your organisation can offer".<sup>329</sup> [ELJ0002-00034\_9]

13.39. Current guidance continues to emphasise consideration of the needs of individual patients when giving information. Clinicians must give patients the information they "need or want" to make a decision, this includes "options for treating or managing the condition, including the option to take no action", "the nature of each option, what would be involved, and the desired outcome" and "the potential benefits, risks of harm, uncertainties about and likelihood of success for each option, including the option to take no action".<sup>330</sup> [ELJ0002-00034\_9] The guidance notes that other relevant information might include "any treatments that you believe have greater

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<sup>328</sup> General Medical Council (2020a: [10]).

<sup>329</sup> General Medical Council (2020a: [13]).

<sup>330</sup> General Medical Council (2020a: [10c]-[10e]).

potential benefit for the patient than those you or your organisation can offer”.<sup>331</sup>  
 [ELJ0002-00034\_9] <sup>332</sup> [ELJ0002-00034\_9]

**(c) What are the principles which ought to govern gathering more information prior to disclosure to the patient?**

13.40. We consider this question in detail below **(21)** as it relates to broader concepts of treatment decision-making.

**14. Should consent always be expressly obtained (assuming that the patient has capacity)?**

14.1. There is no reference to how consent should be obtained in the 1995 guidance; however, there was pertinent guidance on this from the BMA and MDU (see **13.2-13.11**). In the 1995 GMC guidance, consent is only explicitly referred to with respect to confidentiality, and so this guidance is not discussed further in relation to the following questions (**14-17, 19**). In the guidance that followed, a clear principle emerged that consent may be oral, written or implied. In certain high-risk or statutory contexts, consent must be written. Importantly, the only context in which a treatment or procedure could take place without informed consent (express or implied) is in an emergency.

14.2. The 1998 GMC guidance first mentions express consent. It said that this may be given by the patient orally or in writing.<sup>333</sup> [ELJ0002-00019\_8] It appeared that a signature on a consent form could provide evidence that the patient had provided consent – however, the guidance further conveyed that “[a] signed consent form is not sufficient evidence that a patient has given, or still gives, informed consent to the proposed treatment in all its aspects”, and it urged clinicians to review the patient’s decision if significant time had elapsed, there had been any material changes in the circumstances, or new information had become available.<sup>334</sup>  
 [ELJ0002-00019] The document also stated that, depending on “the nature of the risks”, a written record of the patient’s consent “and other wishes” should be recorded in some cases: “Except in an emergency, where the patient has capacity to give consent you should obtain written consent in cases where:

<sup>331</sup> General Medical Council (2020a: [13h]).

<sup>332</sup> General Medical Council (2020a: [12]).

<sup>333</sup> General Medical Council (1998b: [28]).

<sup>334</sup> General Medical Council (1998b: [32]).

- the treatment or procedure is complex, or involves significant risks and/or side effects;
- providing clinical care is not the primary purpose of the investigation or examination;
- there may be significant consequences for the patient's employment, social or personal life;
- the treatment is part of a research programme".<sup>335</sup> [ELJ0002-00019\_8]

14.3. On implied consent, the 1998 GMC guidance stated that "You should be careful about relying on a patient's apparent compliance with a procedure as a form of consent. For example, the fact that a patient lies down on an examination couch does not in itself indicate that the patient has understood what you propose to do and why".<sup>336</sup> [ELJ0002-00019\_8] Notably, statutory requirements for written consent for particular treatments existed at the time (e.g., some fertility treatments).<sup>337</sup> [ELJ0002-00019\_8] Where consent cannot be obtained, in an emergency, this guidance stated that: "In an emergency, where consent cannot be obtained, you may provide medical treatment to anyone who needs it, provided the treatment is limited to what is immediately necessary to save life or avoid significant deterioration in the patient's health. However, you must still respect the terms of any valid advance refusal which you know about, or is drawn to your attention. You should tell the patient what has been done, and why, as soon as the patient is sufficiently recovered to understand".<sup>338</sup> [ELJ0002-00019\_6]

14.4. The 2008 GMC guidance also stated that patients may give consent orally or in writing.<sup>339</sup> [ELJ0002-00021\_20] However, in higher risk cases it was noted that patients "should give written consent so that everyone involved understands what was explained and agreed".<sup>340</sup> [ELJ0002-00021\_20] Notably, some treatments require(d) written consent by law.<sup>341</sup> [ELJ0002-00021\_20] Other contexts highlighted as needing written consent were if:

"a. the investigation or treatment is complex or involves significant risks

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<sup>335</sup> General Medical Council (1998b: [28]).

<sup>336</sup> General Medical Council (1998b: [31]).

<sup>337</sup> General Medical Council (1998b: [30]).

<sup>338</sup> General Medical Council (1998b: [18]).

<sup>339</sup> General Medical Council (2008: [45]).

<sup>340</sup> General Medical Council (2008: [47]).

<sup>341</sup> General Medical Council (2008: [48]).

- b. there may be significant consequences for the patient's employment, or social or personal life
  - c. providing clinical care is not the primary purpose of the investigation or treatment
  - d. the treatment is part of a research programme or is an innovative treatment designed specifically for their benefit".<sup>342</sup> [ELJ0002-00021\_20]
- 14.5. On implied consent, the 2008 GMC guidance stated that patients: "may imply consent by complying with the proposed examination or treatment, for example, by rolling up their sleeve to have their blood pressure taken. In the case of minor or routine investigations or treatments, if you are satisfied that the patient understands what you propose to do and why, it is usually enough to have oral or implied consent".<sup>343</sup> [ELJ0002-00021\_20] Neurosurgical care involves a range of activities with varying levels of risk and complexity. Some aspects of low-risk, low-complexity neurosurgical care (e.g., venepuncture for routine blood tests, or altering the settings on an implanted shunt) might be within the remit of implied consent.
- 14.6. The only occasion where consent may not be required in this guidance was in an emergency: "If it is not possible to get written consent, for example, in an emergency or if the patient needs the treatment to relieve serious pain or distress, you can rely on oral consent. But you must still give the patient the information they want or need to make a decision. You must record the fact that they have given consent, in their medical records".<sup>344</sup> [ELJ0002-00021\_21]
- 14.7. The current GMC guidance on decision-making and consent (2020) emphasises taking a "proportionate approach" to the consent process, and notes that obtaining a patient's consent "needn't always be a formal, time-consuming process".<sup>345</sup> [ELJ0002-00034\_8] It notes that, for most healthcare decisions, clinicians can rely on a patient's verbal consent, as long as they are "satisfied they've had the opportunity to consider any relevant information".<sup>346</sup> [ELJ0002-00034\_8] Patients can give consent verbally or non-verbally.<sup>347</sup> [ELJ0002-00034\_8] Non-verbal consent can be relied on, e.g., for quick or minimally non-invasive interventions.<sup>348</sup> [ELJ0002-00034\_8]

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<sup>342</sup> General Medical Council (2008: [49]).

<sup>343</sup> General Medical Council (2008: [45]-[46]).

<sup>344</sup> General Medical Council (2008: [50]).

<sup>345</sup> General Medical Council (2020a: [6]).

<sup>346</sup> General Medical Council (2020a: [6]).

<sup>347</sup> General Medical Council (2020a: [6]).

<sup>348</sup> General Medical Council (2020a: [7]).

- 14.8. Current guidance for surgeons on this is more stringent. As noted above (**13.24**), a key principle of the RCS guidance is that: “Consent should be written and recorded. If the patient has made a decision, the consent form should be signed at the end of the discussion. The signed form is part of the evidence that the discussion has taken place, but provides no meaningful information about the quality of the discussion”.<sup>349</sup> [ELJ0002-00062\_3]
- 14.9. As with previous guidance, clinicians must not exceed the scope of their patient’s consent, except in an emergency. On this matter, the GMC states that: “In an emergency, if a patient is unconscious or you otherwise conclude that they lack capacity and it’s not possible to find out their wishes, you can provide treatment that is immediately necessary to save their life or to prevent a serious deterioration of their condition. If there is more than one option, the treatment you provide should be the least restrictive of the patient’s rights and freedoms, including their future choices... For as long as the patient lacks capacity, you should provide ongoing care following the guidance [on treating patients who lack capacity]. If the patient regains capacity while in your care, you must tell them what has been done and why, as soon as they are sufficiently recovered to understand. And you must discuss with them the options for any ongoing treatment”.<sup>350</sup> [ELJ0002-00034\_18]
- 14.10. Similarly, according to the current RCS guidance on consent (2018): “In an urgent or emergency situation where it is imperative to save life or limb, or prevent serious deterioration, the surgeon will have to proceed with limited discussion or even without consent”.<sup>351</sup> [ELJ0002-00062\_3]

**15. What do you understand by the concept of implied consent? When, if ever, can it be relied upon by a surgeon?**

- 15.1. Please see the answer above (**14**).

**16. Is it ever acceptable, from an ethical perspective, to treat a person with capacity without their express and informed consent? If so, when?**

- 16.1. Please see the answer above (**14**).

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<sup>349</sup> Royal College of Surgeons of England (2018: 1).

<sup>350</sup> General Medical Council (2020a: [63]-[64]).

<sup>351</sup> Royal College of Surgeons of England (2018: 4).

## 17. How should a patient's consent to proposed treatment in the field of surgery be obtained and recorded?

17.1. According to the 1998 GMC guidance on consent, "You must use the patient's case notes and/or a consent form to detail the key elements of the discussion with the patient, including the nature of information provided, specific requests by the patient, details of the scope of the consent given".<sup>352</sup> [ELJ0002-00019\_8]

17.2. The current (2018) RCS guidance on consent details key elements of the consent discussion, which are required for obtaining consent. These are: providing the right information; making patients aware of material risk (see above); providing written information of diagnoses and treatment where possible; and communicating in a way that is suitable for the patient.<sup>353</sup> [ELJ0002-00062\_5-6] It is also clear that surgeons should take time to explore their patients' values and wishes.<sup>354</sup> [ELJ0002-00062\_6] The surgeon providing the treatment is responsible for making sure the patient has been given enough appropriate information and time to make an informed decision about their care.<sup>355</sup> [ELJ0002-00062\_6] This guidance is clear that consent should be written and recorded.<sup>356</sup> [ELJ0002-00062\_3] In addition to completing the consent form, surgeons should also maintain: "a written decision-making record that contains a contemporaneous documentation of the key points of the consent discussion... and the patient's decision, even if the patient decided not to undergo a procedure or have any treatment. This could be in the form of a letter to the patient and their GP/referring doctor. The record should also contain documentation of any discussion around consent with the patient's supporters and with colleagues. Any written information given to the patient should also be recorded and copies should be included in the patient's notes."<sup>357</sup> [ELJ0002-00062\_6] (The reference here to "the patient's supporters" is not explained at this point in the document. The whole document is about "supported decision-making", and elsewhere it refers to checking with a patient "whether they have a supporter";<sup>358</sup> [ELJ0002-00062] however, the reference in this passage *might* specifically be to a situation in which the patient lacks capacity, in which case others may be involved in supporting decisions about the patient's treatment).

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<sup>352</sup> General Medical Council (1998b: [29]).

<sup>353</sup> See: Royal College of Surgeons of England (2018: [4.1]-[4.5]).

<sup>354</sup> Royal College of Surgeons of England (2018: [4.6]).

<sup>355</sup> Royal College of Surgeons of England (2018: [4.6]).

<sup>356</sup> Royal College of Surgeons of England (2018: 1).

<sup>357</sup> Royal College of Surgeons of England (2018: [4.10]).

<sup>358</sup> Royal College of Surgeons of England (2018: 12).

- 18. What requirements exist on a surgeon to determine if a person has understood the information which has been provided about proposed treatment and is in a position to give informed consent?**
- 18.1. The requirement to ensure patients have understood information dates back to the first edition of the GMC *Good Medical Practice*, which stated that clinicians should "give information to patients in a way they can understand".<sup>359</sup> [ELJ0002-00016\_6] Later, the 1998 GMC guidance on consent stated that clinicians should "Ask patients whether they have understood the information and whether they would like more before making a decision",<sup>360</sup> [ELJ0002-00019\_3] and that clinicians must "consider how well they have understood the details and implications of what is proposed, and not simply the form in which their consent has been expressed or recorded".<sup>361</sup> [ELJ0002-00019\_8]
- 18.2. The 2008 GMC guidance stated that clinicians "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".<sup>362</sup> [ELJ0002-00021\_11] It also states: "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...".<sup>363</sup> [ELJ0002-00021\_13]
- 18.3. Similar to the 1998 guidance, the 2008 GMC guidance also states: "Before accepting a patient's consent, [clinicians] must consider whether they have been given the information they want or need, and how well they understand the details and implications of what is proposed."<sup>364</sup> [ELJ0002-00021\_20]
- 18.4. The current GMC guidance on decision-making and consent (2020) is clear that clinicians must check whether patients have understood the information provided,

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<sup>359</sup> General Medical Council (1995a: [11]).

<sup>360</sup> General Medical Council (1998b: [6]).

<sup>361</sup> General Medical Council (1998b: [27]).

<sup>362</sup> General Medical Council (2008: [11]).

<sup>363</sup> General Medical Council (2008: [21]).

<sup>364</sup> General Medical Council (2008: [44]).

and whether they would like more information before making a decision.<sup>365</sup>

[ELJ0002-00034\_12]

- 18.5. The 2018 RCS guidance emphasises that surgeons must allocate sufficient time for discussion to allow them to understand the patient and their needs.<sup>366</sup> [ELJ0002-00062\_7] The current guidance also provides details on assessing capacity, although this guidance refers only to the (English) Mental Capacity Act 2005.<sup>367</sup> [ELJ0002-00062\_4] In Scotland, as BMA guidance explains, a surgeon should determine whether a patient is in a position to give informed consent in line with the two-stage test contained in the Adults with Incapacity (Scotland) Act 2000: 1) “Is the individual incapable of acting, making decisions, communicating decisions, understanding decisions, or retaining the memory of decisions?”, and “2) If so, is that due to either a mental disorder or to a physical disability or neurological impairment which prevents communication and which cannot be made good by human or mechanical aid?”<sup>368</sup> [ELJ0002-00006]

**19. What ethical principles and obligations should guide the surgeon’s actions at the time treatment decisions require to be taken when a patient is unconscious or under general anaesthetic?**

- 19.1. Guidance issued by the MDU in the 1960s suggested that, in *emergencies*, the surgeon should: first, attempt to obtain the consent of the patient; second, if consent cannot be obtained from the patient, consult a near relative; and, third, if neither is practicable, provide any treatment that is necessary in the best interests of the patient.<sup>369</sup> [ELJ0002-00164]; [ELJ0002-00165]; [ELJ0002-00166] The second and third points also obtained in situations in which the patient was *unconscious*,<sup>370</sup> [ELJ0002-00164]; [ELJ0002-00165]; [ELJ0002-00166] in this situation, the patient is incapable of providing consent (and elsewhere the guidance emphasised the need to obtain specific and written consent from the patient before they received a general anaesthetic).<sup>371</sup> [ELJ0002-00166]

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<sup>365</sup> General Medical Council (2020a: [30]).

<sup>366</sup> Royal College of Surgeons of England (2018: [4.11]).

<sup>367</sup> Royal College of Surgeons of England (2018: [3.2]).

<sup>368</sup> British Medical Association (2025d: 4).

<sup>369</sup> Medical Defence Union (1962: 5); Medical Defence Union (1966: 5); Medical Defence Union (1968: 5).

<sup>370</sup> Medical Defence Union (1962: 5); Medical Defence Union (1966: 5); Medical Defence Union (1968: 5).

<sup>371</sup> E.g., Medical Defence Union (1968: 3).

- 19.2. Similar principles were advanced by the BMA in guidance from the 1990s. A 1992 publication stated: “The doctor should not give more extensive treatment than is necessary to cope with the particular emergency. Nevertheless, a doctor should not treat a patient if it is clearly known and stated in writing that the latter would, if conscious and competent, object to the treatment – for example, if the patient had left explicit written instructions saying he did not wish to be treated if admitted to hospital...”.<sup>372</sup> [ELJ0002-00172] This guidance also referred to (then) recent legal developments, which conveyed that no one could provide consent on behalf of an incapacitated adult, but added that the views of people close to the unconscious patient might nevertheless prove “helpful in providing insight to the patient's opinions”.<sup>373</sup> [ELJ0002-00172]
- 19.3. The following year, further guidance from the BMA referred again to emergencies, including situations in which the patient is unconscious, and it stated: “Consent to operate or act is properly assumed by the doctor unless there is convincing evidence that the patient would have withheld consent. Such evidence may take the form of an advance directive which addresses the particular situation which has arisen...”.<sup>374</sup> The document summarised the position in the following terms: “In emergencies, life-saving treatment should be provided if it is impossible to gain consent. Unconscious patients and those suffering very severe mental impairment cannot act autonomously but may have made an anticipatory decision”.<sup>375</sup>
- 19.4. The GMC addressed the applicable principles and obligations in its 1998 guidance on consent, which stated: “You should raise with patients the possibility of additional problems coming to light during a procedure when the patient is unconscious or otherwise unable to make a decision. You should seek consent to treat any problems which you think may arise and ascertain whether there are any procedures to which the patient would object, or prefer to give further thought to before you proceed. You must abide by patients' decisions on these issues. If in exceptional circumstances you decide, while the patient is unconscious, to treat a condition which falls outside the scope of the patient's consent, your decision may be challenged in the courts, or be the subject of a complaint to your employing authority or the GMC. You should therefore seek the views of an experienced colleague, wherever possible, before providing the treatment. And you must be prepared to explain and justify your decision. You must tell the patient what you

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<sup>372</sup> British Medical Association (1992: 4).

<sup>373</sup> British Medical Association (1992: 4).

<sup>374</sup> British Medical Association (1993: 13).

<sup>375</sup> British Medical Association (1993: 34).

have done and why, as soon as the patient is sufficiently recovered to understand”.<sup>376</sup> [ELJ0002-00019]

- 19.5. Current GMC articulates similar principles: where there are foreseeable circumstances that may be difficult to discuss with the patient at a future time (e.g., due to capacity being impaired by an intervention), clinicians should “should anticipate such circumstances and discuss them with patients in advance if practical, so that when a decision needs to be made patients have already had time and opportunity to consider the relevant information”.<sup>377</sup> [ELJ0002-00034\_13]
- 19.6. Regarding patients who are under general anaesthetic, who are therefore temporarily incapable of providing consent, current guidance emphasises that clinicians should act in a patient’s “best interests” in this context, although it is important to note that in Scotland decision-making for those deemed to lack capacity should prioritise ‘overall benefit’.<sup>378</sup> [ELJ0002-00034\_22]
- 19.7. For further detail, please see the guidance on emergencies and unconscious patients outlined above (**14.6, 14.9-14.10**).

## **20. Have there been any changes in the principles of informed consent since the relevant period?**

- 20.1. In the preceding answers (**13-19**), we discussed several aspects of different iterations of the GMC guidance on consent, which was issued in 1995, 1998, 2008, and 2020. The latter guidance post-dates the relevant period by five years. In addition to the developments in that guidance, we discuss some related developments in “shared decision-making” below (**21.9.3**).

