GMC: Consultation on proposed changes to *Good Medical Practice*

Part one: core questions

Four key themes

Theme one: Tackling discrimination and promoting fairness and inclusion

GMP has an important role to play in supporting medical professionals to take action against racism and other forms of discrimination in healthcare, such as in relation to disability, sex or sexual orientation. We're proposing to add the following new duties to emphasise the need to tackle discrimination, while promoting equality and inclusion in a positive way:

Paragraph 6: 'You must not abuse, discriminate against, bully, exploit, or harass anyone, or condone such behaviour by others.' This applies to all real life and online interactions, including on social media and networking sites.

Paragraph 7: 'You should take action, or support others to take action, if you witness or are made aware of bullying, harassment or unfair discrimination'. We've tried not to be prescriptive so that, for example, taking action could mean asking the person who experienced the discrimination if they're okay.

Paragraph 56: 'You should consider how your attitudes, values, beliefs, perceptions, and personal biases (which may be unconscious) may influence your interactions with others' (e.g., as potential contributors to health inequalities or barriers to accessing some treatments).

Paragraph 72: 'You must not demonstrate uninvited or unwelcome behaviour that can be reasonably interpreted as sexual and that offends, embarrasses, humiliates, intimidates or otherwise harms an individual or group.' This new duty goes beyond what is required by law and includes behaviours such as sexualised 'banter' that are damaging for individuals and teams and have a negative impact on patient care.

1. How far do you agree or disagree with these statements?

Answer each of the three statements below, using one of:

Strongly agree Agree Disagree Strongly disagree Don't know

a. The updated guidance sets the right expectations on discrimination, fairness and inclusion. Agree

b. The amended duties are clear. Disagree

c. The amended duties are realistic. Disagree

We'd welcome your comments on how you think these sections of the guidance could support you or if you can see any unintended consequences arising from them.

Para 6. We suggest that 'discriminate against' should come first in the list and 'abuse' come last. That would follow the general perception of increasing severity. As it stands, by starting the list with 'abuse,' discrimination is in danger of being overlooked.

Para 56. It is impossible to 'consider' one's own unconscious bias unless it is first brought to one's attention, through the observation of colleagues or patients' complaints. Regular appraisals should invite colleagues and patients to comment on these areas as a matter of course.

Theme two: Working in partnership with patients

We've had feedback that GMP doesn't go far enough to demonstrate the responsibility medical professionals have to help patients to make decisions for themselves. Research into patient experiences and expectations shows the continuing importance of medical professionals working in partnership with patients. This includes:

- patients being treated as individuals
- patients receiving enough information to make informed decisions about their care and in a way they can understand
- medical professionals managing conversations in a sensitive way.

We've brought some principles from our *Decision making and consent* guidance into GMP to give them more prominence and we're also proposing to make the following changes:

Paragraph 22: 'You must treat patients with kindness, courtesy and respect'. The new terms we've used focus on the qualities that underpin partnership working. We're particularly interested in views on the words 'kindness' and 'respect', as we've had mixed feedback about what these terms mean in practice and whether they might be open to culturally biased interpretation.

Paragraph 29: 'You must take all reasonable steps to meet patients' language and communication needs'. We propose to change this from a 'should' into a 'must' duty because communication is so fundamental to safe and effective care. We've included the word 'reasonable' to recognise there may be circumstances outside an individual's control which limit the steps that can be taken.

Paragraph 33: Information patients need to make decisions about their care includes 'clear, accurate and up-to-date information, based on the best available evidence, about the potential benefits and risks of harm of available options, including the option to take no action.' We have also added a requirement for medical professionals to be transparent about 'any potential or actual conflicts of interest that may influence the treatment and care options' they discuss with patients.

Paragraph 34: 'You should check [the patient's] understanding of the information they have been given, and make sure they have the time and support to make informed decisions if they are able to'.