## **PART D**

### **SURGICAL TREATMENT AND PRACTICE**

#### **TREATMENT**

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<sup>376</sup> General Medical Council (1998b: [8]).

<sup>377</sup> General Medical Council (2020a: [32]-[33]).

<sup>378</sup> General Medical Council (2020a: [87]).

**21. What ethical principles should inform decision-making about the surgical treatments to offer a patient?**

Please consider this question in the relevant period and since if there have been any changes. In particular, and from a medical ethics perspective:

- (a) What factors should a surgeon consider when determining whether a treatment is clinically indicated and so can be offered to a patient?**
- (b) How should a surgeon weigh those factors?**
- (c) What obligation or responsibility does the surgeon have to identify and offer the best treatment for a patient?**
- (d) What obligation or responsibility does the surgeon have to identify and offer alternative treatments for a patient?**
- (e) In broad terms what kind of information should a surgeon provide to a patient about possible surgical treatments?**
- (f) What obligation or responsibility does the surgeon have to inform the patient of the risks of a particular treatment that is being recommended or considered?**
- (g) Where there is a risk (even a small one), is it always incumbent upon the surgeon to inform the patient of that risk so that the patient can take an informed decision for themselves?**

21.1. We recognise the concepts of treatment decision-making and informed consent share common underlying ethical principles, however, the Inquiry has made a distinction between these concepts by separating questions in **Part C (13-20)** and **Part D (21-31)**. In this section, we outline:

- 21.1.1. Current theoretical ethical obligations for decision-making based on academic literature **(21.2-21.5)**;
- 21.1.2. Current professional ethical obligations that inform decision-making including responses to subsections **(a)** through **(g)** **(21.6-21.7)**; and
- 21.1.3. How ethical obligations to treatment decision making have changed over the last 40 years **(21.8-21.9)**.

Current theoretical ethical obligations for decision-making

- 21.2. The current recommended process of treatment decision-making is described as “shared decision-making” (SDM).
- 21.3. There is no single definition of SDM in the academic literature. A seminal systematic review from 2006 identified 161 definitions of SDM, encompassing 31 distinct concepts.<sup>379</sup> [ELJ0002-00114] Central to most definitions is the idea of a partnership between patients and health professionals as described by, e.g., the Making Informed Decisions Individually and Together in healthcare (MIND-IT) conceptual framework. This draws on “decision science” approaches to develop person-based, decision support to enhance reasoning while making difficult decisions, recognising that multiple interest holders in healthcare contexts need different types of support to enhance reasoning from their clinical or daily life perspective. MIND-IT helps practitioners consider the skills, experience, motivations, role, and goals of each decision-maker, and identify differential elements, enabling each to reason well about their own, and others’, preferences within their different contexts (**Figure 1**).<sup>380</sup> [ELJ0002-00075]

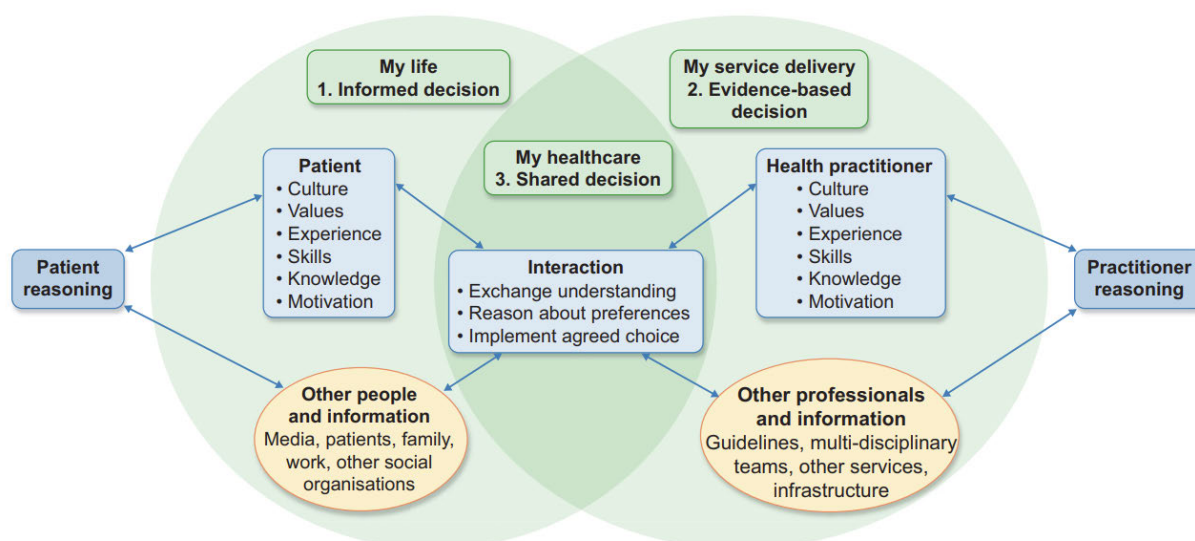


**Figure 1:** Making Informed Decisions Individually and Together in healthcare (MIND-IT) reproduced from Bekker et al (2023)

- 21.4. Specifically, the MIND-IT framework describes three components:

<sup>379</sup> Makoul and Clayman (2006).

<sup>380</sup> Bekker et al. (2023).

- 21.4.1. Patient reasoning in the context of their life (e.g., culture, values, knowledge, interactions with other people).
- 21.4.2. Professional reasoning in the context of evidence-based medicine (e.g., knowledge, skills, experience, interactions with multidisciplinary opinions).
- 21.4.3. Shared reasoning resulting from understanding both perspectives.
- 21.5. Other academic literature describes how this may be operationalised into clinical practice. A highly-cited UK-based example is called the “Three Talk model” (2012), which was later refined and renamed as “Implement-SDM” (2019, **Figure 2**).<sup>381</sup>  
[ELJ0002-00151] This involves the following components:
  - 21.5.1. Preparation phase before the concept of choice is introduced. This allows professionals to gain information about the suitability of different treatments (e.g., obtaining medical history or test results) and patients to reflect on their values and priorities in a health context (e.g., recent cancer diagnosis).
  - 21.5.2. Choice introduction where the availability or rationale of choices are presented.
  - 21.5.3. Tailored discussion of options integrating patients’ values/preferences with professionals’ knowledge/experience.
  - 21.5.4. Planning to implement decisions.
  - 21.5.5. Eliciting patient preferences occurs throughout, as does emotional and practical decision support.
  - 21.5.6. This model recognises that decision-making is not a single event, but a multi-stage process that involves a multi-disciplinary team.

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<sup>381</sup> Williams et al. (2019).

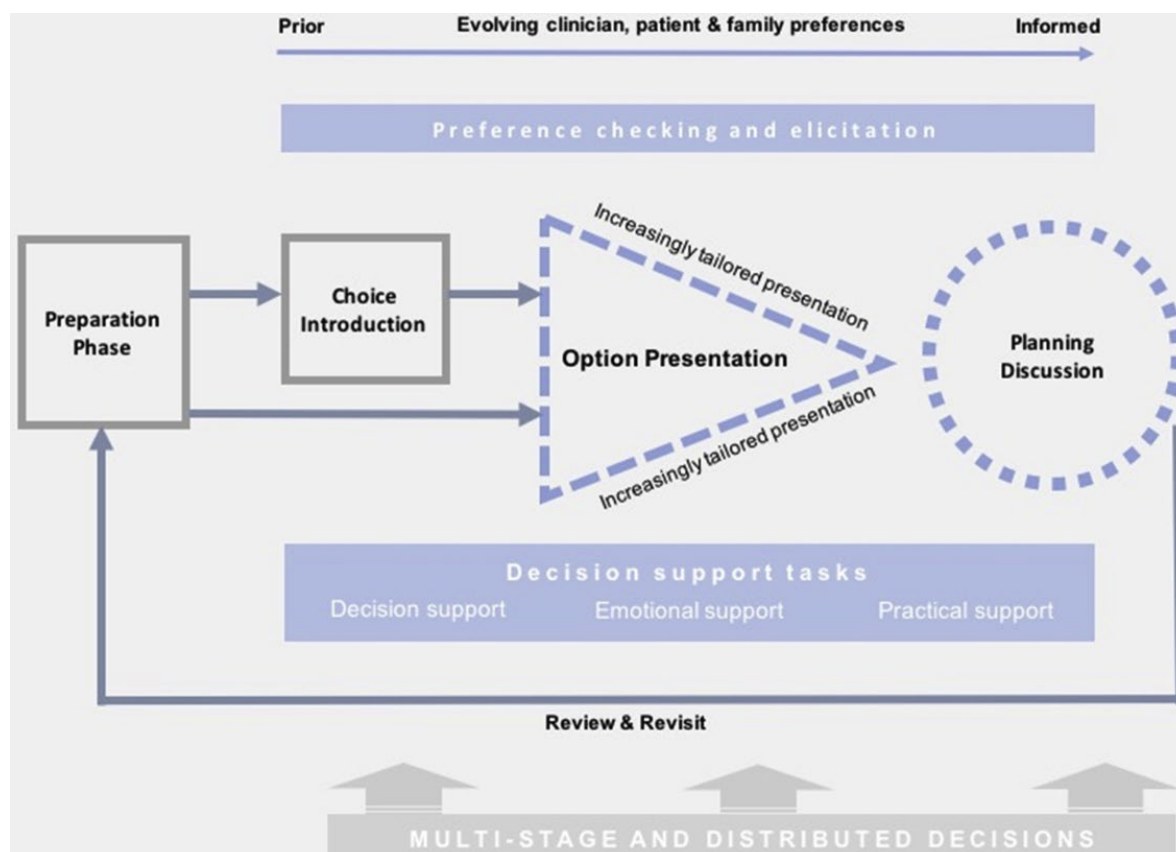


**Figure 2:** The Implement-SDM model of the process of SDM reproduced from Joseph-Williams et al (2019)

### Current professional ethical obligations that inform treatment decision-making

21.6. Surgeons have professional ethical obligations to practice SDM. These include:

- 21.6.1. GMC guidance *Decision-Making and Consent* (2020) [ELJ0002-00034] states “Shared decision making and consent are fundamental to good medical practice”. It describes the concept of SDM through seven principles (see **13.18**), although it does not distinguish between SDM and consent. Details of these obligations are described in **Part C (13-20)**.
- 21.6.2. RCS *Good Surgical Practice* (2025) describes obligations for “Shared decision making and consent” with a similar lack of distinction between those concepts.<sup>382</sup> [ELJ0002-00128]

<sup>382</sup> Royal College of Surgeons of England (2025: [2.4]).

- 21.6.3. GMC guidance *Good Medical Practice* (2024) [ELJ0002-00037] embeds the principles of SDM within domain 2 “Patients, partnership and communication”.
- 21.6.4. National Institute for Health and Care Excellence guideline *Shared Decision Making* (2021) recommends SDM is used in all healthcare settings and describes four mechanisms to support SDM implementation.<sup>383</sup> [ELJ0002-00052]
- 21.6.5. Health and Social Care Act 2012 explanatory note section 26 number 321 states “Section 14U requires CCGs [Clinical Commissioning Groups] in exercising their functions, to promote the involvement of patients and their carers and representatives in decisions about their own care (shared decision-making). This duty is intended to address the commitment outlined in the White Paper *Equity and Excellence: Liberating the NHS* to the policy of ‘no decision about me without me’.”
- 21.7. This section has set out the current theoretical and professional ethical obligations to practice SDM. Specific answers to the question subsections are provided below:
- 21.7.1. **(a)** Surgeons should consider factors necessary to support reasoning as described in the MIND-IT framework. This is highly context specific but may include patient factors (e.g., health problem, individual anatomy, concurrent health problems, etc.) and treatment factors (e.g., knowledge of treatment effectiveness, practical considerations, etc.)
- 21.7.2. **(b)** Surgeons should weigh these factors as part of SDM. See examples of MIND-IT framework and Implement-SDM models, above **(21.3-21.5, Figure 1, Figure 2)**.
- 21.7.3. Subsections **(c)** through **(g)**. The obligation is defined by high-quality SDM, described above.

#### How ethical obligations have changed over the last 40 years

- 21.8. The obligation to practice SDM has formed gradually over the last 40 years as definitions of the concept have improved and had greater impact on public and regulatory policy. The first recorded use of the term “SDM” is thought to be in 1982, when the United States President’s Commission for the Study of Ethical Problems

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<sup>383</sup> National Institute for Health and Care Excellence (2021).

in Medicine and Biomedical and Behavioral Research issued a report on informed consent, *Making Health Care Decisions*. This begins the conceptual divergence of SDM from more legally-focused definitions of informed consent by stating “Ethically valid consent is a process of shared decision making based upon mutual respect and participation, not a ritual to be equated with reciting the contents of a form that details the risks of particular treatments”.<sup>384</sup>

- 21.9. In the UK, we will broadly divide the evolution of SDM into three phases: early policy influences (1990-2010); defining the SDM agenda (2010-2019); implementing SDM across the NHS (2019-present).

21.9.1. *Early policy influences (1990-2010)*: Academic literature during this period is focused on defining the concept of “SDM” (e.g., an influential 1997 paper by Charles et al, titled *Shared decision-making in the medical encounter: What does it mean? (or it takes at least two to tango)*),<sup>385</sup> [ELJ0002-00153] developing tools to measure SDM (e.g., the SDM-Q-9 questionnaire),<sup>386</sup> [ELJ0002-00134] and developing interventions to improve SDM (e.g., decision aids).<sup>387</sup> [ELJ0002-00137] Such academic developments set the foundation for policy around patient choice, engagement and decision-making but did not set out obligations beyond those described in **Part C (13-20)** around informed consent. The history of policy in this period was summarised by Harry Cayton in 2004 and will not be discussed here further.<sup>388</sup> [ELJ0002-00008]

21.9.2. *Defining the SDM agenda (2010-2019)*: This period included the publication of influential policy documents that further set out professional obligations to practice SDM. These included:

- 21.9.2.1. Department of Health white paper *Equity and Excellence: Liberating the NHS* (2010) that would underpin future NHS reforms through public consultation. The first stated objective was that “shared decision-making will become the norm: *no decision about me without me*”.<sup>389</sup> [ELJ0002-00013\_3]

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<sup>384</sup> United States President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1982: 2).

<sup>385</sup> Charles et al (1997).

<sup>386</sup> Simon (2006).

<sup>387</sup> Stacey et al (2024).

<sup>388</sup> Cayton (2004).

<sup>389</sup> Department of Health (2010: [4a]).

- 21.9.2.2. King's Fund report *Making shared decision-making a reality: No decision about me without me* (2011). This highly impactful report described the actions needed to implement SDM in the NHS.<sup>390</sup> [ELJ0002-00009]
- 21.9.2.3. The government response to the white paper is published (2012) and outlines plans to implement SDM.<sup>391</sup> [ELJ0002-00014]
- 21.9.2.4. The Health and Social Care Act 2012, described above (21.6.5), sets out the legal foundation for SDM across NHS commissioning.
- 21.9.2.5. NHS Constitution for England (2013 and 2015 updates) defined patients' right to be involved with decisions about care.<sup>392</sup> [ELJ0002-00015]
- 21.9.3. *Implementing SDM across the NHS (2019-present)*: The NHS Long Term Plan 2019 defined personalised care as a key objective for the following 5 years, including SDM. NHS England simultaneously published guidance, *Universal Personalised Care: Implementing the Comprehensive Model* (2019), which sets out actions needed to implement SDM in the NHS.<sup>393</sup> [ELJ0002-00056] This period also included the publication of regulatory and professional guidance that describe surgeons' obligation to practice SDM, as described above (21.6).

**22. To what extent is there an ethical obligation or responsibility on a surgeon to explain to the patient (or the patient's representative) the factors that he/she has weighed and/or an obligation or responsibility to explain to the patient (or the patient's representative) how he/she has weighed those factors in proposing or recommending a particular course of surgical treatment?**

- 22.1 Surgeons have professional ethical obligations to achieve high quality SDM as described above (21), including an obligation to explore and understand their patients' values and preferences. This may or may not necessitate a discussion about the surgeon's clinical reasoning.

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<sup>390</sup> Coulter and Collins (2011).

<sup>391</sup> Department of Health (2012).

<sup>392</sup> Current version: Department of Health and Social Care (2023).

<sup>393</sup> NHS England (2019).

**23. What ethical responsibility is there on a surgeon to inform a patient (or the patient's representative) about the following. To the extent possible, please also explain the ethical responsibilities on a health board/health trust to provide information to a patient about the following:**

**(a) His or her technical competence or experience of a particular contemplated surgical course?**

- 23.1. We consider this question in the context of standard (non-experimental) surgery that is within the scope of practice of a fully qualified surgeon on the specialist register.
- 23.2. GMC *Good Medical Practice* and RCS *Good Surgical Practice* define an obligation for surgeons to work within limits of competence and scope of practice (Domain 1 Knowledge, skills and development).<sup>394</sup> [ELJ0002-00037] This obligation means that surgeons must have sufficient technical competence or experience to deliver proposed surgical options, or refer patients to another suitably qualified professional.
- 23.3. In the context that a surgeon has met professional ethical obligations described above (23.2), surgeons have an additional obligation to achieve high quality SDM (see 21). This includes an obligation to explore and understand their patients' values and preferences, which may involve discussions about technical competence or experience if this is important to the individual.

**(b) The availability of surgical options in which he or she is not technically proficient?**

- 23.4. GMC *Decision making and consent* guidance states a responsibility to inform patients about "any treatments that you believe have greater potential benefit for the patient than those you or your organisation can offer".<sup>395</sup> [ELJ0002-00034\_9]

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<sup>394</sup> General Medical Council (2024a: esp. [1]-[5]); Royal College of Surgeons of England (2025: 3-7).

<sup>395</sup> General Medical Council (2020a: [13]).

**(c) Not only well-known and widely-accepted risks, but also risks which are beginning to be suspected or known as a result of developing medical and scientific understanding or about which there is little or limited data.**

- 23.5. To clarify, we consider this question in the context of established surgical procedures supported by clinical guidelines issued by reputable organisations such as NICE or national specialty groups. Innovative surgical procedures, in which there are uncertainties about safety or clinical effectiveness, are discussed below **(45.1)**.
- 23.6. The GMC’s *Good medical practice* requires surgeons to remain up-to-date with developing medical and scientific understanding related to their scope of practice (Domain 1), stating: “In providing clinical care you must: [...] e. propose, provide and prescribe effective treatment based on the best available evidence”.<sup>396</sup> [ELJ0002-00037\_10] The GMC guidance does not provide a definition of “best available evidence”. However, NICE, in its role as a world-leading guideline developer, sets out the process of critical appraisal in the document *Developing NICE guidelines: the manual* (2025).<sup>397</sup> [ELJ0002-00053] This process is highly robust and it would be unusual that poor quality research or the absence of data would change established NICE clinical guidelines. Nonetheless, as part of high-quality SDM, it may be appropriate to discuss emerging evidence – and how such evidence relates to established guidelines – if a surgeon identified this as particularly important to an individual patient.