2. How far do you agree or disagree with these statements?

Answer each of the three statements below, using one of:

Strongly agree Agree Disagree Strongly disagree Don't know

a. The amended duties give the right amount of attention to patients' rights, needs and expectations.
   Disagree
b. The amended duties are clear.
   Agree
c. The amended duties are realistic.
   Disagree

We'd welcome your comments on how you think these sections of the guidance could support you or if you can see any unintended consequences arising from them.

We feel the guidance leans too far in the direction of patient autonomy. Whilst we have no wish to return to the days of 'doctor knows best,' we are very much aware of how bewildering modern medicine can be for some patients. 'Just do what you think is best' is a commonly heard request. Very few patients want to be given total responsibility for decisions about their own care, though they do want to be informed and included in the process. It is not realistic to expect all patients to be able to grasp the intricacies of modern medicine or the nuanced weighing of potential benefits against potential risks. In our opinion, Para 33 tries too hard.

In addition, it is not always possible for medical professionals to identify their own bias (which may be unconscious).

We strongly support the use of the word 'kindness' (para 22). We believe kindness is something everyone understands, and something everyone looks for in healthcare professionals. It implies approachability, sensitivity, listening skills and patience – all seen to be as important as knowledge and efficiency.

'Respect' is more difficult to define and is a word that is perhaps changing its meaning in public use. Respect used to imply one's willingness to accept someone else's views even if they were not in agreement with one's own. Increasingly, the word is being weaponised such that if you don't agree with my opinion, you are failing to respect me.

Theme three: Working effectively with colleagues

A key theme emerging from our research and engagement was that a good workplace culture is the foundation for good healthcare. That starts with how medical professionals treat each other, and how teams work together in the interests of patients.

We're proposing to strengthen duties under this theme to highlight the importance of medical professionals working effectively with colleagues, in the interests of patients:

Paragraph 2: requires medical professionals to 'develop and maintain effective teamworking and interpersonal relationships. This includes recognising and showing respect for the roles and skills of the people you work with and listening to their contributions'.

Paragraph 3: 'You must communicate clearly, effectively and courteously with colleagues.' We want this to emphasise that clear and courteous communication in the workplace lies at the heart of good teamwork and builds the positive culture that is crucial to patient safety.

Paragraph 5: ‘You must be aware of how your attitudes and behaviours may influence or affect others. You should contribute to a positive teaching, training and working environment by role modelling supportive, inclusive and compassionate behaviour’.

Paragraph 8: ‘You must contribute to continuity and coordination of patient care’. This is in response to feedback about the importance of good communication between teams, particularly when supporting patients with complex care needs.

Paragraph 11: ‘When you delegate tasks or duties, you must be satisfied that the person you are delegating to has the appropriate qualifications, skills and experience to carry them out, and that they will be appropriately supervised and supported if necessary’. We haven’t added new duties for individuals with tasks delegated to them, as we think this is already covered elsewhere in GMP. We’ve also given specific advice on supervision for PAs and AAs on our ethical hub.

3. How far do you agree or disagree with these statements?

Answer each of the three statements below, using one of:

Strongly agree Agree Disagree Strongly disagree Don't know

a. The amended duties set the right expectations about working effectively with colleagues.
   Strongly agree
b. The amended duties are clear.
   Strongly agree
c. The amended duties realistic.
   Strongly agree

We’d welcome your comments on how you think these sections of the guidance could support you or if you can see any unintended consequences arising from them.

Theme four: Leadership

Our research, engagement and reviews of public inquiries have found recurring evidence of the need for medical professionals to use and develop their everyday leadership skills. These skills help to promote inclusive cultures and have a positive influence on safe patient care. We also heard that medical professionals don’t always recognise that behaviours and skills they demonstrate daily are examples of everyday leadership. We’re proposing to add the following new duties to support all medical professionals with everyday leadership skills:

Paragraph 20: ‘If you have a management role or responsibility you must encourage and support your colleagues to raise concerns and ensure that concerns are responded to appropriately in line with our *Raising concerns* guidance’. We have brought this duty in from our existing *Raising and acting on concerns* guidance. We’ve had feedback that the existing duty about raising concerns puts the burden in the wrong place if people in leadership roles don’t also take responsibility for listening up and following up.