**(d) The fact of, reasons for and conditions of him or her being under clinical supervision?**

- 23.7. In the 1990s, statute governed a doctor’s fitness to practice and any sanctions or restrictions that were to be placed on their practice.<sup>398</sup> The early 2000s brought an increased focus on performance management and clinical governance, following major inquiries (see **3.18.1** and **9.3-9.6**). Guidance was produced, from 2004 onwards, to help fitness-to-practice tribunals decide on any sanctions that might be imposed on a doctor’s practice. Nowadays, the GMC can impose conditions on a doctor’s registration, currently defined by the document *Imposing conditions on a*

<sup>396</sup> General Medical Council (2024a: [7]).

<sup>397</sup> National Institute for Health and Care Excellence (2025).

<sup>398</sup> Medical Act 1983 and related regulations.

*doctor's registration* (2021, into effect 2022).<sup>399</sup> [ELJ0002-00035] This describes three levels of clinical supervision, abridged below for brevity:

23.7.1. *Supervised*: "The clinical supervisor is required to take overall responsibility for the arrangements for the doctor's supervision. In discharging their responsibility to provide the doctor with clinical supervision, it is expected the clinical supervisor will:

- be available to give advice and/or assistance to the doctor as required
- meet with the doctor formally, at least once a fortnight".<sup>400</sup> [ELJ0002-00035\_49]

23.7.2. *Closely supervised*: "The clinical supervisor is required to take overall responsibility for the arrangements for the doctor's supervision. In discharging their responsibility to provide the doctor with clinical supervision, it is expected the clinical supervisor will:

- be available to give advice and/or assistance to the doctor at all times
- meet with the doctor formally, at least once a fortnight, for a case-based discussion
- meet with the doctor at least once a week for a feedback session".<sup>401</sup> [ELJ0002-00035\_50]

23.7.3. *Directly supervised*: The clinical supervisor is required to take overall responsibility for the arrangements for the doctor's direct supervision and ensure all aspects of the doctor's clinical work are subject to oversight. In discharging their responsibility to provide the doctor with clinical supervision, it is expected the clinical supervisor will:

- ensure any activity that involves patient contact, such as in person or remote consultations, examinations and procedures is supervised at all times
- ensure that all of the supervised doctor's prescribing is monitored, in a manner that the clinical supervisor feels provides suitable safeguards
- meet with the doctor formally, at least once a fortnight, for a case-based discussion

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<sup>399</sup> General Medical Council (2021).

<sup>400</sup> General Medical Council (2021: 49).

<sup>401</sup> General Medical Council (2021: 50).

- meet with the doctor at least once a week for a feedback session
- make and oversee arrangements for a suitable deputy or deputies to directly observe all aspects of the doctor's clinical work. The arrangements must include mechanisms for the named deputy or deputies to provide feedback to the clinical supervisor about the doctor's clinical practice. This feedback must be reviewed with the doctor at each feedback session".<sup>402</sup> [ELJ0002-00035\_51]

- 23.8. The GMC defines persons to be informed of conditions of registration in sections C5 and C10 of *Imposing conditions on a doctor's registration*.<sup>403</sup> [ELJ0002-00035\_8-9, 12-13] These sections do not state an obligation to inform patients.
- 23.9. GMC *Decision making and consent* guidance provides "examples of information that may be relevant and, if so, should be shared with patients".<sup>404</sup> [ELJ0002-00034\_9] It states that this may include "the names and roles of key people who will be involved in their care, and who they can contact (and how) if they have questions or concerns".<sup>405</sup> [ELJ0002-00034\_9] The application of this statement in the context of clinical supervision is open to interpretation. It is mandatory for surgeons under direct supervision to have a supervisor present for all patient contact, suggesting the greatest obligation is to inform patients about who will be involved in their care.
- 23.10. A Health Board or NHS Trust may also impose conditions on a doctor's practice, e.g., regarding the scope of their duties, working arrangements and hours, and clinical governance requirements. However, it appears that neither a Health Board nor an NHS Trust is obliged to inform a patient that a doctor is under clinical supervision or to disclose the reasons for such supervision.

**24. Is there an ethical obligation or responsibility on surgeons to keep themselves informed of and up-to-date with current knowledge relating to the risks and benefits of surgical products, devices or techniques they are proposing?**

- 24.1. Surgeons have professional ethical obligations to keep themselves up-to-date based on GMC *Good Medical Practice* and RCS *Good Surgical Practice* guidelines

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<sup>402</sup> General Medical Council (2021: 51).

<sup>403</sup> General Medical Council (2021: 8-9, 12-13).

<sup>404</sup> General Medical Council (2020a: [13]).

<sup>405</sup> General Medical Council (2020a: [13c]).

(domain 1).<sup>406</sup> [ELJ0002-00037\_9, 11, 15] Such obligations were made explicit in the GMC's 1995 iteration of *Good Medical Practice*, which stated: "You must maintain the standard of your performance by keeping your knowledge and skills up to date throughout your working life. In particular, you should take part regularly in educational activities which relate to your branch of medicine".<sup>407</sup> [ELJ0002-00016] It also referred to obligations "to monitor and improve the quality of health care" (via regular and systematic audits),<sup>408</sup> [ELJ0002-00016] and to be aware of laws pertinent to one's practice.<sup>409</sup> [ELJ0002-00016]

## PRODUCTS AND DEVICES

25. **If a surgeon is involved in commissioning or purchasing surgical devices or products for use in treatment, what are the ethical principles that should guide such actions? What factors should a surgeon consider, from an ethical perspective, and how should a clinician weigh those factors?**
- 25.1. Surgeons have professional ethical obligations to identify and manage conflicts of interest, including purchasing surgical devices or products for use in treatment. Standards are provided in the GMC document *Identifying and managing conflicts of interest* (2023, in effect 2024) and are summarised by three guiding principles:
  - 25.1.1. "When interests compete, prioritise patient care";
  - 25.1.2. "Never abuse your position for financial gain";
  - 25.1.3. "Be open and honest about all your interests".<sup>410</sup> [ELJ0002-00036\_5]

## SURGICAL PRACTICE

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<sup>406</sup> General Medical Council (2024a: esp. [3], [11], [30]); Royal College of Surgeons of England (2025: 3).

<sup>407</sup> General Medical Council (1995a: [5]).

<sup>408</sup> General Medical Council (1995a: [6]).

<sup>409</sup> General Medical Council (1995a: [7]).

<sup>410</sup> General Medical Council (2023: 4).

**26. If a surgeon is involved in training, issuing guidance, instruction or advice to other surgeons, what are the ethical principles that should guide such actions? What factors should govern a surgeon's practice in this regard, from an ethical perspective, and how should a clinician weigh those factors?**

26.1. Surgeons have professional ethical obligations when involved in training, issuing guidance, instruction or advice to other surgeons, as defined by the GMC requirements in *Promoting excellence: Standards for medical education and training* (2015, into effect 2016).<sup>411</sup> [ELJ0002-00029]

26.2. These standards are considered supplemental to *Good Medical Practice* and are prefaced by a statement that "patient safety is the first priority".<sup>412</sup> [ELJ0002-00029\_5] Professional ethical obligations therefore clearly recognise the primacy of patient safety when clinicians are weighing factors related to education and training.

26.3. *Promoting excellence: Standards for medical education and training* defines 10 standards organised in five themes that should govern surgeons' practice in this regard.<sup>413</sup> [ELJ0002-00029\_6-7] Themes are listed below without detailed elaboration for brevity:

26.3.1. Theme 1: Learning environment and culture

26.3.2. Theme 2: Educational governance and leadership

26.3.3. Theme 3: Supporting learners

26.3.4. Theme 4: Supporting educators

26.3.5. Theme 5: Developing and implementing curricula and assessments.

**27. What ethical rules govern the following aspects of surgical practice and how should a surgeon balance the various considerations/ factors involved in them:**

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<sup>411</sup> General Medical Council (2015c).

<sup>412</sup> General Medical Council (2015c: 5).

<sup>413</sup> General Medical Council (2015c: 6-7).

- (a) The maintenance of an appropriate workload, including balancing clinical commitments with commitments to private practice, teaching or research?**
- (b) The allocation of surgical responsibilities to junior staff in training?**
- (c) The way in which a surgeon manages, interacts with, instructs, trains and supervises junior colleagues in training?**

- 27.1. Surgeons have professional ethical obligations to balance various considerations/factors involved in surgical practice. GMC *Good Medical Practice* clearly defines good patient care as the greatest obligation by stating “you must make the care of patients your first concern” before all other obligations.<sup>414</sup> [ELJ0002-00037\_8]
- 27.2. Professional ethical obligations to balance clinical commitments with teaching or research are defined by GMC *Good Medical Practice* and RCS *Good Surgical Practice*.<sup>415</sup> [ELJ0002-00037] [ELJ0002-00128] There are separate requirements for private practice in the NHS document *A Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultants* (2004).<sup>416</sup> [ELJ0002-00012]
- 27.2.1. The four domains described in GMC and RCS guidance across clinical care, teaching and research. Implicit in the primacy of making “care of patients your first concern” is the suggestion that surgeons have a greater obligation for direct clinical care and activities supporting direct clinical care than teaching and research. Nonetheless, guidelines stress the importance of these other activities, which should be considered within job planning and wider scope of practice.
- 27.2.2. The NHS Code of Conduct for private practice defines the following key professional ethical obligations:
- 27.2.2.1. “NHS consultants and NHS employing organisations should work on a partnership basis to prevent any conflict of interest between private practice and NHS work. It is also important that NHS consultants and NHS organisations minimise the risk of any perceived conflicts of interest; although no consultant should suffer any penalty (under the code) simply because of a perception”;<sup>417</sup> [ELJ0002-00012\_4]

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<sup>414</sup> General Medical Council (2024a: 7).

<sup>415</sup> General Medical Council (2024a); Royal College of Surgeons of England (2025).

<sup>416</sup> Department of Health (2004).

<sup>417</sup> Department of Health (2004: [1.4]).

- 27.2.2.2. “the provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS services”;<sup>418</sup> [ELJ0002-00012\_4]
- 27.2.2.3. “with the exception of the need to provide emergency care, agreed NHS commitments should take precedence over private work”;<sup>419</sup> [ELJ0002-00012\_4]
- 27.2.2.4. “NHS facilities, staff and services may only be used for private practice with the prior agreement of the NHS employer”.<sup>420</sup> [ELJ0002-00012\_4]

27.3. Professional ethical obligations for the allocation of responsibilities to junior staff and training more widely are defined by GMC standards *Promoting excellence: standards for medical education and training*.<sup>421</sup> [ELJ0002-00029]

## **28. What ethical principles or practices should govern a surgeon’s decision-making/advice about referring NHS patients to private care?**

28.1. The NHS *Code of Conduct for Private Practice: Recommended Standards of Practice for NHS Consultants* defines professional ethical obligations about referring NHS patients to private care, stating:

- 28.1.1. “In the course of their NHS duties and responsibilities consultants should not initiate discussions about providing private services for NHS patients, nor should they ask other NHS staff to initiate such discussions on their behalf”;<sup>422</sup> [ELJ0002-00012\_6]
- 28.1.2. “Where a NHS patient seeks information about the availability of, or waiting times for, NHS and/or private services, consultants should ensure that any information provided by them, is accurate and up-to-date and conforms with any local guidelines”;<sup>423</sup> [ELJ0002-00012\_7]
- 28.1.3. “Except where immediate care is justified on clinical grounds, consultants should not, in the course of their NHS duties and responsibilities, make arrangements to provide private services, nor should they ask any other

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<sup>418</sup> Department of Health (2004: [1.4]).

<sup>419</sup> Department of Health (2004: [1.4]).

<sup>420</sup> Department of Health (2004: [1.4]).

<sup>421</sup> General Medical Council (2015c).

<sup>422</sup> Department of Health (2004: [2.9]).

<sup>423</sup> Department of Health (2004: [2.10]).

NHS staff to make such arrangements on their behalf unless the patient is to be treated as a private patient of the NHS facility concerned”.<sup>424</sup>  
[ELJ0002-00012\_7]

**29. What ethical principles or practices should govern the maintenance by a surgeon of accurate medical records?**

29.1. Surgeons have professional ethical obligations to maintain accurate medical records keep themselves up to date based on:

29.1.1. GMC *Good Medical Practice* guidelines, domain 3 “Recording your work clearly, accurately, and legibly”, which states “You must make sure that formal records of your work (including patients’ records) are clear, accurate, contemporaneous and legible”.<sup>425</sup> [ELJ0002-00037\_69]

29.1.2. RCS *Good Surgical Practice* guidelines domain 3.5, “Record your work clearly, accurately and legibly”, which states “Surgeons must ensure that accurate, comprehensive, legible and contemporaneous records are maintained of all their interactions with patients”.<sup>426</sup> [ELJ0002-00128]

**30. In broad terms, what sort of information should be recorded in a person’s medical records, in particular in the field of neurosurgery?**

30.1. The WFNS Statement of ethics provides some guidance within neurosurgical contexts, however, specific statements remain fairly generic. These include:

30.1.1. “We should keep clear, up to date, detailed, and accurate clinical records, with full descriptions of operative procedures, significant medical events, medical management, the names of other caregivers, and summaries of important discussions with patients and family members”;<sup>427</sup> [ELJ0002-00070\_3]

30.1.2. “Clear records documenting the dates and substance of conversations with patients and their families, as well as our own decision processes, should be kept”.<sup>428</sup> [ELJ0002-00056\_3]

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<sup>424</sup> Department of Health (2004: [2.11]).

<sup>425</sup> General Medical Council (2024a: [69]).

<sup>426</sup> Royal College of Surgeons of England (2025: [3.5]).

<sup>427</sup> World Federation of Neurosurgical Societies (2007: [13]).

<sup>428</sup> World Federation of Neurosurgical Societies (2007: 7).

30.2. *RCS Good Surgical Practice* guidelines provide further granularity in the context of operative record keeping. Guidance states: “Ensure that there are clear (preferably typed) operative notes for every procedure. The notes should accompany the patient into recovery and to the ward and should give sufficient detail to enable continuity of care by another doctor. The notes should include:

- date and time;
- elective/non-elective procedure (see 1.3 for classification of non-elective surgery);
- names of the operating surgeon and assistant;
- name of the theatre anaesthetist;
- operative procedure carried out;
- incision;
- operative diagnosis;
- operative findings;
- any problems/complications;
- any extra procedure performed and the reason why it was performed;
- details of tissue removed, added or altered;
- identification of any prosthesis used, including the serial numbers of prostheses and other implanted materials;
- details of closure technique;
- estimated blood loss;
- antibiotic prophylaxis (where applicable);
- deep vein thrombosis prophylaxis (where applicable);
- detailed postoperative care instructions;
- signature (handwritten or electronic)”.<sup>429</sup> [ELJ0002-00128]

## PART E

### INFORMING PEOPLE WHEN THINGS HAVE NOT GONE AS EXPECTED IN SURGERY

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<sup>429</sup> Royal College of Surgeons of England (2025: [7]).

**31. What should a surgeon inform a patient about what they should expect/should be entitled to know if something goes wrong with a surgery?**

- 31.1. Generally, the information that a surgeon should convey has been covered elsewhere, especially in the discussion of consent (see **Part C, 13-20**). However, professional ethical guidance on the duty of candour (see further **Part H, 46-48**) adds some further relevant points:

Guidance on candour from the GMC

- 31.2. The 1995 edition of *Good Medical Practice* did not state an explicit duty to disclose adverse events or surgical errors to patients. However, that guidance did contain obligations to provide “good standards of practice and care”,<sup>430</sup> [ELJ0002-00016] “be honest and trustworthy”,<sup>431</sup> [ELJ0002-00016] and “keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, information given to patients and any drugs or other treatment prescribed”.<sup>432</sup> [ELJ0002-00016]
- 31.3. The 1998 edition of *Good Medical Practice* directly tackled the issues in a section entitled “If things go wrong”. This conveyed such obligations as the need “to deal with complaints constructively and honestly”,<sup>433</sup> [ELJ0002-00018] co-operate with inquiries or investigations, and obtain insurance or indemnity cover.<sup>434</sup> [ELJ0002-00018] It also stated: “If a patient under your care has suffered serious harm, through misadventure or for any other reason, you should act immediately to put matters right, if that is possible. You should explain fully to the patient what has happened and the likely long- and short-term effects. When appropriate you should offer an apology”.<sup>435</sup> [ELJ0002-00018]
- 31.4. The 2001 edition of *Good Medical Practice* made a similar statement to that just quoted, this time in its section entitled “Good communication”.<sup>436</sup> [ELJ0002-00175] The 2006 iteration then included a section entitled “Being open and honest with patients if things go wrong”, which repeated the same propositions about the obligation to rectify the harm (if possible) and “offer an apology and explain fully and

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<sup>430</sup> General Medical Council (1995: [1]).

<sup>431</sup> General Medical Council (1995: [37]).

<sup>432</sup> General Medical Council (1995: [3]).

<sup>433</sup> General Medical Council (1998: [16]).

<sup>434</sup> General Medical Council (1998: [18]-[19]).

<sup>435</sup> General Medical Council (1998: [17]).

<sup>436</sup> General Medical Council (2001: [22]).

promptly to the patient what has happened, and the likely short-term and long-term effects”.<sup>437</sup> [ELJ0002-00176]

- 31.5. The 2013 edition of *Good Medical Practice* advanced the same propositions, this time in a section on “Maintaining trust”, entitled “Show respect for patients”. This conveyed the obligation in clear terms: “You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should: put matters right (if that is possible); offer an apology; explain fully and promptly what has happened and the likely short-term and long-term effects”.<sup>438</sup> [ELJ0002-00177] The emphasis placed on honesty, trustworthiness, and integrity is apparent from the start of the guidance: the first paragraph states that good doctors are (*inter alia*) “honest and trustworthy, and act with integrity”,<sup>439</sup> [ELJ0002-00177]
- 31.6. The specific professional duty of candour emerged in 2014, when seven UK healthcare regulators, including the GMC, issued a joint statement and draft guidance.<sup>440</sup> [ELJ0002-00182] The definitive GMC guidance on the duty of candour was published in 2015 (see **46-48**). This notes that doctors should discuss risks before beginning treatment or providing care. It states:
- 31.6.1. “Patients must be fully informed about their care. When discussing care options with patients, you must discuss the risks as well as the benefits of the options”.<sup>441</sup> [ELJ0002-00027\_6]
- 31.6.2. “You or an appropriate person must give the patient clear, accurate information about the risks of the proposed treatment or care, and the risks of any reasonable alternative options, and check that the patient understands. You should discuss risks that occur often, those that are serious even if very unlikely, and those that the patient is likely to think are important”.<sup>442</sup> [ELJ0002-00027\_6]

### Guidance on candour from the RCS

- 31.7. The 2002 edition of *Good Surgical Practice* set down explicit obligations in relation to adverse events: not only should surgeons “inform patients of any adverse events that occur during their care”, they should also notify people within and without the

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<sup>437</sup> General Medical Council (2006: [30]).

<sup>438</sup> General Medical Council (2013a: [55]).

<sup>439</sup> General Medical Council (2013a: [1]).

<sup>440</sup> Nursing and Midwifery Council and General Medical Council (2014).

<sup>441</sup> General Medical Council (2015a: [7]).