Paragraph 57: ‘You must seek feedback and respond constructively to it, using it to improve your practice and performance’. This new duty supports self-awareness, which in turn should help with developing teamworking and leadership capabilities

Paragraph 62: 'You should develop leadership skills appropriate to your role, and work with others to make healthcare environments more supportive, inclusive and fair'.

4. How far do you agree or disagree with these statements?

Answer each of the three statements below, using one of:

Strongly agree Agree Disagree Strongly disagree Don't know

a. The amended duties will support me to shape inclusive cultures that deliver safe care.
   Agree
b. The amended duties are clear.
   Agree
c. The amended duties are realistic.
   Agree

We'd welcome your comments on how you think these sections of the guidance could support you or if you can see any unintended consequences arising from them.

We support the intention behind these proposals. But we note that 'leadership' comes to some much more naturally than it does to others. Granted that leadership skills can be learned, it is not helpful to suggest that seniority or responsibility necessarily implies complementary leadership aptitudes. Some are born with that aptitude; others must fight their temperament or personality to develop it. Perhaps a sentence within the text, recognising this, would be helpful.

Questions on other changes in GMP

Updating 'Duties of a doctor'

At the front of GMP is a section called 'The duties of a doctor registered with the GMC'. It summarises the core duties in each domain and is written as a set of statements which doctors must meet.

We're proposing to add 'I will' to the start of this section, as we've had feedback that this could give medical professionals more ownership of these behaviours. Here's the proposed new wording:

As a medical professional, I will:

- Make the care of patients my first concern.
- Work effectively with colleagues in ways that best serve the interests of patients.
- Act promptly if I think the safety, dignity or comfort of patients or colleagues are being compromised.
- Treat patients as individuals and respect their dignity and privacy.
- Listen to, support and work in partnership with patients, to help them to make informed decisions about their care.
- Provide a good standard of practice and care, and be honest and open when things go wrong.
- Work within my competence and keep my knowledge and skills up to date.
- Demonstrate leadership as appropriate to my role, and work with others to make healthcare more supportive, inclusive and fair.
- Protect and promote the health of patients and the public.

- Act with honesty and integrity.
- Never discriminate unfairly against patients or colleagues.
- Make sure my conduct justifies my patients' trust in me and the public's trust in my profession.

5. How far do you agree or disagree with the proposal to use 'I will' for this section?

Strongly agree

Agree

Disagree

Strongly disagree

Don't know X

Any comments about the statements in this section?

The aspirational statements in this section are, or course, commendable. The insertion of the words 'I will' are sure to remind many of their marriage vows and other binding commitments with legal implications. We are comfortable with the statements but concerned lest the addition of 'I will' could lead to a climate where the risk of legal action being taken against those who fail fully to live up to these ideals is increased.

Describing how we use the professional standards when considering a fitness to practise concern

We want to make sure medical professionals, patients, members of the public and others are clear about how GMP is used in our fitness to practise processes

The previous version of GMP says that 'only serious or persistent failure to follow this guidance will put your registration at risk'. In the updated version, we're proposing to include a clearer explanation of this. Here's the proposed new wording:

'Most medical professionals uphold high professional standards, but a small proportion fall seriously short. We will take action where there is a risk to patients or public confidence in medical professionals, or where it is necessary to maintain professional standards.

The professional standards describe good practice, not the thresholds at which medical professionals are safe to work. When assessing the overall risk to public protection posed by a medical professional, through our fitness to practise process we consider the extent of their failure to meet the professional standards, factors that increase and decrease the risk to public protection (including the context in which they were working), and how they responded to the concerns raised'.

We hope that this wording is clearer and more reassuring to medical professionals.

Any comments on how we use the professional standards when considering a fitness to practise concern?

Would it be helpful to explain other sanctions/support given to medical professionals in attempts to help them adjust and improve their practice, short of having their license to practise withdrawn?

Questions on implementing GMP

After launching the new version of GMP, we want to do more to help medical professionals apply it in practice. There are many influences on the everyday practice of medical professionals, and these can vary depending on their working environment. This includes how a service is organised, different workplace/multidisciplinary team cultures, access to training and availability of professional support. There are also a range of factors that can impact on the ability of medical professionals to work in line with GMC standards, such as local employer processes and contractual arrangements.

6. What factors in your working environment might make it difficult to put GMP into practice?

7. What factors in your working environment might make it easier for you to put GMP into practice?

8. What support or advice could we provide to help you put GMP into practice?

Questions on equality, diversity and inclusion

We've considered the range of ways the changes we're proposing could affect people who share protected characteristics. We also want to hear your views on any potential impact this guidance may have on people who share protected characteristics under the Equality Act 2010* (race, disability, age, sex, gender reassignment, sexual orientation, religion and belief, pregnancy and maternity and marriage and civil partnership), people from different socio-economic backgrounds, or medical professionals who gained their primary medical qualification outside the UK.

*For Northern Ireland, visit www.equalityni.org/Legislation

Any comments about ED&I?

BME doctors report a worse experience at work compared to white doctors. (https://www.england.nhs.uk/wp-content/uploads/2021/07/MWRES-DIGITAL-2020_FINAL.pdf)

This trend is seen across the whole career path from medical school to consultant level. Furthermore, even when BME doctors become consultants, they report greater levels of discrimination and harassment. Such widespread experience of unequal treatment suggests the need for cultural change within the NHS. GMP proposals helpfully draw attention to duties under the 2010 Equality Act but of themselves will do little to improve implementation. It is impossible to legislate, or impose guidance, against attitudes and (albeit unconscious) bias that support institutional racism. It has taken many years to change attitudes towards women in the profession, and many women would say that there is still further to go. This is a societal problem. Giving greater weight to E D & I in GMP is a small but helpful step in the right direction.

This is the end of part one, the core questions relevant to all medical professionals.

Would you like to answer the additional questions?

Yes X

No

PART TWO

The second part of this survey focuses on specialist topics and some specific issues.

You can answer as many questions in this section as you'd like. If you want to skip a question, just click on the 'next page' button at the bottom.

Technology and artificial intelligence (AI)

We're considering whether there's a need to include new guidance on technology and AI, given the speed of technological developments in healthcare and the need for GMP to be relevant for years to come.

We've expanded the definition of 'medical devices' in the existing duty about reporting adverse incidents (paragraph 17b). Medical devices now includes 'software, diagnostic tests and apps' in the definition to align with the definitions used by the Medicines and Healthcare products Regulatory Agency. But we're interested in your views on whether we should create any new duties on how medical professionals use technology and AI.

For example, if there is bias in the underlying data used by AI to make decisions about patient care, this could reinforce healthcare inequalities. So, we could warn medical professionals to be vigilant and exercise judgement when relying on such technology.

A. How far do you agree or disagree that GMP should include duties on using technology and AI?

Strongly agree X

Agree

Disagree

Strongly disagree

Don't know

Any comments on technology and AI?

It is a rapidly developing area and any guidance given now is going to need updating regularly. However, it is not too soon, in our opinion, to make a start.

Use of resources, population health and environmental sustainability

We're considering whether GMP should emphasise the risk to public health from climate change. We're also exploring whether we need to acknowledge the tensions that can arise between the needs and expectations of individual patients and the interests of the wider population. For example, medical professionals might need to:

- balance individual and population interests in relation to efficient use of available resources (e.g., avoiding medicines waste)
- consider the wider impact of healthcare activity on population health (e.g., antibiotic resistance) and on the environment (e.g., harm from single use plastics).

We're interested in your feedback on paragraph 65 of the updated guidance, which says that medical professionals 'must provide the best service possible within the resources available, taking account of [their] responsibilities to patients, the wider population, and global health.'