<sup>442</sup> General Medical Council (2015a: [8]).

organisation as necessary (for example, a local audit meeting or the Medical Devices Agency).<sup>443</sup> [ELJ0002-00180] Elsewhere, the section on maintaining trust states that surgeons should “fully inform patients and their supporters of ... any untoward developments as they occur, or as soon as possible afterwards”,<sup>444</sup> [ELJ0002-00180] while the section on communication states that surgeons should “act immediately when patients have suffered harm and apologise when appropriate”.<sup>445</sup> [ELJ0002-00180]

- 31.8. The 2014 edition of *Good Surgical Practice* opened with a foreword from Clare Marx, the then President of the College, who stated in her opening paragraph: “As surgeons we understand the fulfillment of delivering a successful outcome, and the humility and strength required when surgery goes wrong or is unlikely to be a patient’s best option. We are all human, we all make mistakes and so we all benefit from guidance”.<sup>446</sup> [ELJ0002-00181] The guidance included a section entitled “Responding to harm and duty of candour”, which stated (*inter alia*): “Inform patients promptly and openly of any significant harm that occurs during their care, whether or not the information has been requested and whether or not a complaint has been made”; and “Act immediately when patients have suffered harm, promptly apologise and, where appropriate, offer reassurance that similar incidents will not reoccur”.<sup>447</sup> [ELJ0002-00181] The section then set out obligations to report incidents, reflect on such incidents, and participate appropriately in any reviews, investigations, or complaints.
- 31.9. The 2025 edition of *Good Surgical Practice* emphasises the importance of establishing and maintaining effective partnerships with patients,<sup>448</sup> [ELJ0002-00128] and the RCS’ specific guidance on the duty of candour (see **46-48**) notes parallels between consent and candour. The latter guidance cites evidence, which suggests “that having a candid conversation when something goes wrong is far easier when it forms part of an ongoing clinical relationship in which issues of risk and consent have been clearly discussed from the outset”.<sup>449</sup> [ELJ0002-00127] It goes on to add:

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<sup>443</sup> Royal College of Surgeons of England (2002: [2.2]).

<sup>444</sup> Royal College of Surgeons of England (2002: [4.3]).

<sup>445</sup> Royal College of Surgeons of England (2002: [4.4]).

<sup>446</sup> Royal College of Surgeons of England (2014: 4).

<sup>447</sup> Royal College of Surgeons of England (2014: [3.5.4]).

<sup>448</sup> Royal College of Surgeons of England (2025).

<sup>449</sup> Royal College of Surgeons of England (2015a: 5).

- 31.9.1. “Prior to a surgical procedure, and as part of the consent discussion, surgeons are required to provide information on the procedure and its implications, including the risks inherent in the procedure and any side effects and complications. Correspondingly, after the surgical procedure, the surgeon has a duty towards his or her patient to give an account of what happened during the operation”.<sup>450</sup> [ELJ0002-00127]
- 31.9.2. “Surgeons should aim to have a detailed postoperative discussion with every patient as a matter of course, offering a full explanation of all events that happened between the first and last surgical contact. As with the consent process, the duty to be open and honest when things go wrong is not a one-off event, but a process that may require more than one meeting to ensure that all necessary information has been made available and that patients have had the opportunity to reflect on it, and to give patients the opportunity to ask questions”.<sup>451</sup> [ELJ0002-00127]

**32. What ethical principles should inform the approach to telling a patient that something has gone wrong with their surgery, either in the form of a recognised side effect having manifested itself or another adverse outcome?**

Academic positions on communication

- 32.1. This question concerns communication. The importance of good (effective and ethical) communication is recognised in numerous academic publications on surgical ethics. As Ferreres puts it, “Surgical ethics is built not only on principles, but on actions, chief among them, effective communication”.<sup>452</sup> [ELJ0002-00091]
- 32.2. Some sources emphasise how good communication is an integral component of (or is a necessary precondition of meeting) various ethical obligations, including:
- 32.2.1. *Trust*. Some see communication as essential to building a relationship with the patient,<sup>453</sup> [ELJ0002-00090] and particularly to fostering and maintaining trust in the surgeon-patient relationship.<sup>454</sup> [ELJ0002-

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<sup>450</sup> Royal College of Surgeons of England (2015a: 5).

<sup>451</sup> Royal College of Surgeons of England (2015a: 5).

<sup>452</sup> Ferreres (2025b: 54).

<sup>453</sup> Ferreres (2025a: 18).

<sup>454</sup> Brown (2019: 32); Rodriguez and Pellegrini (2019: 175-177); Ferreres (2025b: 37, 38, 39).

00079]; [ELJ0002-00123]; [ELJ0002-00091] As Rodriguez and Pellegrini put it: “A trusting relationship [...] between physicians and their patients lies at the very heart of the practice of medicine. This bond has its base on communication”.<sup>455</sup> Kana et al. link the disclosure of errors to the preservation of trust: “A surgeon has an ethical obligation to disclose medical errors to patients. Doing so honors the sacred trust at the core of the surgeon-patient relationship”.<sup>456</sup> [ELJ0002-00107]

32.2.2. *Respect for autonomy* (see **2.12.1**). Some scholars connect communication skills with obligations that are associated with respect for autonomy, such as informed consent (**13-20**), shared decision-making (**21**), truth-telling, and confidentiality.<sup>457</sup> [ELJ0002-00089]; [ELJ0002-00105]; [ELJ0002-00146]; [ELJ0002-00095]; [ELJ0002-00084]; [ELJ0002-00091]; [ELJ0002-00083]; [ELJ0002-00140]

32.2.3. *Beneficence and non-maleficence* (see **2.12.2-2.12.3**). Communication skills may be integral to benefitting the patient and, in the opposite direction, poor communication may contribute to bad patient outcomes.<sup>458</sup> [ELJ0002-00089]; [ELJ0002-00139]; [ELJ0002-00091]; [ELJ0002-00140]

32.3. Some ethical obligations therefore require good communication. But good communication, in turn, also requires various ethical obligations to be honoured. Scholars suggest that good communication is:

32.3.1. *Transparent*.<sup>459</sup> [ELJ0002-00091] Makhoul et al. recognise that “Disclosure of an adverse surgical event is among the most difficult conversations a surgeon can have. Fear of a negative patient reaction, professional embarrassment, personal feelings of guilt, and the possibility of malpractice litigation have all contributed to a culture of blame and silence regarding mistake-making in surgery”.<sup>460</sup> [ELJ0002-00113] Singh nevertheless suggests that surgeons are under an

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<sup>455</sup> Rodriguez and Pellegrini (2019: 171).

<sup>456</sup> Kana et al (2025: 229).

<sup>457</sup> Ferreres (2019: 51); Jacobson et al (2019: 112, 115-116); Vercler and Deshpande (2019 : 195); Ganai (2019: 227); Cinà and Abouzahr (2025: 25); Ferreres (2025b: 54); Cinà (2025: 243); Streiner (2025: 273).

<sup>458</sup> Ferreres (2019: 51); Steinberg and Warshaw (2019: 81); Ferreres (2025b: 51); Streiner (2025: 273).

<sup>459</sup> Ferreres (2025b: 46).

<sup>460</sup> Makhoul et al. (2022: 70).

“ethical duty to disclose medical errors”.<sup>461</sup> [ELJ0002-00135] Kana et al. concur, but they also go further, in suggesting that a surgeon can be under an “ethical obligation to disclose the errors of others”.<sup>462</sup> [ELJ0002-00107] Steinberg and Warshaw note that this too can be challenging: “Doctors are often hesitant to report or confront colleagues with their failings and errors. The tenet of self-regulation of a profession requires corrective action when there is recognition of a failure or deficiency in the practice of surgery. To meet professional responsibility, proper actions include communication with the relevant erring colleague, patient, family, and, when appropriate, the colleague’s supervisor, institution, or even authorities”.<sup>463</sup> [ELJ0002-00139]

- 32.3.2. *Individualised*. Communication should be inclusive and accessible, e.g., tailored to people with disabilities,<sup>464</sup> [ELJ0002-00085] and/or culturally competent.<sup>465</sup> [ELJ0002-00094]; [ELJ0002-00091]
- 32.3.3. *Empathic*.<sup>466</sup> [ELJ0002-00087] Ferreres notes how communication may be verbal, non-verbal, and para-verbal, so “whether delivering bad news or discussing unexpected findings in a benign condition”, surgeons “should maintain eye contact, engage attentively, smile when appropriate, listen actively, and convey empathy, compassion, and therapeutic presence”.<sup>467</sup> [ELJ0002-00091]
- 32.3.4. Such communication aligns with the concept of SDM described above (21). High quality SDM requires professionals to understand patients’ reasoning in the context of their life (e.g., culture, values, knowledge). SDM is often framed as a pre-operative concept when considering the irreversible nature of surgery, but academic theory is clear that SDM is a continuous process that should be reviewed/revisited through time as the consequences of treatments become known. Surgeons therefore have professional ethical obligations to discuss negative consequences of surgery, tailored to patients’ values and preferences, through subsequent rounds of SDM for future treatments.

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<sup>461</sup> Singh (2022: 226).

<sup>462</sup> Kana et al (2025: 237).

<sup>463</sup> Steinberg and Warshaw (2019: 81).

<sup>464</sup> Cinà and Versace (2025: 230).

<sup>465</sup> French and Walsh (2019: 127); Ferreres (2025b: 42).

<sup>466</sup> Fenner and Sur (2022).

<sup>467</sup> Ferreres (2025b: 41).

### Professional positions on communication

32.4. Echoing some of the academic literature (**32.1-32.3**), guidance from various professional organisations conveys that communication should be:

- 32.4.1. Trustworthy (**32.5-32.8**);
- 32.4.2. Respectful (**32.9-32.12**);
- 32.4.3. Individualised (**32.13-32.16**);
- 32.4.4. Timely (**32.17**); and
- 32.4.5. Secure (**32.18**).

### *Trustworthy*

32.5. Professional guidance conveys that communication should be accurate, honest, and trustworthy (see also **Part H, 46-48**).

32.6. The GMC requires doctors to be open and honest with patients, including when things go wrong:

- 32.6.1. In the latest iteration of *Good Medical Practice* (2024), the GMC expresses the doctor's obligation in non-negotiable terms: "You must be open and honest with patients if things go wrong".<sup>468</sup> [ELJ0002-00037\_17] Elsewhere the guidance states, "You must be honest and trustworthy [...] in all your professional written, verbal and digital communications".<sup>469</sup> [ELJ0002-00037\_27] It adds: "You must make sure any information you communicate as a medical professional is accurate, not false or misleading. This means: (a) you must take reasonable steps to check the information is accurate; (b) you must not deliberately leave out relevant information; (c) you must not minimise or trivialise risks of harm; [and] (d) you must not present opinion as established fact".<sup>470</sup> [ELJ0002-00037\_27]
- 32.6.2. Specific mention of what clinicians should do "if things go wrong" was first included in the 1998 edition of *Good Medical Practice*. It referred to several principles, which still stand today, including "dealing with

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<sup>468</sup> General Medical Council (2024a: [45]).

<sup>469</sup> General Medical Council (2024a: [88]).

<sup>470</sup> General Medical Council (2024a: [89]).

complaints constructively and honestly”.<sup>471</sup> [ELJ0002-00018\_9] It went on to detail that: “If a patient under your care has suffered serious harm, through misadventure or for any other reason, you should act immediately to put matters right, if that is possible. You should explain fully to the patient what has happened and the likely long- and short-term effects. When appropriate you should offer an apology”.<sup>472</sup> [ELJ0002-00018\_9]

- 32.7. In its guidance on candour for surgeons, the RCS calls for “open communication”: this (*inter alia*) requires surgeons to “Be factual”, and “does not include: [...] speculation; Provision of conflicting information from different individuals; Making excuses, being misleading, defensive or evasive”.<sup>473</sup> [ELJ0002-00127]
- 32.8. The WFNS statement on neurosurgical ethics contains a section on “Patient Communication”, which includes the following statements:
- 32.8.1. “We should be careful about discussing outcomes that our proposed treatment or surgery may be unlikely to provide, and should never guarantee that a particular treatment will be effective”;<sup>474</sup> [ELJ0002-00070\_4]
- 32.8.2. “We must ensure that the information we provide is accurate and up to date, and can be verified if challenged”;<sup>475</sup> [ELJ0002-00070\_4]
- 32.8.3. “We should be honest with patients and their families about the reasons for complications, and express our sincere regret when the situation does not go according to plan”.<sup>476</sup> [ELJ0002-00070\_4]

### *Respectful*

- 32.9. Professional guidance conveys that communication – with patients, those close to them, and/or colleagues – should be respectful, sensitive, and compassionate:
- 32.10. The GMC’s *Good Medical Practice* sets out obligations towards patients, those close to them, and colleagues:
- 32.10.1. Patients: “You must treat patients with kindness, courtesy and respect. This doesn’t mean agreeing to every request [...] or withholding relevant

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<sup>471</sup> General Medical Council (1998a: [16]).

<sup>472</sup> General Medical Council (1998a: [17]).

<sup>473</sup> Royal College of Surgeons of England (2015a: 12).

<sup>474</sup> World Federation of Neurosurgical Societies (2007: [39]).

<sup>475</sup> World Federation of Neurosurgical Societies (2007: [40]).

<sup>476</sup> World Federation of Neurosurgical Societies (2007: [42]).

information that may be upsetting or unwelcome [...]. It means: (a) communicating sensitively and considerately, particularly when you're sharing potentially distressing issues about the patient's prognosis and care...".<sup>477</sup> [ELJ0002-00037\_14]

32.10.2. Those close to patients: "You must be considerate and compassionate to those close to a patient and be sensitive and responsive in giving them support and information" (whilst also maintaining confidentiality: see **32.18**).<sup>478</sup> [ELJ0002-00037\_16]

32.10.3. Colleagues: "You must treat colleagues with kindness, courtesy and respect";<sup>479</sup> "To develop and maintain effective teamworking and interpersonal relationships you must [...] communicate clearly, politely and considerately...".<sup>480</sup> [ELJ0002-00037\_19]

32.11. The RCS similarly sets out obligations towards patients, those close to them, and colleagues:

32.11.1. Patients and those close to them: *Good Surgical Practice* states: "Communicate clearly and compassionately with patients and, with the patient's consent, with their supporters and, in the case of children, with their parents/responsible adults";<sup>481</sup> [ELJ0002-00128] "Listen to and respect patients' views and preferences and respond to their concerns".<sup>482</sup> [ELJ0002-00128] The RCS's guidance on the duty of candour specifically addresses the disclosure of bad news: "Disclose harm in a sensitive and compassionate manner, and in a way that is appropriate for the individual concerned".<sup>483</sup> [ELJ0002-00127]

32.11.2. Colleagues: *Good Surgical Practice* states: "Communicate respectfully with colleagues and refrain from dismissive or intimidating behaviour and inappropriate, offensive or pejorative language, including swearing".<sup>484</sup> [ELJ0002-00128] The guidance on candour states that "Open communication does not include: [...] Attribution of blame or

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<sup>477</sup> General Medical Council (2024a: [23]).

<sup>478</sup> General Medical Council (2024a: [37]).

<sup>479</sup> General Medical Council (2024a: [48]).

<sup>480</sup> General Medical Council (2024a: [49]).

<sup>481</sup> Royal College of Surgeons of England (2025: [2.2.1]).

<sup>482</sup> Royal College of Surgeons of England (2025: [2.2.2]).

<sup>483</sup> Royal College of Surgeons of England (2015a: 12).

<sup>484</sup> Royal College of Surgeons of England (2025: [3.1.3]).

criticism of the care or response of other professionals or providers”.<sup>485</sup>  
[ELJ0002-00127]

- 32.12. The WFNS statement on neurosurgical ethics states: “We should listen to patients, respect their views, and respond to their questions”,<sup>486</sup> [ELJ0002-00070\_4] and “We should be sensitive to the patient’s feeling of vulnerability”.<sup>487</sup> [ELJ0002-00070\_4]

### *Individualised*

- 32.13. Professional guidance conveys that communication should be clear, accessible, and individualised, i.e., tailored to the individual.
- 32.14. The GMC’s *Good Medical Practice* states “You must take steps to meet patients’ language and communication needs, so you can support them to engage in meaningful dialogue and make informed decisions about their care”.<sup>488</sup> [ELJ0002-00037-15] Its guidance on confidentiality adds that “Wherever possible, you should communicate with patients in a format that suits them”.<sup>489</sup> [ELJ0002-00030\_32]
- 32.15. The RCS similarly requires communication to be clear and individualised:
- 32.15.1. *Good Surgical Practice* requires surgeons not only to communicate “clearly”,<sup>490</sup> [ELJ0002-00128] but also to “Recognise patients’ varying needs for information and explanation and give them the information they want or need using appropriate language in a way that they can understand. Where this is necessary, liaise with your hospital to obtain an independent translator”.<sup>491</sup> [ELJ0002-00128]
- 32.15.2. RCS guidance on the duty of candour requires surgeons to “Give clear and unambiguous information” and “Speak in a language that the patient can understand. Do not overwhelm with information, but do not oversimplify either”.<sup>492</sup> [ELJ0002-00127] The disclosure of bad news should also be handled “in a way that is appropriate for the individual concerned”.<sup>493</sup> [ELJ0002-00127]

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<sup>485</sup> Royal College of Surgeons of England (2015a: 12).

<sup>486</sup> World Federation of Neurosurgical Societies (2007: [34]).

<sup>487</sup> World Federation of Neurosurgical Societies (2007: [35]).

<sup>488</sup> General Medical Council (2024a: [32]).

<sup>489</sup> General Medical Council (2017a: [132]).

<sup>490</sup> Royal College of Surgeons of England (2025: [2.2.1]).

<sup>491</sup> Royal College of Surgeons of England (2025: [2.2.3]).

<sup>492</sup> Royal College of Surgeons of England (2015a: 12).

<sup>493</sup> Royal College of Surgeons of England (2015a: 12).

- 32.16. The WFNS statement on neurosurgical ethics enjoins neurosurgeons “to provide patients with clear information”,<sup>494</sup> [ELJ0002-00070\_4] and further states: “We must weigh our decisions on what information to disclose and how to present that information, with consideration for cultural mores and values, as well as the makeup of individual patients”.<sup>495</sup> [ELJ0002-00070\_4]

### *Timely*

- 32.17. In *Good Surgical Practice*, the RCS includes statements about timely communication:
- 32.17.1. “Ensure that working arrangements allow adequate time to listen and understand patients’ needs and to communicate adequately with them and their supporters. Enough time should also be available for a detailed explanation of the clinical problem and the treatment options. The appropriate clinical manager must be informed if there are inadequacies”;<sup>496</sup> [ELJ0002-00128]
- 32.17.2. “Inform patients and their supporters of the plans and procedures of their treatment, the risks and anticipated outcomes and any untoward developments as they occur, or as soon as possible afterwards”.<sup>497</sup>

### *Secure*

- 32.18. The GMC also refers to obligations to ensure that patients’ confidences are respected, with *Good Medical Practice* stating that a doctor “must [...] maintain patient confidentiality in all your professional written, verbal and digital communications”.<sup>498</sup> [ELJ0002-00037\_27] In its specific guidance on confidentiality, the GMC notes that “Most communication methods pose some risk of interception – for example, messages left on answering machines can be heard by others and emails can be insecure. You should take reasonable steps to make sure the communication methods you use are secure”.<sup>499</sup> [ELJ0002-00030\_33]

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<sup>494</sup> World Federation of Neurosurgical Societies (2007: [37]).

<sup>495</sup> World Federation of Neurosurgical Societies (2007: [38]).

<sup>496</sup> Royal College of Surgeons of England (2025: [2.2.4]).

<sup>497</sup> Royal College of Surgeons of England (2025: [2.2.5]).

<sup>498</sup> General Medical Council (2024a: [88]).

<sup>499</sup> General Medical Council (2017a: [133]).

**33. Are there any circumstances in which it would be ethical for a clinician to withhold the fact of or information about something having gone wrong with a surgery from a person with capacity? If so, what are they?**

- 33.1. For the purposes of answering this question, we will assume that the person in question is the patient who underwent surgery in which something went wrong. In our answer, we will focus on key points from the relevant professional guidance.
- 33.2. There appear to be four circumstances in which information about something having gone wrong with surgery might be withheld from a patient with capacity:
- 33.2.1. Exceptionally, when disclosure would cause the patient serious harm (**33.4**);
  - 33.2.2. When disclosure would reveal confidential information about someone else (**33.5-33.6**);
  - 33.2.3. When the patient does not want to know (**33.7-33.10**);
  - 33.2.4. When no harm resulted (“near miss”) (**33.11-33.15**).
- 33.3. However, even in these circumstances, the general tenor of professional guidance suggests that a patient who has capacity should be informed that something has gone wrong with their surgery.

Exceptionally, when disclosure would cause the patient serious harm

- 33.4. The GMC guidance on *Decision making and Consent* notes that there may be circumstances in which disclosure is delayed, but nevertheless conveys that disclosure should still occur.<sup>500</sup> [ELJ0002-00034\_10] It then goes on to note an exceptional circumstance in which disclosure might be withheld: “You should not withhold information a patient needs to make a decision for any other reason [than a need to delay], including if someone close to the patient asks you to. In very exceptional circumstances you may feel that sharing information with a patient would cause them serious harm and, if so, it may be appropriate to withhold it. In this context ‘serious harm’ means more than that the patient might become upset, decide to refuse treatment, or choose an alternative. This is a limited exception and

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<sup>500</sup> General Medical Council (2020a: [14]).

you should seek legal advice if you are considering withholding information from a patient”.<sup>501</sup> [ELJ0002-00034\_10]

#### When disclosure would reveal confidential information

- 33.5. We hypothesise that there may be situations in which the legal and professional obligation to maintain confidentiality would limit or prevent the disclosure of information about an error to a person with capacity. As such, if disclosure would reveal confidential information about another person, then there may be an obligation to withhold information. However, in line with GMC guidance, it could still be possible in this scenario to disclose the “minimum [information] necessary for the purpose” of informing the patient who has been wronged, without breaching confidentiality.<sup>502</sup> [ELJ0002-00030]
- 33.6. We note that the professional guidance on candour and raising concerns did not appear to address this scenario; we will not discuss it further.

#### When the patient does not want to know

- 33.7. Professional guidance on candour addresses the situation in which a patient does not want (further) information.
- 33.8. The GMC guidance on candour states: “Patients will normally want to know more about what has gone wrong. But you should give them the option not to be given every detail. If the patient does not want more information, you should try to find out why. If after discussion, they don’t change their mind, you should respect their wishes as far as possible, having explained the potential consequences. You must record the fact that the patient does not want this information and make it clear to them that they can change their mind and have more information at any time”.<sup>503</sup> [ELJ0002-00027\_7-8]
- 33.9. The RCS guidance on candour similarly states: “Respect the patient’s wishes if he or she insists that he or she does not want more information, explaining potential consequences. Give the patient the opportunity to say that he or she does not want

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<sup>501</sup> General Medical Council (2020a: [15]).

<sup>502</sup> General Medical Council (2017a: [8a],[10d]).

<sup>503</sup> General Medical Council (2015a: [13]).

to be given any more information and document this in the patient's record".<sup>504</sup>  
[ELJ0002-00127]

- 33.10. As such, professional guidance holds that the patient should be informed that something has gone wrong, but they can decline to receive "more information", and the surgeon should respect that decision and document it.

#### When no harm resulted ("near miss")

- 33.11. Professional guidance on candour and on raising concerns addresses the situation in which something has gone wrong in surgery but no harm has resulted ("near miss"). Here, professional guidance provides the surgeon with some discretion to decide about disclosing a near miss to a patient, but they are obliged to disclose this within the organisation.

#### *Discretion to disclose to the patient*

- 33.12. The GMC guidance on candour allows doctors some discretion over the disclosure of near misses to patients:

- 33.12.1. "A 'near miss' is an adverse incident that had the potential to result in harm but did not do so. You must use your professional judgement when considering whether to tell patients about near misses. Sometimes there will be information that the patient needs to know or would want to know, and telling the patient about the near miss may even help their recovery. In these cases, you should talk to the patient about the near miss..." following the general principles governing candour (see **46**);<sup>505</sup> [ELJ0002-00027\_10]
- 33.12.2. "Sometimes failing to be open with a patient about a near miss could damage their trust and confidence in you and the healthcare team. However, in some circumstances, patients may not need to know about an adverse incident that has not caused (and will not cause) them harm, and to speak to them about it may distress or confuse them unnecessarily. If you are not sure whether to talk to a patient about a near miss, seek advice from your healthcare team or a senior colleague".<sup>506</sup> [ELJ0002-00027\_11]

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<sup>504</sup> Royal College of Surgeons of England (2015a: 12).

<sup>505</sup> General Medical Council (2015a: [21]).

<sup>506</sup> General Medical Council (2015a: [22]).

33.13. The RCS guidance on candour similarly allows surgeons some discretion over the disclosure of near misses to patients:

33.13.1. “There is no expectation to disclose to patients near misses or incidents that have resulted in no harm. However, surgeons may decide to do so if they think that the patient may want to know this information and that the lack of disclosure may undermine the relationship of trust between surgeon and patient”.<sup>507</sup> [ELJ0002-00127]

*Obligation to disclose within the organisation*

33.14. Although doctors are given some discretion over disclosure to patients, GMC guidance on candour and on raising concerns requires the reporting of near misses within the organisation, in order to facilitate a learning culture:

33.14.1. “All health and care organisations have a duty to support their staff to report adverse incidents. Health and care organisations should have a policy for reporting adverse incidents and near misses...”;<sup>508</sup> [ELJ0002-00027\_11]

33.14.2. All doctors “must also follow the procedure where you work for reporting adverse incidents and near misses. This is because routinely identifying adverse incidents or near misses at an early stage, can allow issues to be tackled, problems to be put right and lessons to be learnt”;<sup>509</sup> [ELJ0002-00027]; [ELJ0002-00024\_6]

33.14.3. “Senior clinicians have a responsibility to set an example and encourage openness and honesty in reporting adverse incidents and near misses. Clinical leaders should actively foster a culture of learning and improvement”.<sup>510</sup> [ELJ0002-00027\_13]

33.15. The RCS guidance on candour similarly requires the reporting of near misses within the organisation:

33.15.1. “Local trust policies may also require doctors to disclose no-harm incidents and near misses, depending on circumstances and the patient’s best interest. In every case, low-harm incidents as well as near misses and incidents that resulted in no harm must be reported through

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<sup>507</sup> Royal College of Surgeons of England (2015a: 4).

<sup>508</sup> General Medical Council (2015a: [24]).

<sup>509</sup> General Medical Council (2015a: [26]); see also General Medical Council (2012a: [11]).

<sup>510</sup> General Medical Council (2015a: [30]).

the trust's local reporting systems to support learning and service improvement, and to avoid future harm";<sup>511</sup> [E:J0002-00127]

- 33.15.2. "Errors should be reported at an early stage to put matters right and to learn any lessons so that future patients may be protected from harm. All incidents should be reported for learning purposes, even no-harm incidents and near misses".<sup>512</sup> [ELJ0002-00127]

**34. What kind of counselling or support should be offered to a patient by a surgeon who is informing them that they have suffered an adverse outcome following surgery?**

- 34.1. We consider this question in the context of the current part of the Inquiry entitled "Informing people when things have not gone as expected in surgery", and therefore interpret the question as "What kind of counselling or support should be offered to a patient by a surgeon who is informing them that they have contracted a serious disease *as a result of when things have not gone as expected in surgery?*" (emphasis added).
- 34.2. We did not identify any professional guidance on the kind of counselling or support that should be offered to a patient by a surgeon who is informing them that they have contracted a serious disease.
- 34.3. Professional guidance generally refers to an obligation to provide such remedial support as might be necessary (see **36.2-36.6, 42.3, 46.5, 46.11**). For example, the GMC guidance on candour refers to the doctor "doing what you can to put matters right".<sup>513</sup> [ELJ0002-00027\_7]

**35. What information should be provided to a patient by a surgeon about their right to take further action (including complaints processes etc) when something has gone wrong with a surgery?**

- 35.1. We did not identify any professional guidance on specific information that should be provided to a patient by a surgeon about their right to take further action (including complaints processes etc.) when something has gone wrong with a surgery.

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<sup>511</sup> Royal College of Surgeons of England (2015a: 4).

<sup>512</sup> Royal College of Surgeons of England (2015a: 15).

<sup>513</sup> General Medical Council (2015a: [10]).

35.2. There are, however, health service level obligations that suggest best practice.

These include:

- 35.2.1. GMC guidance on *Raising and acting on concerns* states “you have a duty to help people report their concerns and to enable people to act on concerns that are raised with them”.<sup>514</sup> [ELJ0002-00024\_9] While this is framed around staff reporting concerns, it may align with the scenario that something had gone wrong with a surgery.
- 35.2.2. The NHS Constitution for England states: “You [the patient] have the right to have any complaint you make about NHS services acknowledged within three working days and to have it properly investigated”,<sup>515</sup> [ELJ0002-00015] and “The NHS also pledges to: ensure that you are treated with courtesy and you receive appropriate support throughout the handling of a complaint; and that the fact that you have complained will not adversely affect your future treatment”.<sup>516</sup> [ELJ0002-00015\_13]
- 35.2.3. NHS complaints regulations (2009) require every NHS body to have an arrangement for handling complaints, including assistance so patients can understand the process.<sup>517</sup> This is framed as a healthcare provider responsibility, rather than that of an individual surgeon.
- 35.2.4. The Parliamentary and Health Service Ombudsman define complaint handling procedures for NHS services, including *Model complaints handling procedure for providers of NHS services in England* (2022).<sup>518</sup> [ELJ0002-00058] This provided<sup>519</sup> which states: “We expect all staff to proactively respond to service users and their representatives and support them to deal with any complaints raised at the ‘first point of contact’. We will provide training so they can do this. We expect all our staff who have contact with patients, service users, or those that support them, to deal with complaints in a sensitive and empathetic way. This includes making sure people are aware of our local independent advocacy provider and/or

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<sup>514</sup> General Medical Council (2012a: [21]).

<sup>515</sup> Department of Health and Social Care (2023).

<sup>516</sup> Department of Health and Social Care (2023).

<sup>517</sup> The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

<sup>518</sup> Parliamentary and Health Service Ombudsman (2022).

<sup>519</sup> The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

national sources of support and advice. We expect all staff to listen, provide<sup>520</sup> [ELJ0002-00058\_23]

35.2.5. The Patient Advice and Liaison Service (PALS) was formed by the *NHS Plan* (2000) to listen to patients and resolve concerns promptly.<sup>521</sup> [ELJ0002-00011] Department of Health guidance required every NHS Trust to establish PALS from 2002. Contemporary PALS services offer confidential advice, support, and information about, and signposts to, the NHS complaints process and independent advocacy.

35.3. While these guidelines do not explicitly define information that should be provided to patients from surgeons, surgeons should be aware of these responsibilities as they relate to local clinical governance protocols (see also **Part F**).

## PART F

### PROFESSIONAL CONSIDERATIONS AND WHISTLEBLOWING

**36. If a surgeon or other medical professional becomes aware of events occurring which (a) appear to deviate from standard practice(s) or (b) appear to involve actual or potential detriment to patient safety or care, what obligation or responsibility does the surgeon or other medical professional have, from an ethical perspective, to intervene or take action?**

36.1. Various professional organisations have issued guidance about raising concerns, which is discussed below (see **41-44, 46-48**). Some of that guidance addresses when and how a surgeon is obliged to intervene or take action.

#### Doctors' obligations

36.2. The GMC's *Good Medical Practice* states: "You must act promptly if you think that patient safety or dignity is, or may be, seriously compromised".<sup>522</sup> [ELJ0002-00037\_24] In addition to setting out an obligation to raise concerns, the guidance states:

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<sup>520</sup> Parliamentary and Health Service Ombudsman (2022: 21).

<sup>521</sup> Department of Health (2000).

<sup>522</sup> General Medical Council (2024a: [75]).

- 36.2.1. “If a patient is not receiving basic care to meet their needs, you must act to make sure the patient is cared for as soon as possible, for example by asking someone who delivers basic care to attend to the patient straight away”.<sup>523</sup> [ELJ0002-00037\_24]
- 36.2.2. “If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should first protect patients and put the matter right if that’s possible”.<sup>524</sup> [ELJ0002-00037\_24]
- 36.3. The GMC has also issued, in 2012, specific guidance, *Raising and acting on concerns about patient safety*. This guidance echoes the statement in *Good Medical Practice*: “You must take prompt action if you think patient safety, dignity or comfort is being compromised”.<sup>525</sup> [ELJ0002-00024\_4] It then sets out obligations around raising a concern and acting on a concern.

### Surgeons’ obligations

- 36.4. The RCS’s *Good Surgical Practice* includes an obligation to “respond to risks to safety”: “Every surgeon, regardless of seniority or grade, must put the care and safety of patients above all other considerations and take action or speak up through the appropriate channels when concerns arise”.<sup>526</sup> [ELJ0002-00128] This guidance then sets out obligations around raising a concern.
- 36.5. The RCSEd *Code of Conduct* states: “The College encourages a culture that emphasises the importance of raising concerns and that such concerns are investigated and assessed fairly”.<sup>527</sup> [ELJ0002-00124] The RCSEd website states that the College “is committed to fostering increased openness and transparency in healthcare, encouraging prompt action to address instances of malpractice or other serious health and safety concerns that may impact patient care”.<sup>528</sup> [ELJ0002-00126] The website then sets out the steps for raising concerns.<sup>529</sup> [ELJ0002-00126]

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<sup>523</sup> General Medical Council (2024a: [75]).

<sup>524</sup> General Medical Council (2024a: [75]).

<sup>525</sup> General Medical Council (2012a: 3).

<sup>526</sup> Royal College of Surgeons of England (2025: [3.6]).

<sup>527</sup> Royal College of Surgeons of Edinburgh (2024: 8).

<sup>528</sup> Royal College of Surgeons of Edinburgh (2026b).

<sup>529</sup> Royal College of Surgeons of Edinburgh (2026b).

## Neurosurgeons' obligations

36.6 The WFNS statement on ethics includes a specific statement about the obligation to protect patients, including from colleagues' harmful behaviour: "If there is reason to believe the actions of a colleague are endangering patients, we have a duty to make every effort to persuade that colleague to change his or her practice. If this approach fails, we must act to protect patients from risk when there is good reason to believe the ability of a colleague to provide a high standard of care is compromised".<sup>530</sup> [ELJ0002-00070\_6]

### **37. If so, what alternatives by way of intervention or action would be available to that surgeon or other medical professional?**

37.1. The GMC's *Good Medical Practice* appears to be most explicit about the action(s) that should be taken if "patient safety or dignity" is (seriously) compromised, when it refers to providing basic care (**36.2.1**) and otherwise protecting patients, e.g., from unsafe premises or systems (**36.2.2**).

### **38. What principles or considerations would require to be weighed in the decision-making process around whether to take action or what action to take?**

38.1. Professional guidance essentially conveys that the first, and overriding, obligation is to the patient (see, e.g., **5.10.2**, **6.9**, **36.2**). Indeed, the GMC's duties of a doctor, set down in *Good Medical Practice*, opens with the statement: "Patients must be able to trust medical professionals with their lives and health. To justify that trust you must make the care of patients your first concern...".<sup>531</sup> [ELJ0002-00037\_8]

38.2. The GMC's *Good Medical Practice* recognises that there may be other obligations to consider. For example, the guidance states that doctors "must treat colleagues with kindness, courtesy and respect".<sup>532</sup> [ELJ0002-00037\_19] This section of the guidance includes the statement: "You must be compassionate towards colleagues who have problems with their performance or health".<sup>533</sup> [ELJ0002-00037\_19]

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<sup>530</sup> World Federation of Neurosurgical Societies (2007: [64]).

<sup>531</sup> General Medical Council (2024a: 7).

<sup>532</sup> General Medical Council (2024a: [48]).

<sup>533</sup> General Medical Council (2024a: [51]).

However, the guidance then states: “But you must put patient safety first at all times”.<sup>534</sup> [ELJ0002-00037\_19]

- 38.3. The priority given to patient safety and welfare is echoed and reinforced in the guidance issued to (neuro)surgeons by other professional organisations. As noted above (36.4), the RCS requires surgeons to “put the care and safety of patients above all other considerations”.<sup>535</sup> [ELJ0002-00128] The WFNS statement on ethics similarly states in its introduction that, “Above all, we are obligated not to harm to our patients, and to provide treatment that is of potential benefit”.<sup>536</sup> [ELJ0002-00070\_1]

## OBLIGATIONS AMONGST SURGEONS

39. **What ethical obligations or considerations do surgeons have to provide information about their cases or to seek advice from [or] to other professional colleagues, including but not limited to seeking advice about risks/benefits of proposed surgical options and when things have gone wrong?**
- 39.1. Current GMC guidance states that clinicians must report incidents, so they can be “reviewed or investigated as appropriate – and lessons can be learnt and patients protected from harm in the future”.<sup>537</sup> [ELJ0002-00037\_17] More generally, clinicians must consult colleagues or seek advice from supervising clinicians “where appropriate” (this is not limited to where things have gone wrong).<sup>538</sup> [ELJ0002-00037\_10]
- 39.2. The RCS guidance on this is similar.<sup>539</sup> [ELJ0002-00128]

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<sup>534</sup> General Medical Council (2024a: [51]).

<sup>535</sup> Royal College of Surgeons of England (2025: [3.6]).

<sup>536</sup> World Federation of Neurosurgical Societies (2007: 1).

<sup>537</sup> General Medical Council (2024a: [45d]).

<sup>538</sup> General Medical Council (2024a: [7]).

<sup>539</sup> Royal College of Surgeons of England (2025).

**40. In particular, what ethical obligations or considerations do surgeons have to:**

**(a) Engage with colleagues in other medical specialities in decision-making around patient care, including participation in multi-disciplinary meetings about patients.**

- 40.1. According to current RCS guidance, surgeons have a general duty to “[a]ttend and contribute to regular meetings with colleagues in the same and related specialties and attend multidisciplinary meetings”.<sup>540</sup> [ELJ0002-00128]

**(b) Report problems, concerns or poor outcomes to their professional colleagues.**

- 40.2. According to current RCS guidance, an ethical obligation with regards to teamworking requires that surgeons “Encourage a culture of safety, candour and constructive challenge in your team, in which difficulties and problems that may cause harm to the patient can surface and be openly discussed and mitigated”.<sup>541</sup> [ELJ0002-00128] This may fall under a broader obligation to:

40.2.1. “Report all incidents where significant harm has occurred through the relevant governance processes of your organisation”,<sup>542</sup> [ELJ0002-00128] and

40.2.2. “Be familiar with local processes and agreed thresholds for recording adverse incidents and keep a record of incidents in which you have been directly involved. You should report such incidents to those responsible in your hospital and, where relevant, to a local audit meeting”.<sup>543</sup> [ELJ0002-00128]

- 40.3. The RCS guidance on candour (see **46-48**) also states that: “As part of their professional duty of candour, all surgeons must also be open and honest with their colleagues and employers, and take part in reviews and investigations when requested. They have the responsibility to familiarise themselves with their organisation’s relevant policies and comply with local disclosure processes around the duty of candour. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other

<sup>540</sup> Royal College of Surgeons of England (2025: [1.1.12]).

<sup>541</sup> Royal College of Surgeons of England (2025: [3.2.6]).

<sup>542</sup> Royal College of Surgeons of England (2025: [2.5.3]).

<sup>543</sup> Royal College of Surgeons of England (2025: [3.6.11]).

to be open and honest, and not stop someone from raising concerns”.<sup>544</sup> [ELJ0002-00127]

## WHISTEBLOWING ETC

### **41. What ethical obligations or considerations do surgeons have to participate fully in clinical governance systems, including:**

**(a) Complaints or feedback processes;**

**(b) Formal investigations into surgical and/or corporate oversight processes such as those listed in Term of Reference 12; and**

**(c) Whistleblowing systems relating to the care provided by professional colleagues.**

41.1. The answers to **41(a)-(c)** have been taken together.

41.2. There is a general obligation to raise concerns according to GMC guidance: “All medical professionals have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies and procedures in the organisations in which they work. They must also encourage and support a culture in which staff can raise concerns openly and safely”.<sup>545</sup> [ELJ0002-00024\_6]

41.3. As noted above (**39**), clinicians have a duty to report incidents in line with their organisation’s policy.<sup>546</sup> [ELJ0002-00037\_17] They should respond promptly, fully and honestly to complaints.<sup>547</sup> [ELJ0002-00037\_18] Crucially, clinicians “must” cooperate with formal inquiries, investigations, and complaints procedures: “To maintain patient safety, you must cooperate with formal inquiries, patient safety investigations, and complaints procedures. You must provide all relevant information and be open and honest”.<sup>548</sup> [ELJ0002-00037\_28]

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<sup>544</sup> Royal College of Surgeons of England (2015a: 5).

<sup>545</sup> General Medical Council (2012a: [7]).

<sup>546</sup> General Medical Council (2024a: [45d]).

<sup>547</sup> General Medical Council (2024a: [46]).

<sup>548</sup> General Medical Council (2024a: [98]).

- 41.4. Clinicians should also comply with the GMC's specific guidance *on Reporting criminal and regulatory proceedings*.<sup>549</sup> [ELJ0002-00026] This also applies to whistleblowing: "If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body, or us. If you are still concerned, you must report this, in line with your workplace policy and our more detailed guidance on 'Raising and acting on concerns about patient safety'".<sup>550</sup> [ELJ0002-00037\_24]
- 41.5. Those with leadership or management roles have further obligations to make sure staff can talk about concerns and errors: "If you have a formal leadership or management role, you must take active steps to create an environment in which people can talk about errors and concerns safely. This includes making sure that any concerns raised with you are dealt with promptly and adequately, in line with your workplace policy and our more detailed guidance on 'Raising and acting on concerns about patient safety'".<sup>551</sup> [ELJ0002-00037\_25]
- 41.6. Clinicians also have specific obligations, depending on whether they are responsible toward those who raise a concern,<sup>552</sup> [ELJ0002-00037\_14] or whether they are themselves responsible for investigating incidents or complaints.<sup>553</sup> [ELJ0002-00037\_16]

**42. What ethical obligations or considerations exist on surgeons to take action when they are aware of something has gone wrong in the practice of a colleague? What considerations require to be taken into account and how should they be weighed?**

- 42.1. As discussed elsewhere (**32.3.1**), some academic scholars maintain that surgeons have an obligation to take "corrective action" when their colleagues make errors, which includes informing patients.<sup>554</sup> [ELJ0002-00139]
- 42.2. As noted elsewhere (**31, 36**), professional organisations hold that clinicians are required to be open and honest when things go wrong.
- 42.3. The obligation is detailed in the GMC's current guidance on *Good Medical Practice* as: "You must be open and honest with patients if things go wrong. If a patient

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<sup>549</sup> General Medical Council (2013b).

<sup>550</sup> General Medical Council (2024a: [75c]).

<sup>551</sup> General Medical Council (2024a: [76]).

<sup>552</sup> General Medical Council (2024a: [23]).

<sup>553</sup> General Medical Council (2024a: [34]).

<sup>554</sup> Steinberg and Warshaw (2019: 81).

under your care has suffered harm or distress, you must follow our guidance on Openness and honesty when things go wrong: the professional duty of candour, and you should:

- a. put matters right, if possible
- b. apologise (apologising does not, of itself, mean that you are admitting legal liability for what's happened)
- c. explain fully and promptly what has happened and the likely short-term and long-term effects
- d. report the incident in line with your organisation's policy so it can be reviewed or investigated as appropriate – and lessons can be learnt and patients protected from harm in the future".<sup>555</sup> [ELJ0002-00037\_17]

- 42.4. On raising concerns about others, GMC guidance states that: "Wherever possible, you should first raise your concern with your manager or an appropriate officer of the organisation you have a contract with or which employs you – such as the consultant in charge of the team, the clinical or medical director or a practice partner. If your concern is about a partner, it may be appropriate to raise it outside the practice – for example, with the medical director or clinical governance lead responsible for your organisation. If you are a medical professional in training, it may be appropriate to raise your concerns with a named person in your training organisation".<sup>556</sup> [ELJ0002-00024\_7]

**43. What actions are open to a surgeon to take in such circumstances? What other individuals or bodies ought to become involved and when, and at whose instigation?**

- 43.1. In addition to the points made elsewhere (**41-42**), the GMC notes the following in its dedicated policy on whistleblowing, which was published in 2018: "The easiest way to raise a concern about a doctor is through the GMC's online complaint form at [GMC website]. This form guides complainants through all the information we need to consider their concern. Whistleblowers can also report a doctor to us by writing to us at [...]. Alternatively, if your concern is not about a doctor or you otherwise prefer

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<sup>555</sup> General Medical Council (2024a: [45]).

<sup>556</sup> General Medical Council (2012a: [13]).

to do so, you can share information via our confidential helpline...”.<sup>557</sup> [ELJ0002-00033\_5]

**44. What are the ethical principles that should guide clinicians in reporting matters via such systems?**

- 44.1. As discussed elsewhere (**41-43, 46-48**), clinicians have a duty to report concerns.
- 44.2. In terms of overcoming obstacles to reporting, in its 2012 guidance on raising concerns, the GMC instructs clinicians to bear the following factors in mind:
- “a. You have a duty to put patients’ interests first and act to protect them, which overrides personal and professional loyalties.
- b. The law provides legal protection against victimisation or dismissal for individuals who reveal information to raise genuine concerns and expose malpractice in the workplace.
- c. You do not need to wait for proof – you will be able to justify raising a concern if you do so honestly, on the basis of reasonable belief and through appropriate channels, even if you are mistaken”.<sup>558</sup> [ELJ0002-00024\_6]
- 44.3. Generally, clinicians should follow the professional duty of candour (see **46-48**). As well as specific guidance for surgeons from the RCS,<sup>559</sup> [ELJ0002-00127] the professional duty of candour is detailed in specialised guidance by the GMC, first published in 2015:<sup>560</sup> [ELJ0002-00027]
- “Every health and care professional must be open and honest with patients and people in their care when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress. This means that health and care professionals must:
- tell the person (or, where appropriate, their advocate, carer or family) when something has gone wrong
  - apologise to the person (or, where appropriate, their advocate, carer or family)
  - offer an appropriate remedy or support to put matters right (if possible)

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<sup>557</sup> General Medical Council (2018b: 5).

<sup>558</sup> General Medical Council (2012a: [10]).

<sup>559</sup> Royal College of Surgeons of England (2015a).

<sup>560</sup> General Medical Council (2015a).

- explain fully to the person (or, where appropriate, their advocate, carer or family) the short and long term effects of what has happened.

Health and care professionals must also be open and honest with their colleagues, employers and relevant organisations, and take part in reviews and investigations when requested. They must also be open and honest with their regulators, raising concerns where appropriate. They must support and encourage each other to be open and honest, and not stop someone from raising concerns”.<sup>561</sup> [ELJ0002-00027\_4]

## PART G

### RESEARCH

#### 45. What ethical principles should inform decisions about participation in research?

##### Overarching ethical principles

45.1. For the purposes of this report, we understand “research” as defined by the NHS Health Research Authority (HRA).<sup>562</sup> [ELJ0002-00041] However, it is critical for this Inquiry to understand the wider issues in the development, evaluation and implementation of new surgical techniques and technology in the NHS as they relate to patient care. These issues are themselves the focus of research at the NIHR Bristol Biomedical Research Centre, of which Huxtable and McNair are both members. In particular, we refer to activity known as “surgical innovation”, which can sometimes overlap with “research” or with more routine clinical care. We note:

45.1.1. *There is no unified definition of surgical innovation.* While we have adopted a narrow definition of “research” for the purposes of this report, activities related to the broader concept of surgical innovation may occur outside of a research context, and therefore outside of research ethics standards and processes. This is discussed in detail in articles by Birchley et al (2019 and 2020).<sup>563</sup> [ELJ0002-00076]; [ELJ0002-00077] For example, surgical innovation may not involve a new surgery but may relate to a new *place* (a

<sup>561</sup> General Medical Council (2015a: 3).

<sup>562</sup> Health Research Authority (2025).

<sup>563</sup> Birchley et al (2019); Birchley et al (2020).

new procedure to the UK that is used in other countries) or *product* (encompassing everything from minor modifications to existing products through to wholly new devices), along with others.

- 45.1.2. *Professional ethical obligations vary according to how innovation is defined.* In contrast to the formal, rigorous governance required for the introduction of new medicines, we are aware of at least three sets of obligations for surgical innovation that broadly correspond to recommendations issued by the NICE Interventional Procedure Advisory Committee (IPAC):<sup>564</sup>
- 45.1.2.1. The most stringent governance is to consider the activity “research” as defined by the HRA (IPAC recommendation “research only”);
- 45.1.2.2. Alternatively, some innovation is governed by local hospital “new procedure committees”, however, a review of these bodies demonstrated significant heterogeneity in process and outcome monitoring, which has implications for patient safety (IPAC recommendation “evidence generation”);<sup>565</sup> [ELJ0002-00147]
- 45.1.2.3. Alternatively, some innovation is considered incremental modification of existing practice without additional oversight, e.g., a new model of an existing electrocautery device (IPAC recommendation “can use”).
- 45.1.3. Although we focus below on research, we therefore invite the Inquiry to bear in mind the related, but potentially distinct, phenomenon of “surgical innovation” which has been touched on in other public inquiries such as the Independent Medicines and Medical Devices Safety (IMMDS) review.
- 45.1.4. Given the scope of this Inquiry, we wish to highlight that we have recently completed action 2.22 from the IMMDS review to produce a recommended “core information set” for informed consent for surgical innovation. This was published in the *British Journal of Surgery* in 2025.<sup>566</sup> [ELJ0002-00099] We are now in discussion with NICE and the GMC to include our findings in future guidelines and we welcome support in this endeavour.

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<sup>564</sup> National Institute for Health and Care Excellence (2026b).

<sup>565</sup> Wallis et al. (2025).

<sup>566</sup> Hoffmann et al (2025).

45.2. Turning to research, there is an academic literature on the ethics of research in surgery,<sup>567</sup> [ELJ0002-00121]; [ELJ0002-00140]; [ELJ0002-00083] as well as on the ethics of surgical innovation.<sup>568</sup> [ELJ0002-00076] [ELJ0002-00077]; [ELJ0002-00109] However, decisions about research participation in the UK are guided by professional duties, legal safeguards, and regulatory standards, which is where we focus here. The key sources include:

45.2.1. GMC, *Good Practice in Research*,<sup>569</sup> [ELJ0002-00038] and *Consent to Research*,<sup>570</sup> [ELJ0002-00022]

45.2.2. RCS, *Good Surgical Practice*,<sup>571</sup> [ELJ0002-00128]

45.2.3. Health Research Authority, *UK Policy Framework on health and social care research*,<sup>572</sup> [ELJ0002-00041]

45.2.4. World Medical Association, *Declaration of Helsinki*,<sup>573</sup> [ELJ0002-00071] and

45.2.5. Global Health Network's International Council for Harmonisation (ICH), *Guideline for Good Clinical Practice*.<sup>574</sup> [ELJ0002-00049]

45.3. From these sources, several core ethical requirements emerge:

45.3.1. Voluntary participation;

45.3.2. Scientific validity and social value;

45.3.3. Favourable risk-benefit balance;

45.3.4. Protection of vulnerable groups;

45.3.5. Fair selection and equity;

45.3.6. Confidentiality and data protection; and

45.3.7. Transparency, accountability, and ethical oversight.

45.4. In a surgery-specific context, it is worth noting that the RCS' *Good Surgical Practice* (2025) provides detail on actions surgeons should take if they undertake research. They should:

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<sup>567</sup> E.g., Postlewait and Singh (2022); Streiner (2025); Cinà (2025).

<sup>568</sup> E.g., Birchley et al (2019); Birchley et al (2020); Landeen et al (2022).

<sup>569</sup> General Medical Council (2024b).

<sup>570</sup> General Medical Council (2010a).

<sup>571</sup> Royal College of Surgeons of England (2025).

<sup>572</sup> Health Research Authority (2025).

<sup>573</sup> World Medical Association (2024).

<sup>574</sup> International Council for Harmonisation (2025).

1. "Acknowledge the wellbeing of the individual patient as the paramount concern, regardless of the value of the research project.
2. Submit full protocols of proposed research and details of intended new technical procedures to your local research ethics committee before starting.
3. Ensure that all clinical trials you undertake are registered and all trial results are published, including negative results or results where the outcome is different to what was expected.
4. Treat patients participating in research as partners, respecting their dignity and unique clinical circumstances. You should be satisfied that the expected benefits of the research outweigh any anticipated risks.
5. Fulfil the recommendations of the Declaration of Helsinki statement of ethical principles for medical research involving humans, including identifiable human material and data [NB this is currently under revision by the World Medical Association].
6. Fully inform research participants about your research aims, intentions, values, relevance, methods, risks and discomforts, and record this in their notes.
7. Fully inform patients in randomised trials about the procedures being compared and their risks and benefits, and record this in their notes.
8. Inform participants how their confidentiality will be respected and protected.
9. Accept that a patient may refuse to participate or withdraw during the programme, in which case their treatment must not be adversely affected.
10. Seek guidance from the ethics committee concerning the need for consent for the use of tissue removed during an operation for research purposes in addition to routine histopathology.
11. Seek permission to remove tissue beyond that excised diagnostically or therapeutically.
12. Acquire explicit permission to use any removed tissue for commercial purposes; for example, to grow cell lines or for genetic research.
13. Discourage the publication of research findings in non-scientific media before reporting them in reputable scientific journals or at meetings.
14. Disclose any personal affiliation or financial and commercial interest in relation to your research and its funding. This includes, for example, private

healthcare companies, pharmaceutical companies or instrument manufacturers.

15. Report any fraud that is detected or suspected to the local research/ethics committee.
  16. Recognise and be familiar with the Human Tissue Act 2004 regulations and obtain appropriate licences where necessary.
  17. Fulfil the strict regulations of the Animals (Scientific Procedures) Act 1986 when obtaining permission to carry out research on animals.”<sup>575</sup> [ELJ0002-00128]
- 45.5. Regarding neurosurgery specifically, the WFNS statement on ethics (2007) includes various provisions relating to clinical research and clinical trials,<sup>576</sup> [ELJ0002-00070\_11-12] including statements about the protection of patients and research subjects (participants),<sup>577</sup> [ELJ0002-00070\_12-13] maintaining confidentiality, protecting intellectual property, and publishing research findings,<sup>578</sup> [ELJ0002-00070\_13-14] and conflicts of interest,<sup>579</sup> [ELJ0002-00070\_14-15] amongst other topics.
- 45.6. Further detail relating to research, and the application of the above noted principles (45.3), is mainly found in guidance issued by the GMC, which is the primary source of the discussion below.

**(a) What factors should a surgeon take into account when considering whether a patient might take part in a research project or otherwise be the subject of research or study?**

- 45.7. Generally, it is recognised that doctors – including surgeons – have professional ethical obligations to support high-quality research with appropriate governance safeguards. GMC guidance on *Good practice in research* states: “Research is vital in improving our understanding of health conditions, increasing the availability of options for effective prevention, treatment, and care, and improving outcomes for

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<sup>575</sup> Royal College of Surgeons of England (2025: [1.4]).

<sup>576</sup> World Federation of Neurosurgical Societies (2007: [114]-[122]).

<sup>577</sup> World Federation of Neurosurgical Societies (2007: [123]-[129]).

<sup>578</sup> World Federation of Neurosurgical Societies (2007: [130]-[140]).

<sup>579</sup> World Federation of Neurosurgical Societies (2007: [141]-[150]).

patients and the population. All medical professionals can play a role in achieving these benefits”.<sup>580</sup> [ELJ0002-00038\_5]

45.8. According to relevant current guidance, there are several factors that should be taken into account when considering whether a patient might take part in a research project or otherwise be the subject of research or study:

45.8.1. GMC guidance notes that “Some groups, such as women, children and young people, older people, ethnic minorities, and people with disabilities, are less well represented in clinical studies and other research activity”.<sup>581</sup> [ELJ0002-00038\_5] It states an obligation: “To support more people to access and contribute to research, you should:

- a. tell patients if you’re aware of opportunities for them to participate in research activities that may be relevant to their condition or of particular interest to them
- b. signpost patients to research teams who can provide further information about a specific study
- c. signpost patients who express a general interest in research to information on how they can get involved (see Annex B for examples)
- d. avoid making assumptions about who may be interested in taking part, or eligible to be involved
- e. encourage people from under-represented groups to consider getting involved”.<sup>582</sup> [ELJ0002-00038\_5-6]

45.8.2 Whether the patient has given valid, informed consent (see **13-20, 45.11-45.19**). This includes effective communication of potential benefits, risks, etc.<sup>583</sup> [ELJ0002-00022\_6-7]; [ELJ0002-00038\_8] Clinicians “must be satisfied as far as you can that the anticipated benefits of the research outweigh the foreseeable risks to participants”.<sup>584</sup> [ELJ0002-00038\_8]

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<sup>580</sup> General Medical Council (2024b: [7]).

<sup>581</sup> General Medical Council (2024b: [10]).

<sup>582</sup> General Medical Council (2024b: [11]).

<sup>583</sup> General Medical Council (2010a: [4]-[8]); General Medical Council (2024b: [23]).

<sup>584</sup> General Medical Council (2024b: [23]).

- 45.8.3 The patient's capacity,<sup>585</sup> [ELJ0002-00037\_14-15] and/or vulnerability.<sup>586</sup> [ELJ0002-00022\_9]; [ELJ0002-00034\_19]
- 45.8.4 Whether the proposed research has received proper approval (i.e., via a Research Ethics Committee (REC)) and any relevant requirements.
- 45.8.5 Any potential issues relating to confidentiality and data protection.<sup>587</sup> [ELJ0002-00030]
- 45.8.6 Other relevant professional ethical principles, including honesty and transparency with patients regarding the research.<sup>588</sup> [ELJ0002-00038\_11-12]
- 45.9. Relevant guidance also asks that clinicians consider the types of groups they involve when designing research studies:
- “Before you submit a proposal or protocol for approval, you should consider whether it pays sufficient attention to:
- a. including people from groups that are less well-represented in research
  - b. ensuring that people who share protected characteristics have equal access to participate and equal opportunity to benefit from the proposed research
  - c. the perspective of people with lived experience of any condition to be studied”.<sup>589</sup> [ELJ0002-00038\_8]
- 45.10. Aspects of the above are considered further in answer to **(b)-(e)**, below **(45.11-45.30)**.

**(b) What obligation or responsibility does the surgeon have to inform the patient that they are participating in a research project or are the subject of research or study?**

**(c) In broad terms, what kinds of information should a surgeon provide to a patient to enable the patient to give informed consent to participating in a research project or being the subject of research or study?**

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<sup>585</sup> See General Medical Council (2024a: [23]-[29]).

<sup>586</sup> Referred to in General Medical Council (2010a: [21]-[22]) and General Medical Council (2020a: [71]).

<sup>587</sup> See, generally, General Medical Council (2017a).

<sup>588</sup> See General Medical Council (2024b: [47]-[54]).

<sup>589</sup> General Medical Council (2024b: [25]).

45.11. The answers to **(b)** and **(c)** have been taken together. The general guidance on consent has applied to research, as it has evolved over the years (see **13-20**). With regards to specific guidance on research, this answer proceeds chronologically with the evolution of ethical guidance.

45.12. The first edition of *Good medical practice* (1995) was clear that, in carrying out research, clinicians should: prioritise patient interests,<sup>590</sup> [ELJ0002-00016\_15] following correct protocols,<sup>591</sup> [ELJ0002-00016\_15] honestly record results,<sup>592</sup> [ELJ0002-00016\_15] and comply with guidance on confidentiality.<sup>593</sup> [ELJ0002-00017] As noted elsewhere (**13-20**), emphasis on consent was not introduced into *Good medical practice* until the second (1998) edition. From here, it becomes clear that consent (usually written) is of core importance. With regards to research, it stated:

“[If Y]ou take part in clinical drug trials or other research involving patients or volunteers, you must make sure that the individual has given written consent to take part in the trial and that the research is not contrary to the individual's interests. You should always seek further advice where your research involves adults who are not able to make decisions for themselves. You may also benefit from additional advice where your research involves children. You must check that the research protocol has been approved by a properly constituted research ethics committee.”<sup>594</sup> [ELJ0002-00018\_19]

45.13. Further emphasis was placed on clinicians’ “absolute duty” to conduct research with honesty and integrity:

- “you must follow all aspects of the research protocol; you may accept only those payments approved by a research ethics committee;
- your conduct must not be influenced by payments or gifts;
- you must always record your research results truthfully and maintain adequate records;
- when publishing results you must not make unjustified claims for authorship;

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<sup>590</sup> General Medical Council (1995a: [43]).

<sup>591</sup> General Medical Council (1995a: [44]).

<sup>592</sup> General Medical Council (1995a: [45]).

<sup>593</sup> General Medical Council (1995b).

<sup>594</sup> General Medical Council (1998a: [56]).

- you have a duty to report evidence of fraud or misconduct in research to an appropriate person or authority”.<sup>595</sup> [ELJ0002-00018\_20]
- 45.14. In 1998, the GMC also published their first dedicated guidance on consent (withdrawn in 2008; see also **13-20**). It made clear that clinicians “must”:
- “... take particular care to be sure that anyone you ask to consider taking part in research is given the fullest possible information, presented in terms and a form that they can understand. This must include any information about possible benefits and risks; evidence that a research ethics committee has given approval; and advice that they can withdraw at any time. You should ensure that participants have the opportunity to read and consider the research information leaflet. You must allow them sufficient time to reflect on the implications of participating in the study. You must not put pressure on anyone to take part in research. You must obtain the person's consent in writing. Before starting any research you must always obtain approval from a properly constituted research ethics committee”.<sup>596</sup> [ELJ0002-00019\_10]
- 45.15. In 2002, the GMC began publishing specialised guidance on *Good Practice in Research*. This was in place until 2010, when it was withdrawn. Again, the core principles of ethical research mentioned in the first part of this answer are reflected clearly here:
- “Participants' consent is legally valid and professionally acceptable only where participants are competent to give consent, have been properly informed, and have agreed without coercion”.<sup>597</sup> [ELJ0002-00020\_5]
- 45.16. This guidance also reflected the more general principles of consent (as discussed in **13-20**). For example, it was stated that clinicians should provide patients information about:
- “what the research aims to achieve, an outline of the research method, and
  - confirmation that a research ethics committee has approved the project;
  - the legal rights and safeguards provided for participants;
  - the reasons that the patient or volunteer has been asked to participate;

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<sup>595</sup> General Medical Council (1998a: [57]).

<sup>596</sup> General Medical Council (1998b: [36]).

<sup>597</sup> General Medical Council (2002: [16]).

- if the project involves randomisation, the nature of the process and reasons for it, and the fact that in double-blind research trials neither the patient nor the treatment team will know whether the patient is receiving the treatment being tested or is in the control group;
- information about possible benefits and risks;
- an explanation of which parts of the treatment are experimental or not fully tested;
- advice that they can withdraw at any time and, where relevant, an assurance that this will not adversely affect their relationship with those providing care;
- an explanation of how personal information will be stored, transmitted and published;
- what information will be available to the participant about the outcome of the research, and how that information will be presented;
- arrangements for responding to adverse events;
- details of compensation available should participants suffer harm as a result of their participation in the research”.<sup>598</sup> [ELJ0002-00020\_6]

45.17. The next edition of *Good Practice in Research* (2010, withdrawn 2024) again emphasised that clinicians must get consent from participants before involving them in research, and in doing so should follow the guidance in *Consent to research*.<sup>599</sup> [ELJ0002-00023\_9-10] The general principles of consent are reflected here, i.e.:

- 45.17.1. “Seeking consent is fundamental in research involving people. Participants’ consent is legally valid and professionally acceptable only if they have the capacity to decide whether to take part in the research, have been properly informed, and have agreed to participate without pressure or coercion”.<sup>600</sup> [ELJ0002-00022\_6]
- 45.17.2. It also noted that “[i]t is a legal requirement to get written consent from a person to participate in a clinical trial of investigational medicinal products”.<sup>601</sup> [ELJ0002-00023\_13]

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<sup>598</sup> General Medical Council (2002: [20]).

<sup>599</sup> General Medical Council (2010b: [28]-[30]).

<sup>600</sup> General Medical Council (2010a: [1]).

<sup>601</sup> General Medical Council (2010b: 12).

- 45.18. The GMC also issued specific guidance on *Consent to Research* during this time period (2010, withdrawn 2024). In terms of information that patients should be given, it stated that:

“You must give people the information they want or need in order to decide whether to take part in research. How much information you share with them will depend on their individual circumstances. You must not make assumptions about the information a person might want or need, or their knowledge and understanding of the proposed research project.”<sup>602</sup> [ELJ0002-00022\_6] Patients should also be given further information if requested”.<sup>603</sup> [ELJ0002-00022\_6]

- 45.19. The current relevant guidance, *Good Research Practice* (2024) and *Good Decision-Making* (2020), continues the emphasis on obtaining consent,<sup>604</sup> [ELJ0002-00038\_9] and promotes a “person-centred, proportionate approach to providing information”.<sup>605</sup> [ELJ0002-00038\_10] The GMC also points to the Heath Research Authority (HRA) and Medical Research Council (MRC)’s online tool, which gives guidance on consent and the preparation of information for participants.<sup>606</sup> [ELJ0002-00143]; [ELJ0002-00045]; [ELJ0002-00046]

**(d) What obligation or responsibility does the clinician have to tell the patient that information about them is being provided to others for research or monitoring?**

- 45.20. Telling patients that their information will be shared for research, and with whom, is a core feature of obtaining informed consent (see also **13-20**).<sup>607</sup> [ELJ0002-00034\_8-9]
- 45.21. According to the guidance on *Consent to Research* (2010, withdrawn 2024), those with direct involvement in the patient’s care or in the research project may be given patient information *with their consent*:

“With the participant’s consent, you should usually inform their GP and other clinicians responsible for their care about their involvement in a research project, and you should provide the doctors with any other information necessary for the

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<sup>602</sup> General Medical Council (2010a: [4]).

<sup>603</sup> General Medical Council (2010a: [6]).

<sup>604</sup> General Medical Council (2024b: [35]).

<sup>605</sup> General Medical Council (2024b: [36]).

<sup>606</sup> UKRI, Medical Research Council, Heath Research Authority (2020). Other key resources include: Heath Research Authority (2008); Heath Research Authority (2019).

<sup>607</sup> General Medical Council (2020a: [10]-[13]).

participant's continuing care. You should follow this advice regardless of whether the participant is a patient or a healthy volunteer.

If a participant objects to information being shared in this way, you should explain to them the potential consequences of not sharing information. If the participant continues to object, you must respect their wishes, unless sharing the information is justified in the public interest".<sup>608</sup> [ELJ0002-00022\_7]

45.22. Sometimes it may not be practicable to obtain express consent, but patients should still be given information about who has access to their records, and the right to object. In the first edition of *Good Research Practice* (2002, withdrawn 2010), it was noted that:

45.22.1. "Where it is not practicable for the person who holds the records either to obtain express consent to disclosure, or to anonymise records, data may be disclosed for research, provided participants have been given information about access to their records, and about their right to object. Any objection must be respected. Usually such disclosures will be made to allow a person outside the research team to anonymise the records, or to identify participants who may be invited to participate in a study".<sup>609</sup> [ELJ0002-00020\_8]

45.22.2. The guidance went on to detail: "Where it is not practicable to contact participants to seek their consent to the anonymisation of data or use of identifiable data in research, this fact should be drawn to the attention of a research ethics committee so that it can consider whether the likely benefits of the research outweigh the loss of confidentiality to the patient. Disclosures may otherwise be improper, even if the recipients of the information are registered medical practitioners. The decision of a research ethics committee would be taken into account by a court if a claim for breach of confidentiality were made, but the court's judgement would be based on its own assessment of whether the public interest was served".<sup>610</sup> [ELJ0002-00023\_8]

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<sup>608</sup> General Medical Council (2010a: [12]-[13]).

<sup>609</sup> General Medical Council (2002: [32]).

<sup>610</sup> General Medical Council (2010b: [34]).

- 45.23. For more on this, please see the answer to **(e)** below **(45.24-45.30)**. It should be noted that on the matter of confidentiality, clinicians should follow relevant guidance on confidentiality, issued by the GMC since 1995.<sup>611</sup>

**(e) Are there any circumstances in which it would be ethical for a surgeon to enrol a patient in a research project, or make them an object of research or study, without the patient's knowledge or informed consent?**

- 45.24. In modern ethics, the default principle is that it is unethical to enrol a patient in research without their knowledge and informed consent. However, there are limited, exceptional circumstances where research without explicit consent may be permissible.

Emergency research

- 45.25. The position on emergency research, where an adult is not able to consent for themselves, differs in different countries.

45.25.1. Emergency research is allowed in Northern Ireland, England and Wales in certain situations:

- “Treatment needs to be given urgently;
- It is not reasonably practicable to seek advice from a consultee;
- The procedure is approved by a NHS Research Ethics Committee;<sup>612</sup> [ELJ0002-00152] and
- A consultee is consulted as soon as possible to seek advice on the participant's likely views and feelings”.<sup>613</sup> [ELJ0002-00152]

45.25.2. The position is different in Scotland:

- As the HRA notes: “the law does not provide any 'exemptions' or alternatives for the involvement of adults not able to consent for themselves in non-CTIMP research, even in emergency situations.

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<sup>611</sup> Previous guidance, from 1993 onward, existed on confidentiality, but this was specifically with regard to HIV/AIDs and communicable diseases.

<sup>612</sup> In Northern Ireland, the procedure should be approved by one of the UK Health Department's Research Ethics Committees. See: “Principle of consent: Emergency Research (Northern Ireland)” in UKRI, Medical Research Council, Heath Research Authority (2020).

<sup>613</sup> See: “Principle of consent: Emergency Research (England and Wales)” in UKRI, Medical Research Council, Heath Research Authority (2020).

Therefore, to include an adult not able to consent for themselves in emergency non-CTIMP research in Scotland, you must obtain consent before the adult can be involved in your study from [the] Welfare Attorney/Welfare guardian..[or the] Adults [sic] nearest relative”.<sup>614</sup> [ELJ0002-00152]

- This was also noted in the GMC’s *Consent to Research* (2010, withdrawn 2024) which stated that: “You may want to undertake urgent research into procedures or treatments used in emergencies when a person is unconscious or otherwise unable to make a decision. In an emergency situation it is not always possible to get consent to involve a person in research using the standard consent procedures. The Adults with Incapacity (Scotland) Act 2000 provides for emergency clinical trials of investigational medicinal products but not for other types of emergency research. If this situation arises you should seek legal advice on how to proceed”.<sup>615</sup> [ELJ0002-00022\_11]

45.26. Across the UK, the law allows adults not able to consent for themselves to be recruited into Clinical Trials of Investigational Medicinal Products (CTIMPs) without prior consent in emergency situations, under certain conditions.<sup>616</sup> [ELJ0002-00152] In Scotland, Northern Ireland, England and Wales, this type of treatment/research may be given in an emergency without consent if:

- “Treatment needs to be given urgently;
- It is also necessary to take urgent action to administer the drug ... for the purposes of the trial;
- It is not reasonably practicable to obtain consent from a legal representative;
- The procedure is approved by a NHS Research Ethics Committee;
- Consent is sought from a legal representative as soon as possible”.<sup>617</sup> [ELJ0002-00152]

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<sup>614</sup> See: “Principle of consent: Emergency Research (Scotland)” in UKRI, Medical Research Council, Heath Research Authority (2020).

<sup>615</sup> General Medical Council (2010a: [33-34]).

<sup>616</sup> See: “Principle of consent: Emergency Research (Scotland)” in UKRI, Medical Research Council, Heath Research Authority (2020).

<sup>617</sup> See: “Principle of consent: Emergency Research (Scotland)” in UKRI, Medical Research Council, Heath Research Authority (2020).

### Research involving de-identified data or samples

45.27. RECs may waive the requirement for informed consent for use of patient data under certain conditions, i.e., when the data has been anonymised and cannot be linked back to the patient. According to the Council for International Organizations of Medical Sciences (CIOMS) guidelines:

“A research ethics committee may approve a modification or waiver of informed consent to research i: if the research would not be feasible or practicable to carry out without the waiver or modification; if the research has important social value; and if the research poses no more than minimal risks to participants.... These three conditions must also be met even when a study involves identifiable data or biological specimens, meaning that the data or specimens carry a person’s name or are linked to a person by a code”.<sup>618</sup> [ELJ0002-00010]

45.28. In England and Wales, if a research project involves accessing confidential patient information without consent, researchers need to apply to the Confidentiality Advisory Group (CAG). In Scotland, approval for accessing, processing, or linking to NHS Scotland data is carried out by the Public Benefit and Privacy Panel (PBPP). As the HRA notes:

“Where confidential patient information has been anonymised so that it cannot be used to identify someone, it can be disclosed without a legal basis. This means that the information has been modified such that it cannot be used by the recipient to identify the patients or service users to which it relates (either directly or indirectly using separate information to which the recipient has access), and where appropriate safeguards that prevent the use of means reasonably likely to identify the natural person are in place. Data can be rendered anonymous in this context even if it retains a pseudonym”.<sup>619</sup> [ELJ0002-00040\_3]

### Public health

45.29. In general terms, exceptions exist to obtaining consent for using patient information where disclosure of information is in the public interest:<sup>620</sup> [ELJ0002-00030\_33-34]

45.29.1. “Personal information may be disclosed in the public interest, without the individual’s consent, where the benefits to an individual or to society

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<sup>618</sup> Council for International Organizations of Medical Sciences (2016: 37-38).

<sup>619</sup> See: Health Research Authority (2022).

<sup>620</sup> See General Medical Council (2017a: 34-36).

of the disclosure outweigh the public and the individual's interest in keeping the information confidential".<sup>621</sup> [ELJ0002-00020\_9]

- 45.29.2. "Even in these cases, clinicians must be satisfied of one of the following: the participant is not competent to give consent; it is not practicable to seek consent; participant has been asked but withheld consent".<sup>622</sup> [ELJ0002-00020\_9] This exception may only apply in limited circumstances in the present context. For example:

"Some epidemiology, health surveillance and monitoring is, for good reason, undertaken without research ethics committee approval. Data can be used in these cases where there is a statutory requirement to do so, for example where the data relates to a known or suspected 'notifiable' disease, or where there is a relevant order under the Health and Social Care Act 2001".<sup>623</sup> [ELJ0002-00020\_9]

- 45.30. Please also see the answer to **(d) (45.20-45.23)** above, regarding sharing of patient records.

## PART H

### CANDOUR

#### **46. From an ethical perspective, what role does openness and candour towards patients have in surgical decision-making and practice?**

- 46.1. Professional ethical guidance specifies the role of openness and candour in surgical decision-making and practice. However, the duty of candour is both a *professional* and a *statutory* (legal) obligation. In line with our brief, our primary focus here is on the professional duty, aspects of which have been discussed elsewhere (e.g., **7.16-7.19**). However, we begin with an outline of the statutory duty.

#### Statutory duty of candour

- 46.2. *Scope (jurisdiction)*: Different jurisdictions (legal systems) in the UK have different legislation on candour, although the duties they contain are broadly similar. A

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<sup>621</sup> General Medical Council (2002: [34]).

<sup>622</sup> See General Medical Council (2002: [38]).

<sup>623</sup> General Medical Council (2002: [35]).

statutory duty was introduced in England in 2014,<sup>624</sup> then in Scotland in 2018.<sup>625</sup>

The Care Quality Commission has produced guidance for organisations in England,<sup>626</sup> [ELJ0002-00007] while the Scottish Government has produced non-statutory guidance for organisations in Scotland, both of which were last updated in 2025.<sup>627</sup> [ELJ0002-00067]

- 46.3. *Threshold (harm)*: The statutory duty essentially focuses on errors, and specifically on errors of a particular magnitude. The duty is triggered when a safety incident has been caused through the provision of care, which has resulted (or has the potential to result) in *moderate harm, severe harm, or death*. The incident should be unintended or unexpected for the statutory duty to apply.
- 46.4. *Focus*: The statutory duty of candour is essentially an *organisational* duty, so the focus is on organisations. However, individual professionals – including surgeons – must discharge the duty on behalf of their organisations, so they are required to have a clear understanding of the difference between the professional and statutory duty.
- 46.5. *Discharging the duty*: When the harm threshold has been met (**46.3**), the organisation must:
  - 46.5.1. Be open and transparent with patients (including all aspects of the professional duty);
  - 46.5.2. Investigate the causes of the incident and share these with the patient;
  - 46.5.3. Provide a written and then verbal apology;
  - 46.5.4. Provide reasonable support to the patient; and
  - 46.5.5. Establish a formal and defined process of harm disclosure.

#### Professional duty of candour

- 46.6. Just as professional guidance on informed consent pre-dated the position adopted in law (see **13-20**), the professional duty of candour pre-dated the statutory duty. The RCS's 2015 guidance on candour refers to the professional duty existing in the

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<sup>624</sup> Health and Social Care Act 2008 (Regulated Activities), Regulations 2014, Regulation 20.

<sup>625</sup> Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016; Duty of Candour Procedure (Scotland) Regulations 2018.

<sup>626</sup> Care Quality Commission (2025).

<sup>627</sup> Scottish Government (2025).

2013 iteration of the GMC's *Good Medical Practice* and in the 2014 iteration of the RCS's own *Good Surgical Practice*.<sup>628</sup> [ELJ0002-00127]

*Professional duty for all doctors*

- 46.7. In addition to the principles set out in *Good Medical Practice*,<sup>629</sup> [ELJ0002-00037\_17, 23, 25] the GMC has issued specific guidance on the professional duty of candour, which first came into effect on 29 June 2015 (and was last updated on 13 December 2024).<sup>630</sup> [ELJ0002-00027] The guidance explicitly conveys that this is a duty with which doctors “must” comply.<sup>631</sup> [ELJ0002-00027\_5]
- 46.8. *Scope*: Although there are distinct legal duties in the different countries of the UK, the RCS makes explicit that the professional duty “is applicable across all UK nations”.<sup>632</sup> [ELJ0002-00127]
- 46.9. *Threshold (wrong)*: The professional duty essentially focuses on situations “when something goes wrong” with the treatment or care of a patient, which “causes, or has the potential to cause, harm or distress”.<sup>633</sup> [ELJ0002-00027]
- 46.10. *Focus*: As its name implies, the professional duty of candour is essentially a professional duty, so the focus is on professionals, including doctors.
- 46.11. *Discharging the duty*: When the threshold has been met (**46.9**), the professional must discharge duties to the patient (or, if appropriate, to those close to them) and to colleagues, employers, regulators, and other relevant organisations:
- 46.11.1. *Discharging the duty to patients*:<sup>634</sup> [ELJ0002-00027\_6-11] The professional must:
- Inform the patient when something has gone wrong;
  - Apologise to the patient;
  - Offer support or an appropriate remedy to the patient; and
  - Explain fully to the patient the short and long-term effects of what has happened.

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<sup>628</sup> Royal College of Surgeons of England (2015a: 3).

<sup>629</sup> General Medical Council (2024a: [45], [73], [76]).

<sup>630</sup> General Medical Council (2015a).

<sup>631</sup> E.g., General Medical Council (2015a: 3).

<sup>632</sup> Royal College of Surgeons of England (2015a: 7).

<sup>633</sup> General Medical Council (2015a: 3).

<sup>634</sup> General Medical Council (2015a: [7]-[22]).

46.11.2. *Discharging the duty to colleagues, employers, regulators, and other relevant organisations:*<sup>635</sup> [ELJ0002-00027\_11-13] The professional must:

- Be open and honest;
- Participate in reviews and investigations when requested;
- Raise concerns to the regulator where appropriate; and
- Support colleagues to be open and honest, including not preventing others from raising concerns.

### *Professional duty for surgeons*

46.12. In addition to the principles set out in *Good Surgical Practice*,<sup>636</sup> [ELJ0002-00128] the RCS issued specific guidance on the duty of candour in 2015.<sup>637</sup> [ELJ0002-00127] The RCS guidance refers to the general guidance to all doctors (**46.7-46.11**), then offers additional or expanded points, including guidance on:

- 46.12.1. The parallels between consent and candour, both of which depend on an ongoing clinical relationship, which involves a process of dialogue;<sup>638</sup> [ELJ0002-00127]
- 46.12.2. Disclosure processes for low-harm incidents (professional duty of candour) and notifiable safety incidents (statutory duty of candour);<sup>639</sup> [ELJ0002-00127]
- 46.12.3. Who should have the discussion with the patient, with reference to seniority, experience, expertise, and relationship with the patient;<sup>640</sup> [ELJ0002-00127]
- 46.12.4. Open communication, including sensitivity, compassion, clarity, accuracy, and respect;<sup>641</sup> [ELJ0002-00127] and
- 46.12.5. Documentation.<sup>642</sup> [ELJ0002-00127]

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<sup>635</sup> General Medical Council (2015a: [23]-[29]).

<sup>636</sup> Royal College of Surgeons of England (2025: 11).

<sup>637</sup> Royal College of Surgeons of England (2015a).

<sup>638</sup> Royal College of Surgeons of England (2015a: 5).

<sup>639</sup> Royal College of Surgeons of England (2015a: 8-9).

<sup>640</sup> Royal College of Surgeons of England (2015a: 10).

<sup>641</sup> Royal College of Surgeons of England (2015a: 12).

<sup>642</sup> Royal College of Surgeons of England (2015a: 13).

**47. Are there different considerations depending on whether any errors identified are by individual clinicians, by organisations or as a result of defective systems?**

47.1. Professional guidance appears not to distinguish between situations in which harm has resulted from the (in)activities of individual clinicians, organisations, or as a result of defective systems.

47.2. GMC guidance sets down *general* obligations to protect patients, raise concerns (see also **36-44**), and be open and honest about mistakes. However, GMC guidance does contain some specific references to harm or errors that are attributable to organisations and systems:

47.2.1. *Protecting patients: Good Medical Practice* states: “If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should first protect patients and put the matter right if that’s possible”.<sup>643</sup> [ELJ0002-00037\_24]

47.2.2. *Raising concerns*: GMC guidance on raising concerns states: “All medical professionals have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or the systems, policies and procedures in the organisations in which they work...”.<sup>644</sup> [ELJ0002-00024\_6] In terms of acting on a concern that has been raised, the guidance states: “Concerns about patient safety can come from a number of sources, such as patients’ complaints, colleagues’ concerns, critical incident reports and clinical audit. Concerns may be about inadequate premises, equipment, other resources, policies or systems, or the conduct, health or performance of staff or multidisciplinary teams. If you receive this information, you have a responsibility to act on it promptly and professionally. You can do this by putting the matter right (if that is possible), investigating and dealing with the concern locally, or referring serious or repeated incidents or complaints to senior management or the relevant regulatory authority”.<sup>645</sup> [ELJ0002-00024\_9]

47.2.3. *Being open and honest*: Guidance on the duty of candour includes guidance on saying sorry: “When apologising to patients and explaining

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<sup>643</sup> General Medical Council (2024a: [75b]).

<sup>644</sup> General Medical Council (2012a: [7]).

<sup>645</sup> General Medical Council (2012a: [20]).

what has happened, we do not expect you to take personal responsibility for something going wrong that was not your fault (such as system errors or a colleague's mistake). But the patient has the right to receive an apology from the most appropriate team member [...], regardless of who or what may be responsible for what has happened".<sup>646</sup> [ELJ0002-00027\_8]

- 47.3. Similar to the GMC, the RCS appears not to distinguish between situations in which harm has resulted from the (in)activities of individual clinicians, organisations, or as a result of defective systems. However, in its guidance on the duty of candour, the RCS includes some specific guidance for situations in which organisations or systems appear to have contributed to patient harm:

- 47.3.1. *Who should have the discussion with the patient:* The RCS states: "In cases where the harm occurred owing to the environment of care or organisational systems, a senior manager of the relevant service should be responsible for communicating with the patient and his or her supporters. The healthcare professional responsible for treating the person should also be present to assist in the initial discussion, and to provide clinical information around the likely effects on the patient and next steps in his or her treatment".<sup>647</sup> [ELJ0002-00127]
- 47.3.2. *When a safety incident has occurred:* The RCS sets down recommendations for employers and surgeons when a safety incident has occurred, which include: "In morbidity and mortality meetings, during case reviews and the assessment of safety incidents, all factors should be carefully considered, both surgeon-related and system-related. Jumping to critical conclusions about the performance of colleagues may lead to systems factors going unnoticed. Overlooking individual performance and focusing on systems factors alone is equally dangerous".<sup>648</sup> [ELJ0002-00127]
- 47.3.3. *Building a culture of learning, openness, and safety:* The RCS sets down recommendations for employers on building an open culture, which include: "Investigations should not focus exclusively on the last individual to provide care. Individual errors are often underpinned by

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<sup>646</sup> General Medical Council (2015a: [16]).

<sup>647</sup> Royal College of Surgeons of England (2015a: 10).

<sup>648</sup> Royal College of Surgeons of England (2015a: 14).

organisational factors. Therefore, such errors should be seen as a consequence of flaws in the healthcare systems, not just the individual, and any learning should consider the human factors in the context of team, organisation and system factors”.<sup>649</sup> [ELJ0002-00127]

**48. What role does openness and candour towards professional regulators/the health board or trust have in surgical practice? How far does it extend? How does it sit with the requirement of confidentiality?**

48.1. As noted above (46.11.2), the RCS makes explicit in its guidance on the duty of candour that a surgeon *must* be open and honest, and co-operate, with their employing organisation, their regulator, and other relevant organisations.

48.2. The GMC’s *Good Medical Practice* states the following:

“To help keep patients safe you must:

- a. contribute to confidential inquiries
- b. contribute to adverse event recognition
- c. report adverse incidents involving medical devices (including software, diagnostic tests, and digital tools) that put the safety of a patient or another person at risk, or have the potential to do so
- d. contribute to incident reviews and/or investigations
- e. report suspected adverse drug reactions
- f. respond to requests from organisations monitoring public health.

When providing information for these purposes you must follow our guidance on *Confidentiality: good practice in handling patient information*”.<sup>650</sup> [ELJ0002-00037\_23-24]

48.3. The GMC guidance on confidentiality, which came into effect on 25 April 2017 and was last updated on 13 December 2024, provides specific guidance on the professional duty of candour and confidentiality. This notes that:

- 48.3.1. If something has gone wrong and the patient has died or lost capacity, then “it may be appropriate to speak to those close to the patient. When providing information for these purposes, you should still respect the

<sup>649</sup> Royal College of Surgeons of England (2015a: 15).

<sup>650</sup> General Medical Council (2024a: [73]).

patient's confidentiality. If a patient has previously asked you not to share personal information about their condition or treatment with those close to them, you should abide by their wishes. You must still do your best to be considerate, sensitive and responsive to those close to the patient, giving them as much information as you can",<sup>651</sup> [ELJ0002-00030\_27]

48.3.2. There are various systems in the UK for reporting adverse incidents and near misses, alongside some organisational duties of candour, which have been written into law (see **46.2-46.5**). The GMC advises that:<sup>652</sup> [ELJ0002-00030\_27]

- If disclosure is legally required, then the doctor should disclose such information as is required, in the way that is required, and should generally inform the patient about such disclosures;<sup>653</sup> [ELJ0002-00030\_24-25]
- If disclosure is not legally required, then the doctor should seek consent to disclose personal information, unless this is inappropriate or impracticable (e.g., because the patient lacks capacity, or disclosure would put the doctor or others at risk of serious harm);<sup>654</sup> [ELJ0002-00030\_10]
- In exceptional circumstances, disclosure without consent may be justified in the public interest, "if the benefits to an individual or society outweigh both the public and the patient's interest in keeping the information confidential",<sup>655</sup> [ELJ0002-00030\_12] this includes disclosure "for important health and social care purposes".<sup>656</sup> [ELJ0002-00030\_28-29]

## PART I

## CONCLUSIONS

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<sup>651</sup> General Medical Council (2017a: [101]).

<sup>652</sup> General Medical Council (2017a: [102]).

<sup>653</sup> General Medical Council (2017a: [87]-[94]).

<sup>654</sup> General Medical Council (2017a: [14]).

<sup>655</sup> General Medical Council (2017a: [22]).

<sup>656</sup> General Medical Council (2017a: [106]-[112]).

**49. Please highlight any limitations on your ability to compile the report, based on the material provided or available to you, including (where relevant) materials relating to the matters you have been asked to address in your report which you would suggest that the Inquiry should recover to assist with its investigations.**

49.1. We believe that we have reasonably captured the general tenor of the academic and professional sources we identified.

49.2. However, our ability to compile the report has been constrained by:

49.2.1. The limited time available, including alongside our other commitments;

49.2.2. The considerable complexity of the regulatory landscape;

49.2.3. The significant volume of professional guidance that needed to be identified, located, read, summarised, and analysed; and

49.2.4. The difficulty in obtaining relevant historical iterations of professional guidance, especially sources that exist only in print and not online.

49.3. These constraints meant that:

49.3.1. We could not run time-consuming systematic searches, e.g., to identify further academic literature that addresses relevant theoretical ethical obligations;

49.3.2. We were limited to professional guidance we could identify online. This meant that, in some of our answers, we focused primarily on the current professional position.

49.4. Depending on the needs of the Inquiry, we are prepared to review and revise our answers, after we have been granted access to additional (older) materials.

**50. Please set out any other particular matters relating to the field of medical ethics arising from your consideration of the matters listed above which appear to you to be relevant to the Inquiry's Terms of Reference or List of Issues, which you think should be brought to the Inquiry's attention and/ or you think the Inquiry should investigate further.**

50.1. There are two matters which are potentially relevant to the Inquiry's work:

50.1.1. Surgical innovation (**50.2**);

50.1.2. Ethics committees in the Royal Colleges (**50.3-50.6**).

### Surgical innovation

- 50.2. As we discussed above (**45.1**), the distinction(s) between treatment, research, and innovation are not always clear. We invite the Inquiry to consider whether its focus is on “research” (as we have narrowly defined it at **45.1**), or the broader concept of “surgical innovation”. If the latter is in scope, then the Inquiry may wish to obtain further information (noting that we have expertise in this area).

### Ethics committees in the Royal Colleges

- 50.3. It may be relevant to note the different positions taken by the various Royal Colleges with regard to the existence and functions of an ethics committee.
- 50.4. The Academy of Medical Royal Colleges is the membership body for the 24 medical Royal Colleges and Faculties (hereafter Colleges) across the four nations of the UK.<sup>657</sup> [ELJ0002-00001] Its website provides links to 22 of the Colleges’ individual websites; the other two Colleges are the Faculty of Dental Surgery, which is included in the RCS website, and the Faculty of Dental Surgery of Edinburgh, which is included in the RCSEd website.
- 50.5. Judging by the information publicly available on their websites, 11/22 of the Colleges listed by the Academy of Medical Royal Colleges appear to have (or have had) an ethics committee (see **Table 6**). These ethics committees have various functions:
- 50.5.1. *Providing advice, guidance.* All the committees (bar that of the Royal College of Physicians of Ireland) provide advice and guidance to the organisation and/or its members on matters of ethics. Some additionally provide advice and guidance on legal matters (Royal College of Paediatrics and Child Health, College/Faculty of Intensive Care Medicine).
- 50.5.2. *Horizon scanning.* Some committees have a horizon scanning function, e.g., this is explicitly included in the remit of the ethics committee of the Royal College of Physicians. The ethics committee of the Royal College of Pathologists similarly has a role in alerting “the College to emerging issues on which an ethical view needs to be taken and to advise accordingly”.

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<sup>657</sup> The Academy of Medical Royal Colleges website variously refers to there being 23 or 24 royal colleges, and its list of Academy members only lists 22: Academy of Medical Royal Colleges (2026).

- 50.5.3. *Providing education.* Some committees play a role in education, e.g., members of the committee of the Royal College of Anaesthetists “support the College through speaking at events and providing educational resources on ethics-related issues”.
- 50.5.4. *Appraising research.* The Royal College of Physicians of Ireland differs from the other Colleges, as it has a dedicated Research Ethics Committee. (Some non-medical Colleges have made the same provision, e.g., the Royal College of Music and the Royal College of Art.)
- 50.6. Judging by the information publicly available on their websites, the remaining 11/22 of the Colleges listed by the Academy of Medical Royal Colleges do not appear to have an ethics committee. These include the RCS, the RCSEd, and the Royal College of Surgeons of Ireland, and the Royal College of Physicians and Surgeons of Glasgow.
- 51. Are there any other matters or areas which are covered by the Inquiry’s Terms of Reference or provisional List of Issues to which the area of medical ethics relates? Please explain how your area(s) of expertise cover(s) any such areas or issues.**
- 51.1. Nothing to add beyond the answer above (50).
- 52. Are there any other matters or areas which are covered by the Inquiry’s Terms of Reference or provisional List of Issues on which other areas of expertise would be able to provide relevant and helpful evidence? Please explain how any other area of expertise could assist the Inquiry and which issues evidence from any such field of expertise would be able to contribute to resolving (beyond those matters already raised with existing expert groups, as set out in the letters of instruction for the experts in neurosurgery and healthcare administration/ management, copies of which are attached to this letter)**
- 52.1. Nothing to add beyond the answer above (50).

**Table 6:** *Ethics committees in the Royal Colleges*

| <b>College</b>                                | <b>Committee</b>                         | <b>Advice,<br/>guidance</b> | <b>Horizon<br/>scan</b> | <b>Education</b> | <b>Research</b> |
|-----------------------------------------------|------------------------------------------|-----------------------------|-------------------------|------------------|-----------------|
| Royal College of Physicians                   | Committee on Ethical Issues in Medicine  | Yes                         | Yes                     | --               | --              |
| Royal College of Paediatrics and Child Health | Ethics & the Law Advisory Committee      | Yes                         | --                      | Yes              | --              |
| Royal College of Psychiatrists                | Professional Practice & Ethics Committee | Yes                         | --                      | --               | --              |
| Royal College of General Practitioners        | Medical Ethics Committee                 | Yes                         | --                      | --               | --              |
| Royal College of Anaesthetists                | Ethics Committee                         | Yes                         | --                      | Yes              | --              |
| Royal College of Pathologists                 | Ethics Committee                         | Yes                         | Yes                     | --               | --              |
| Royal College of Physicians of Ireland        | Research Ethics Committee                | --                          | --                      | --               | Yes             |
| College/Faculty of Intensive Care Medicine    | Legal and Ethical Policy Unit            | Yes                         | --                      | --               | --              |
| Faculty of Occupational Medicine              | Ethics Committee                         | Yes                         | --                      | --               | --              |
| Faculty of Pharmaceutical Medicine            | Ethics & Practice Committee              | Yes                         | --                      | --               | --              |
| Faculty of Public Health                      | Ethics Committee                         | Yes                         | --                      | --               | --              |

**STATEMENT OF TRUTH**

We confirm that we have made clear which facts and matters referred to in this report are within our own knowledge and which are not. Those that are within our own knowledge we confirm to be true.

We understand our duty to provide independent evidence and have complied with that duty in the provision of this report. The opinions we have expressed represent our true and complete professional opinions on the matters to which they refer

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PROFESSOR RICHARD HUXTABLE

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PROFESSOR ANGUS McNAIR

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.....  
DR CATRIONA McMILLAN

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