B. How far do you agree or disagree with including this statement in GMP?

Strongly agree

Agree

Disagree

Strongly disagree

Don't know X

Any comments on resources, population health and environmental sustainability?

We applaud this proposal in principle, but para 65 we think needs greater definition. For example, there is an argument for not providing further Covid vaccine top-ups in the UK until every person on the face of the globe has received their basic doses. With limited global resources, some practitioners might want to prioritise a more equitable distribution of the vaccines. Similarly, ensuring the provision of readily accessible clean water to all parts of the world would do more for health outcomes globally than any UK health measure. What are our responsibilities to global health as compared to the patient in front of us in our UK practice?

Conscientious objection

Paragraph 24: We've removed the requirement for medical professionals to explain to a patient if they have a conscientious objection to a particular treatment. This reflects feedback we've had about the impact it can have on patients to be told about the personal beliefs of the medical professional. So, we're proposing to change the guidance to allow medical professionals to use their discretion when deciding whether to tell the patient the reason they are unable to provide care themselves.

Any comments on conscientious objection?

We have no objection to the proposed change of wording. However, we are concerned that this change does not affect the current conscience provision in *'personal beliefs and medical practice'.*

Situations arise where the 'rights' of different parties are in competition. To take an obvious example, a woman's legal right to access abortion services and a doctor's right not to refer her for abortion on conscience grounds. We note the trend in healthcare provision in the UK towards preferring a patient's rights over a healthcare professional's conscience rights. In the above example, this would require the doctor directly to refer the patient seeking abortion, rather than her suffer any delay or inconvenience, even if she was deemed able to follow information provided to help her

access for herself the service she needs. The doctor would be required to suffer internal conflict, moral distress and possible moral injury over his or her sincerely held beliefs, in favour of meeting the patient's need as promptly as possible.

The BMA passed policy at its 2021 ARM which acknowledged that moral injury may result from inadequate conscience provision. Now that the language of moral injury is common in medical parlance, we think it is important that it be explicitly linked to situations where reasonable conscience provision is not made.

Please confirm that the proposed minor change in the wording of GMP will not lead to further erosion of the conscience provision in *Personal Beliefs and Medical Practice*.

Treating patients who pose risks

We're proposing to add the word 'unreasonably' to the paragraph that currently says that says medical professionals 'must not deny treatment to patients because their medical condition may put you at risk'. The current wording has been interpreted as meaning that medical professionals must provide care to patients without regard to the risks to themselves. So, we're proposing to change it to say:

Paragraph 44: 'You must not unreasonably deny a patient access to treatment or care that meets their needs. If a patient poses a risk to your own health and safety, or that of other patients or staff, you should take all available steps to minimise the risk before providing treatment or making alternative arrangements for treatment.

We've also widened the paragraph beyond the patient's medical condition so now it could include other threats to a medical professional's wellbeing, such as from:

- a patient threatening them
- a patient behaving in a discriminatory manner, such as refusing to be treated by a particular person because of their ethnicity.

We plan to publish supporting information and advice to expand on our expectations around this.

Any comments on treating patients who pose risks to medical professionals?

With reference to the example we used in the previous section, would it be seen as 'reasonable' or 'unreasonable' to deny direct referral for treatment or care that would harm the medical professional's own moral integrity, health and wellbeing? (Para 44)

Communicating as a professional

Paragraph 74: In response to feedback, we've clarified medical professionals' responsibilities when communicating publicly, especially on social media. GMP now says that:

'When communicating publicly as a medical professional you must:

- be honest and trustworthy
- make clear the limits of your knowledge
- make reasonable checks to make sure any information you give is not misleading

- declare any conflicts of interest
- maintain patient confidentiality.

This applies to all forms of written, spoken and digital communication'

Any comments on communicating as a professional?

'Reasonable checks' (bullet point 3) is an imprecise and elastic term. Perhaps 'exercise due diligence to ensure…' would be better in this context?

Conflicts of interest

Paragraph 81: We've clarified that conflicts of interest are not confined to financial interests and may include other personal or professional interests. We've also widened the current paragraph to include conflicts that may be seen to affect a medical professionals' practice. And we've added references to conflicts of interest at paragraphs 33 (patients' rights to be involved in decisions about their treatment and care) and 74 (communicating as a medical professional).

Any comments on conflicts of interest?

Conflicts of interest can include philosophical and ethical beliefs, whether acknowledged or not. In discussion of abortion, for instance, doctors who hold a conscientious objection, perhaps due to a religious belief, are often deemed to have a conflict of interest, whereas another doctor, who is strongly committed to a 'pro-choice' philosophy, may have just as strong a worldview commitment as their colleague who objects on conscience grounds. Yet the strongly 'pro-choice' doctor may not recognise their own tendency to overvalue the merits of an abortion, or downplay potential risks to the woman, because of their unacknowledged yet deeply held belief. This balance needs to be reflected in the guidance, if possible, as it is in 'Personal Beliefs and Medical Practice', para 3, which states 'all doctors have personal values that affect their day-to-day practice'.

Explanatory guidance

GMP is supported by a range of explanatory guidance to help medical professionals, patients and others understand how the high-level principles in GMP should be applied in practice.

The explanatory guidance doesn't create new principles of good practice, but instead expands on the duties in GMP. This might include advice about how to make decisions when different GMP principles point to potentially conflicting approaches.

We'll use the feedback from this consultation to help us update these pieces of guidance:

- Personal beliefs and medical practice
- Financial and commercial arrangements and conflicts of interest
- Doctors' use of social media
- Ending your professional relationship with a patient
- Intimate examinations and chaperones
- Maintaining a professional boundary between you and your patient
- Sexual behaviour and your duty to report colleagues
- Delegation and referral

- Acting as a witness in legal proceedings
- Writing references

We welcome your comments on these pieces of explanatory guidance, particularly:

- which topics we should prioritise for redrafting and why
- if there's a theme in a particular piece of guidance that needs more detail
- if there is anything we could add or remove

If you're suggesting any new topics, please say which paragraph of the draft GMP content it would be supporting (if known) and why it's needed.

Any comments on the explanatory guidance?

See our comments above (under Conscientious Objection) about Personal beliefs and medical practice, paras 8-13.

Also, in para 37c, may we suggest changing 'all possible steps' to 'all reasonable steps', which would remove the 'possible' step of euthanising the patient!

Questions on the consultation process

We'd value your feedback on how easy or difficult it was to respond to this survey. This information helps us continually improve our consultation process. When answering these questions, please think about the survey itself but also the supporting information which was available on our website.

9. How far do you agree or disagree with these statements?

Strongly agree	Agree	Disagree	Strongly disagree	Don't know

a. The proposals were well explained
   Agree
b. The survey was easy to complete
   Agree
c. I felt I was able to express my views
   Agree

Any comments about the consultation process?

10. How did you hear about this consultation? Please select all that apply.

GMC website

Another website

GMC news ebulletin

Other GMC newsletter/ebulletin

Joined GMC's community of interest for GMP

Social media X

GMC event, workshop or meeting

Non-GMC event

Media/newspaper/radio

Word of mouth

Search engine

Other (please say what):

About you

Your personal information

We will process your data in line with the General Data Protection Regulation. Our privacy and cookies policies explain how your data will be used, how cookies will be set and how to control or delete them.

At the end of the consultation process, we will publish reports explaining our findings and conclusions. We won't include any personally identifiable information in these reports but may include illustrative quotes from consultation responses. We may also provide responses to third parties for quality assurance or to approved research projects, which are anonymised before disclosure where possible.

Freedom of information

Your response to this consultation may be subject to disclosure under the Freedom of Information Act 2000, which allows public access to information we hold. This doesn't necessarily mean your response will be made available to the public, as there are exemptions relating to information given in confidence and information to which the General Data Protection Regulation applies.

Would you like your response to be treated as confidential?

Yes

No X

If yes, please also tell us why:

We would be very grateful if you could give us some information about you to help us analyse the responses to this survey.

First name Rick

Last name Thomas

Email address Rick.Thomas@cmf.org.uk

Responding as an individual

11. Which of these categories best describes you? Please only select one. N/A

Doctor (if you select this, please answer the next two questions, otherwise go to 'age')

Anaesthesia associate

Physician associate

Medical student

Anaesthesia associate student

Physician associate student

Other healthcare profession

Other (please say what): Retired medical doctor; Researcher with Christian Medical Fellowship

12. Which of these categories best describes you? Please only select one

GP

Consultant

Doctor in training

Staff and Associate Grade

Locum (GP)

Locum (secondary care)

Trainer/medical educationalist

Responsible Officer/Medical Director

Other leadership or management role

Academic researcher X

Practising outside the UK

GMC/MPTS Associate

Retired

Other clinical practice (e.g. prison health service). Please say what:

Other non-clinical practice. Please say what:

13. Where were you awarded your PMQ?

UK X

European Economic Area (EEA)

Rest of the world

Demographic questions

In this section we ask for information about your background. We use this information to help make sure we are consulting as widely as possible. Specifically, we use this information when we analyse responses to make sure we understand the impact of our proposals on diverse groups. Although we will use this information in the analysis of the consultation response, it will not be linked to your response in the reporting process.

14. What is your age?

0–18

19–24

25–34

35–44

45–54

55–64

65+ X

Prefer not to say.

15. What is your sex?

Female

Male X

Prefer not to say

16. Is the gender you identify with the same as your sex registered at birth?

Yes X

No

Prefer not to say

17. If you selected 'no' to the last question, how would you prefer to self describe your gender?

18. Do you have a disability?

The Equality Act 2010* defines a person as disabled if they have a physical or mental impairment, which has a substantial and long term (i.e. has lasted or is expected to last at least 12 months) and adverse effect on the person's ability to carry out normal day to day activities.

*For Northern Ireland, visit www.equalityni.org/Legislation

Yes

No X

Prefer not to say

19. What is your ethnic group? (Please tick one)

White

English, Welsh, Scottish, Northern Irish or British X

Irish

Gypsy or Irish traveller

Roma

Mixed or multiple ethnic group

White and black Caribbean

White and black African

White and Asian

Asian or Asian British

Indian

Pakistani

Bangladeshi

Chinese

Black, African, Caribbean or black British

Caribbean

African

Other ethnic group

Arab

Prefer not to say

Prefer not to say

Any other ethnic group not mentioned above

Any other ethnic group not mentioned above

20. What is your religion?

No religion

Buddhist

Christian – Baptist

Christian – Brethren

Christian – Catholic

Christian – Church of England

Christian – Church of Ireland

Christian – Church of Scotland

Christian – Free Presbyterian

Christian – Methodist

Christian – Other

Christian – Presbyterian

Christian – Protestant X

Christian – Pentecostal

Hindu

Jewish

Muslim

Sikh

Prefer not to say

Other (please say what):

May we politely suggest that the current options are imbalanced? The multiplicity of options for Christian denominations is unnecessary, as the difference between a Baptist and a Brethren Christian may be minimal in this situation. On the other hand, a Sunni or Shia Muslim may have very different views, and an Orthodox or Liberal Jew also. We suggest that the GMC revises its scale of religious options to be more reflective of the reality of the UK today. We would be very happy to contribute to such a discussion.

21. Which of these options best describes your sexual orientation?

Bisexual

Heterosexual or straight X

Gay man

Gay woman/lesbian

Prefer not to say

Other (please say what):

22. What is your country of residence?

England X

Northern Ireland

Scotland

Wales

Other (European Economic Area)

Other (rest of the world).

If you selected ‘other, EEA’ or ‘other, rest of the world’, please say where: