



## **GMC – Follow up qualitative research to the 2010 Guidance Survey**

### **Research Report (FINAL)**

**9<sup>th</sup> June 2011**



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# 1. Executive Summary

## 1.1 Introduction, objectives and methodology

The General Medical Council (GMC) registers and licenses doctors to practise medicine in the UK. The GMC has a power to 'provide in such a manner as the Council thinks fit', advice for members of the medical profession on standards of professional conduct; standards of professional performance; or medical ethics'.

To fulfil this role, the GMC publishes guidance which sets out the ethical principles that underpin good practice. *Good Medical Practice*<sup>1</sup> (2006) is its core guidance. *Good Medical Practice (GMP)* is supported by a range of more detailed guidance booklets which sets out the standards of conduct and care which society and the profession expect of all doctors throughout their careers. The guidance applies to all registered doctors, whether or not they hold a licence to practise and regardless of their specialty, grade or area of work (i.e. NHS or independent practice).

In March 2010, the GMC received the findings of an online survey of doctors asking about their awareness and views of GMC guidance, and their preferences for accessing learning materials. They then commissioned a follow up piece of qualitative work in order to supplement the findings of the initial survey.

The specific focus of research was as follows:

- Understanding the level of familiarity with the guidance, including perceptions of the relationship between the core and supplementary guidance
- Exploring the use of learning materials
- Understanding preferences in terms of format
- Exploring triggers and barriers to the use of GMC guidance and learning materials
- Exploring the response to possible changes in format.

A random sample of doctors registered on the GMC database was sent an email invitation to attend a group discussion. Those who opted in completed a short online survey to provide some personal details in order to allow for a mix of participants to be selected. An incentive of £75 of vouchers or a charity donation was provided. Group discussions, each lasting ninety minutes, were conducted in London, Manchester and Edinburgh. A total of 22 doctors participated in the research.

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<sup>1</sup> *Good Medical Practice* (2006) is available on the GMC website along with the other supporting guidance documents on the 'Guidance on good practice' pages: <http://www.gmc-uk.org/guidance/index.asp>

## **1.2 Key findings and recommendations**

Key findings and recommendations have been grouped into the following five themes:

### ***1.2.1 Convincing doctors that the GMC and its guidance is for them as doctors and individuals***

As was the case in the quantitative Guidance Survey<sup>2</sup>, the vast majority of participants were familiar with GMP and most could recall at least one instance in their careers when they had used the guidance, with most usage relating to training, job interviews and appraisals.

Participants did not tend to use the guidance in relation to their own clinical practice, preferring to use other sources in the first instance. Typically in the event of a clinical query or issue, most would refer to colleagues, their own organisations' HR or legal departments and / or their medical defence organisation.

However, it was apparent that some doctors had negative perceptions of the GMC and this perception of the organisation as a whole was deterring participants from greater levels of engagement with the guidance materials. There was a call for the organisation to be 'humanised' and to more effectively demonstrate that it is there to support good medical practice as well as having a more punitive role.

It was also felt that the guidance itself was not sufficiently targeted and that the content could be made more relevant to them as individuals through more explicit linkage with Royal Colleges or Societies or through the personalisation of content on the website (so that relevant case studies or other information come up once a doctor signs in). Some were discouraged from using the learning materials because they were perceived as being too simplistic or patronising and suggested that the tone and style should be reviewed. Others felt that the case studies were not for them as they focus on situations relevant to GPs rather than those working in secondary care.

### ***1.2.2 Improving the promotion and accessibility of the guidance***

A commonly cited barrier to using the GMC guidance was a general lack of time and a lack of awareness of the scope of its coverage.

Suggested changes to the guidance content and structure to help overcome these barriers included integrating the case studies into the guidance to illustrate

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<sup>2</sup> GMC Guidance Survey: Online survey of 997 doctors December 2009, Ipsos Mori

key points and ensure it is more compelling, ensuring that it is written as concisely as possible and providing more bite-sized pieces of information (for example, emails with information on specific cases and links to the relevant guidance).

The website was criticised by some, with a number of problems experienced with navigation (particularly finding relevant interactive case studies and the search function). Further research on perceptions of the website could be conducted to explore these issues further.

Other suggestions to improve the user-friendliness of the guidance include better promotion of the help-line and the production of online frequently asked questions and a framework of guidance i.e. how the core and supplementary guidance relate to each other.

### ***1.2.3 Encouraging usage by persuading doctors there is something in it for them***

Some felt that it was not necessary for them to review the guidance. A number of reasons were given for this including assuming that the content is known because they have read other sources or that they have read the guidance in the past. It was clear that participants felt that they would need a trigger to review the guidance and the best way to encourage them to proactively read the guidance was to persuade them that it would be of some benefit to them.

Some felt that doctors would be spurred to review the guidance if doing so was linked to their Continuous Professional Development and if the process was certificated. They also felt that the usefulness of the guidance in particular contexts (appraisals or job interviews) could be better promoted, in addition to dissemination of the key message that doctors need to know the content in order to provide good medical care and, more compellingly, to avoid others' mistakes.

### ***1.2.4 Managing expectations***

Some participants were negative about the content of the guidance because they had not been provided with a definitive answer in the past. Others were unclear about the role of the GMC and why they were spending resources on the development of learning materials and a mobile website. Recommendations, therefore, include better management of expectations of the role of both the guidance and the GMC.

### ***1.2.5 Reviewing the automatic provision of hard copy guidance***

In terms of format, most participants indicated that they had (or would if necessary) use online formats rather than the hard copy. Few participants (who tended to be older) indicated that they preferred hard copy.

A general consensus was that hard copies should not be sent out routinely to everyone but should be available on request. A caveat was that, if this were to happen, communication needs to be improved to ensure that all doctors are aware of the guidance.

## 2. Introduction, Objectives and Methodology

### 2.1 Introduction

The General Medical Council (GMC) registers and licenses doctors to practise medicine in the UK. Its purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

The GMC has four main functions under the *Medical Act 1983*:

- keeping up-to-date registers of qualified doctors
- fostering good medical practice
- promoting high standards of medical education and training
- dealing firmly and fairly with doctors whose fitness to practise is in doubt.

The GMC has a power to 'provide in such a manner as the Council thinks fit', advice for members of the medical profession on standards of professional conduct; standards of professional performance; or medical ethics'.

To fulfil this role, GMC publishes guidance which sets out the ethical principles that underpin good practice. [\*Good Medical Practice\*](#)<sup>3</sup> (2006) is its core guidance to the profession which sets out the standards of conduct and care which society and the profession expect of all doctors throughout their careers. The guidance applies to all registered doctors, whether or not they hold a license to practise and regardless of their specialty, grade or area of work (i.e. NHS or independent practice).

*Good Medical Practice* is supported by a range of more detailed guidance booklets which explain the ethical considerations in key areas including *Confidentiality* (2009) and *Consent: patients and doctors making decisions together* (2008). Shorter statements about how the high level principles in guidance apply in situations that doctors may find challenging to address are also published, for example advice on '*Raising concerns about patient safety*'. The GMC has also published learning materials which show how its guidance applies in a range of scenarios which doctors and the public often ask about or find difficult to fit to statements of general principle.

In March 2010, the GMC received the findings of an online survey of doctors asking for their awareness and views of GMC guidance, and their preferences for accessing learning materials.

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<sup>3</sup> *Good Medical Practice* (2006) is available on the GMC website along with the other supporting guidance documents on the 'Guidance on good practice' pages: <http://www.gmc-uk.org/guidance/index.asp>

While the overall results of the survey were very positive, the GMC felt that there was scope for improvement in how the guidance is promoted to doctors and that they should take account of their preferences for accessing and using guidance and learning materials to facilitate the understanding and application of ethical obligations in day-to-day practice. Further qualitative research was, therefore, commissioned.

## **2.2 Objectives**

The specific objectives of the qualitative research were to better understand the following:

- What are the barriers to doctors accessing GMC's guidance (both online and in hardcopy)?
- What level of knowledge or understanding do doctors have of GMC's guidance? What does 'being familiar' with the guidance mean?
- What understanding, if any, do doctors have of the relationship between the core and supplementary guidance documents?
- When and why do doctors use case studies and other learning materials (GMC and more generally)?
- What resources (e.g. colleagues, phone advice, written, web-based) do doctors use when they have an 'ethical' problem at work?
- What would help doctors access them more readily?

An additional requirement of the research was to engage with doctors who do not normally engage with the GMC in any of its functions.

## **2.3 Methodology**

A random sample of doctors registered on the GMC database were sent an email invitation to attend a group discussion in one of three locations. In total 1,178 doctors were invited to participate (428 in London, 450 in Manchester and 300 in Edinburgh). Three waves of recruitment were conducted in order to achieve the required number of participants. Fewer invitations were sent to doctors based in Scotland because of a better initial response than for the other two locations. A copy of the text of the invitation is provided in Appendix C.

Those who opted into the research completed a short online survey to provide some personal details in order to allow for a mix of participants to be selected. An incentive of £75 of vouchers or a charity donation was provided.

The Manchester and Edinburgh groups were slightly oversubscribed so a small number of doctors who had expressed an interest in attending the groups were



asked to stand down. The size of the groups was limited to ensure that all the participants who did attend were able to give their views effectively.

Three ninety-minute focus groups were conducted with doctors in May 2011 as follows:

Date	Location	Number of attendees
3 <sup>rd</sup> May 2011	London	6
9 <sup>th</sup> May 2011	Manchester	8
11 <sup>th</sup> May 2011	Edinburgh	8

Each group comprised a mix of participants by key demographics. More detail on the profile of participants is provided in Appendix A. None of the participants currently work as a GMC Associate (ie Fitness to Practise panellist, Education Visitor, PLAB examiner).

Groups followed a semi-structured guide in order to allow participants to elaborate on and discuss their views and perceptions freely. Hypothetical scenarios were used to prompt discussion about the usage of different sources of guidance and advice in various situations. The focus groups were facilitated by Community Research, an independent research organisation. No-one from the GMC attended the groups to ensure that participants did not feel constrained in what they said. The groups were audio recorded and transcribed. The detailed discussion guide and the scenarios used are provided at Appendix B.

***Note on reading the report:***

It should be borne in mind that a key research objective was to obtain the views primarily of those who have had little previous contact with the GMC. This report is, therefore, reflective of this group of doctors only and clearly those doctors who are more engaged with the organisation are likely to be more familiar with the guidance, use it more regularly and in different ways.

### 3. Key Findings

#### 3.1 Current levels of awareness and familiarity

##### 3.1.1 Good Medical Practice (GMP)

All participants were aware of the GMP (although some had been prompted by their attendance of the group discussion to review what guidance materials were produced by the GMC). This finding mirrors those of the quantitative research conducted in December 2009. In a survey of just under 1,000 doctors, 90% recognised GMP as being the current guidance issued by the GMC that they should follow throughout their working lives.<sup>4</sup>

It was generally felt that the GMC fulfilled a necessary function by providing overarching, supra-collegiate guidance and there was a need for the provision of a 'gold' standard:

*"I think its got to exist because the standards have to be defined somewhere... because essentially what the GMC are about is striking us off when we get it wrong, setting standards and then checking we meet them. So if we're going to be held accountable against a set of standards they need to be written down somewhere, they can't just say you need to be a good doctor."*  
(London group)

*"The GMC, at the end of the day we have to follow GMC guidance. Okay, everybody else might be producing stuff but how consistent is it with this? In the translation process there may have been some miscommunication. This is the absolute standard you'd be judged by."* (Manchester group)

*"So if we take something like treatment towards the end of your life, its quite helpful to have something that isn't produced by the Palliative Care docs or the Oncology docs or the GPs, all of whom will come at this with quite a different stance but is something that we're all signed up to the same package. So maybe that's where their role comes in, stuff that by its nature requires to be above the level of speciality, that is another level of sort of healthcare."*  
(London group)

Most participants indicated that they considered themselves broadly familiar with themes covered in the GMP but did not have a detailed knowledge of its contents

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<sup>4</sup> GMC Guidance Survey: Online survey of 997 doctors December 2009, Ipsos Mori

as it was not something that they referred to regularly. One commented that it was important to know it was there rather than needing to 'commit it to memory'.

*"Your point about sometimes bringing it up to the surface again, when you're busy and doing your day to day job you can sometimes lose sight of the more basic things of what we're really trying to do here and I think having a core group of booklets actually does serve some purpose there in actually reminding you what's underpinning all of this. It's not something you refer to on a daily basis." (Edinburgh group)*

*"For myself I would say the sort of different books you get from the GMC, they sort of merge into one quite a lot and I wouldn't particularly be able to tell you what's in Good Medical Practice opposed to the other books. I wouldn't be able to isolate which one is which but I have a vague knowledge of all them as guidelines in the back of my head." (Edinburgh group)*

Three participants (one at each of the groups) described themselves as being very familiar with the contents of the GMP:

- One was a member of a Federation representing a specific group of doctors and was concerned about a recent change to the content of the GMP and so was very knowledgeable about its coverage.
- Another with a high level of familiarity was the Clinical Director of a PCT who commented that he used the guidance in this capacity but not in his practice as a GP Specialty Registrar. He also commented that the GPs that he came into contact with in his Director role were not familiar with the guidance.
- Finally, one Edinburgh participant who sat on an Ethics Committee was very familiar with the guidance.

### ***3.1.2 Other core guidance***

The participants generally had lower awareness of the content of the other core guidance booklets than the GMP (as was also the case in the quantitative online survey where 53% indicated that they were familiar with GMP and some of the supporting guidance booklets<sup>5</sup>). They were not very aware of the relationship between the GMP and the supplementary guidance, although they made the assumption that the other core guidance gave more detail to specific aspects of the GMP. This suggests that the broad structure of the guidance makes intuitive sense.

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<sup>5</sup> GMC Guidance Survey: Online survey of 997 doctors December 2009, Ipsos Mori

Some assumed that the core guidance was relevant to all but that the supplementary guidance was more specific:

*“If you're not a Paediatrician then you wouldn't read the guidance for children, for example.” (London group)*

Generally participants were most familiar with the core guidance on confidentiality and consent (subjects also most associated with GMC, as being areas that they would be likely to advise on).

One participant who is a Paediatric Endocrinologist in a children's hospital was surprised by the coverage of the guidance and was not aware of the guidance on caring for 0 – 18 year olds.

One participant remembered looking at the guidance relating to End of Life which came out in 2010 because of some controversy relating to the content on nutrition and hydration.

### ***3.1.3 Learning materials***

Familiarity with the learning materials was lower than for GMC guidance.

Only one participant in London was familiar with the learning materials, having read some of the case studies in the bulletin and used the interactive case studies when teaching. Several of the younger participants in Manchester had looked at the learning materials whilst training. One of the participants in Edinburgh had viewed some of the online case studies.

The lack of awareness was illustrated by participants suggesting that the GMC should produce case studies as a way of bringing their guidance to life.

## **3.2 Use of GMC guidance**

### ***3.2.1 Triggers for looking at GMC guidance***

The main triggers for seeking out GMC guidance were as follows:

- Specific events related to their own personal development, for example whilst training or preparation for a job interview or an appraisal
  - This was also a trigger identified in the quantitative survey, with 24% of doctors indicating that they had last referred to GMC guidance when preparing for a job interview<sup>6</sup>

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<sup>6</sup> GMC Guidance Survey: Online survey of 997 doctors December 2009, Ipsos Mori

- Specific events related to others' personal development, for example training or appraising
- Writing or updating standards documents for their own organisation
- Sitting on an ethics committee
- Checking if they have acted in the spirit of the guidance after a specific event
- Dealing with disciplinary cases within their own organisation
- At start of career in this country (either when initially training in the UK or if international medical graduates coming to work in the UK).

*"I remember receiving those and trying to read it...because I changed countries at some stage, I was quite interested in the difference, yes." (Manchester group)*

Few participants had looked at the guidance in a clinical capacity with only a handful of instances recalled. These instances tended to relate to confidentiality issues. Even those few participants who were very familiar with the guidance and who used it extensively in other situations, tended not to use it in relation to their own clinical practice. Only the doctor who sat on the Ethics Committee in Scotland mentioned referring to the GMC as a first port of call.

It was striking that when initially asked, participants tended to indicate that they had not looked at the guidance and then, as the discussion progressed, remembered instances when they had, in fact, reviewed it. Most of the participants had used the guidance in some capacity in the past (although for some this was very limited). Those few participants who had not used the guidance had a reason for not doing so, for example one had only just started practising in the UK. This mirrors the findings of the quantitative survey which found that the majority of doctors who are familiar with the guidance (95%) had referred to the guidance at some point during their medical careers.

### ***3.2.2 Specific examples of use of GMC guidance***

A number of instances of using GMC guidance were recalled which are summarised below.

#### ***Medical school and training***

- Referring to the guidance whilst at medical school:  
*"I remember as a medical student, think there's twelve items and we had to write a whole summary on each outcome and to provide evidence for a final year viva." (Edinburgh group)*
- One consultant who taught at a **medical school** had used the guidance when updating key documents:

*"I must confess that I don't use it in my clinical work but it's very useful from a medical school perspective...we incorporate quite a lot of information from this in their documents, in our medical student documents. For example, the Student Charter that was written in 2006, so I've just been reviewing that for our medical school and I was looking for Good Medical Practice because that was written in 2006 and it's not as up to date as the information you're looking at [the Duties of a doctor booklet]." (Manchester group)*

- One doctor had used the interactive case studies in her **training of other staff:**

*"I teach quite a lot of medical students and it is a fantastic resource because it's the gold standard in terms of... particularly for the grey issues, you could say this is what the GMC say and the argument stops at what it says. You could use it quite well for teaching either medical students or GP Registrars and specialist trainees who often are coming to these issues in real life now and going "ooh, what do we do?" (London group)*

### **Appraisals and job interviews**

- Several participants had used the material in their preparation to **conduct appraisals**, using the GMP as a guide to structure the session:

*"The only time I've ever looked at the guidance is when completing an appraisal as an appraiser because it tells you what you're supposed to do." (London group)*

- Several participants had used the guidance when getting ready for their **own appraisal or for a job interview**
  - It was mentioned that one of the questions in the GP appraisal in Scotland is 'have you read the GMP this year?'
- One doctor had used the guidance in his capacity as a member of an **Ethics Committee:**

*"I read it all the time because the question of Good Medical Practice, Confidentiality and Consent always comes as a subject in the Ethics Committee. It's very important for me that I keep up to*

*date with it...I normally take a copy with me and if there is a query I will talk to the lay members because the Ethics Committee consists of doctors and lay people and I explain to them what it means." (Edinburgh group)*

### **Consent and confidentiality**

- A doctor checked the guidance relating to **consent** after a patient refused treatment:

*"I have been in a situation where you're trying to give treatment like to a confused person on the ward who tried to walk off and you call Security. You often have to deal with a situation in moments and you still don't know whether you dealt with it well. I remember once going onto the GMC website to clarify whether or not it was professional and what we did was correct, though intrinsically as a team we felt we did." (Manchester group)*
- Several participants had used the guidance to try to clarify specific issues relating to **confidentiality**
  - One doctor (a specialist in forensic examination of victims of sexual assault) had used the guidance to inform her actions relating to a difficult case of a rape victim who was held at gunpoint.
  - Another doctor had had referred to the guidance on what to do about a patient who was threatening to push someone in front of a tube train.
  - Another was asked by the police for confidential information from a patient's records:

*"I had a situation where the police came to my practice and he asked me to give confidential information from the patient's records because this patient was a criminal and he was on the run. Now, at that particular point in time I was not confident whether to give the information or not so I asked the police and they said can you come back later, I had to get some advice, you see. So the immediate thing that I did at that point was to look at the GMC website and phone my Medical Director and both of them gave me the same advice that, in the public interests, in order to protect the practice then you can break the confidential events. Because this person was a danger to the public, he could go out and kill other people." (Edinburgh group)*

### *Other specific issues*

- One GP referred to the GMC guidance when they wanted clarification of what they could say when they wanted to **advertise to the public** to increase their list size.
- One doctor had referred to the guidance to establish best practice when **offered a gift** by a patient.
- One doctor dealt with a patient's death during a weekend on call and after the event checked the guidance relating to **End of Life care**:  
*"I was interested to see what was written about CPR and about involving patients and their families in decisions and actually having that generic review was quite useful in that instance...What I found quite helpful is they make a lot of references as well which I hadn't appreciated so they have a lot of links to quite useful sounding documents as well which I haven't yet explored. They...make clear what the differences are in England and Scotland. (Edinburgh group)"*

### *3.2.3 Use of other information sources*

In spite of most participants having used GMC guidance in some capacity in their career, it was not the first port of call for the majority. The use of other information sources was widespread, with the medical defence organisations top of mind and dominating discussions.

#### *For a specific query*

Most participants indicated that they would try internal sources in the first instance and mentioned discussing issues with colleagues. This was particularly so for more junior participants who would refer to senior colleagues. The legal or HR department in their own organisation was also mentioned as a first port of call.

*"So each Trust will have their own intranet, is that the first port of call?"*

*Yeah, because that's what you need to be using, in whatever hospital, clinic you're working in. It doesn't matter what the GMC says, it matters what the local people say." (Edinburgh group)*

If they were in a situation where they required advice on ethical issues that could have legal implications then they would contact a medical defence organisation in order to ensure that they are covered.



*"Whereas the BMA who I use for legal stuff or MDS for medical stuff or sort of legal stuff, again, I feel like they're on my side rather than trying to get me." (London group)*

*"There's also the fact that if I get this wrong, if I screw up and do the wrong thing, it's going to be my defence organisation that are backing me or not and so I want their backing before this whole thing starts and I want them to advise me where to go because its going to be their solicitor that's looking after me if I make the wrong call." (London group)*

The rapid response at any time outside of the standard working week was also mentioned as a positive in relation to medical defence unions.

*"If you phone the Defence Union on a Sunday night, if you want to speak to another doctor and he'll tell you don't do this or do that and you know that he will then back you if you do what he advised." (Edinburgh group)*

Few participants were aware that the GMC has a helpline number that they could call regarding specific enquiries.

### ***General information / updates***

For more general information or updates a range of sources were mentioned:

- Respective Royal Colleges or Societies

*"Most of that is for us as GPs, they take the GMC rules and interpret them for your particular speciality. So I find it useful to look at RCGP guidelines..." (Edinburgh group)*

- BMA (and BMJ)
- Pulse
- Doctors.net

Medical defence organisations were also mentioned in this context as providing useful training workshops:

*"MPS came down of their own accord and provided a free session, they gave us lots of different scenarios and made it relevant and then we had to offer them different scenarios that we'd come up with over our, how ever many, years of experience. The engagement was a lot better and they still provided some literature, the literature was, again, based around different case*

*examples so you could always apply information and made us actually refer back to the GMC guidelines, but they did it in a way that was more interesting.” (Manchester group)*

### **3.2.4 Barriers to use of GMC guidance and learning materials**

The quantitative survey<sup>7</sup> found that, of those who had referred to the GMC guidance, 89% said that they found the guidance helpful, with over a third saying that they found the guidance very helpful. As outlined in Section 3.2.1, participants in the group discussions found the guidance helpful in a number of contexts (including personal development and as a learning resource) but less helpful generally in a clinical context. They identified a number of barriers to using the guidance more which can be grouped into a number of key themes as follows:

- A general lack of time.
- Lack of awareness of the scope.
- A perception that it is not necessary (belief that they know the content because have read other sources or that they have read the guidance in the past).
- Negative perceptions of the GMC (deterring participants from engaging with the organisation or using the materials).
- Negative perceptions of the guidance itself (resulting from a lack of a definitive response when used previously, perception that the guidance is not for them or written in the wrong tone / style).

These points are discussed in further detail below.

#### ***Practical issues***

Many participants mentioned the volume of information that they receive and need to look at as part of their everyday job. They felt that it was difficult to read and keep abreast of everything that is produced by the raft of organisations that they are in contact with.

*“I think part of the problem is that there’s a phenomenal amount of information we’re meant to absorb as General Practitioners, Specialists, whatever it is and the problem is trying to differentiate what you really should read versus what you can do if you have time and this is just part and parcel of that. Sometimes it’s missed but it’s really quite overwhelming the amount of stuff we’re meant to read and keep up to date with.” (London group)*

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<sup>7</sup> GMC Guidance Survey: Online survey of 997 doctors December 2009, Ipsos Mori

The majority of participants were not aware of some of the guidance and felt that communication could be improved. This was particularly the case with awareness of learning materials, with some calling for more case studies (not realising that they are already produced).

For many, using GMC guidance is not top of mind and they automatically go to other sources.

*"It just seems to be so many levels between us and GMC. So you've got your local intranet site... then you've got your colleagues you can talk to and then your own college, MDU, MPS, whatever it is. GMC just seems to be a long way down the line." (Edinburgh group)*

### ***Not necessary***

There was a strong belief by some that they did not need to review the guidance because either they have read information produced by other sources or because they have read the GMC guidance in the past:

- For example, one of the younger participants who had recently qualified commented that he had read the GMP whilst at medical school but not since as he assumed it had not changed:

*"I think during Medical School you're given one set of this, I think which was a bit different from this one, and I've read through that extensively because we were preparing for finals and exams and everything. But when I got this through the post I looked at it and thought it's under kind of the same sub headings so I kind of assumed it must be similar stuff so I've not read it yet." (Manchester group)*

- There was a prevalent presumption that other sources of information would be based on the GMC guidance (but be tailored to their specialty) so that it was not necessary to go to the original source:

*"It sounds like a number of people here, if you work in several hospitals, Institutions, NHS areas each one has a local guidance which is based upon all the GMC books and so you don't read the GMC version you read the local version which is inherently part of GMC." (Edinburgh group)*

## *Negative perceptions of GMC*

- Many participants indicated that they would not naturally refer to the GMC in the first instance, actively avoiding any contact with it as an organisation and instead going to organisations which they view as being more supportive:

*"I think, to me anyway, they seem a bit Big Brother ish and that if you do something wrong then they'll come knocking. But if you're ever in doubt or need help you tend to go to anyone apart from the GMC, you don't tell them if you've got a problem with a patient."* (Edinburgh group)

*"[Participant 1] I don't think I've ever met anyone from the GMC. That sounds really bad, doesn't it? You've always met people from the MDS, MDU, whoever else so you kind of have a feel but the GMC – behind masks, you don't know who they are.*

*[Participant 2] They send me these documents but apart from sending out documents who are they? They reprimand those who are in trouble and I have no interaction with them.*

*[Participant 3] You don't really want to hear from them, if you hear from them it's something bad usually and you're like okay, I'll just stay out of it."* (Manchester group)

*"I think that's it, I've always felt the GMC are a quite distant body. I'd only associate it with negative things, like you would not want to get a phone call from the GMC; do you know what I mean? I've never had any positive dealings with them whereas with every other organisation you've had positive dealings they want to help you, they want to give you advice, whatever, and I think that also might come across in the booklets."* (Manchester group)

The negative perceptions were influenced by the following:

- A lack of trust in the fitness to practise processes and some questioning of the experience of some of the advisers, with several mentioning that they had received contradictory advice when contacting the GMC with a specific query:

*"My experience with calling the GMC about confidentiality is one day you talk to one person they give you one answer, the following day you ask the same question to another person who gives you another answer."* (London group)

- A perception that doctors do not receive much in return for their registration and retention fees
- A general feeling that the organisation is distant, lacks a 'human face' and is 'on the side' of the public rather than doctors
- Confusion over the role of the GMC, with some expectation that the GMC should behave more like a membership organisation rather than a punitive regulator

### ***Negative perceptions of the guidance and learning materials***

- There was a perception by a few participants who had had specific queries that the GMC guidance was not helpful, as it had not given them a clear definitive answer to a specific question. This unmet expectation was mentioned by three participants (two who had had queries relating to confidentiality and one relating to doctors accepting gifts from patients):

*"I just feel that like at times when I have once or twice referred to them but it wasn't 100% clear, like what you're looking for you couldn't get the answer out of the guidance necessarily. Like, for example, if a patient gave you a gift, I remember reading the guidance and it was a bit wishy washy and I was like can I take this or can I not, is there a value, what do I do? I know you're not going to accept something that's really expensive but if somebody came to you with a, I don't know, fifty pound value gift, is that too much? Do you know what I mean? (Manchester group)*

*"Once I had a case of a phone call, a lady had been sexually assaulted at gun point so my question was can we... we do forensic examination on an anonymous basis, okay, but could I guarantee the anonymity to the person, to the victim, because there was a gun involved....So I contacted GMC for that and MPS and the Legal Department and all that...They came up with different answers...At the end they said its your choice actually to keep confidentiality or not..." (London group)*

*"I remember when I was doing my finals I was trying to look up some ethics on confidentiality and I think in the book they only told you the absolute basics and the things that you really want to know you're not getting it, you know, the really difficult confidentiality or ethical issues bit, you're actually not finding the answers in there so I just kind of looked elsewhere really and spoke to colleagues." (Manchester group)*

- A belief that the guidance is too generic (albeit in the absence of knowledge about the existence of case studies which show how the broad principles can be applied in particular situations) or not relevant to day to day clinical practice:

*"I have to say the cases are useful because the sort of things that happen in the cases are the sort of things you get asked at interviews and they ask you to learn things like GMC guidance. So it's useful to have them but I think in the real clinical world they're not going to be that useful." (Edinburgh group)*

- A perception that the guidance is written in a dry, longwinded and not particularly engaging way

*"I tried to read them, they're not really interesting to be honest and I really much more enjoy reading these GMC regular newspapers" (Manchester group)*

- Some saw the guidance as being patronising:

*"The two issues I have right from cover to cover is good medical practice and confidentiality, I can comment on those, the others ones... well, consent I've done. What irritated me a little bit, very often it was repetitive, I think I have read this before but we are now on page so and so and I found, but this is my personal view, it's a little bit patronising." (Manchester group)*

- The learning materials were seen as being focussed around situations applicable to GPs and not relevant to other specialties. Some also felt that the style, tone and content could be improved citing the following:
  - Avoid the use of old-fashioned language, for example the use of a patient '*falling into bad company*' mentioned in one of the summaries of the case studies. Although this appeared to be one isolated example, participants felt strongly that it sent the wrong message and would deter them from spending time reviewing the case studies.
  - Some of the hypothetical situations used were seen as being simplistic and, therefore, patronising.
  - There was a concern about how some of the issues were presented and the portrayal of how the situation was resolved perpetuating negative impressions of the GMC being punitive rather than supportive:

*“There was a case study. It was something about a GP or a doctor who’s been drinking or something’s going on and you’re not quite sure whether they’re safe to continue and you have to stop them in the middle of the practice and take them out. It’s like we would stop them at the end. It was a bit nasty the way it was done.”*  
(Manchester group)

- The use of inappropriate design with the participants at the Edinburgh group particularly critical of the design of the waiting room in the interactive case studies:  
*“That is too cartoonish, I couldn’t take that seriously....Oh, that is awful, that is really bad actually. I’m not doing that...It’s insulting.”*  
(Edinburgh group)

### **3.2.5 Use of GMC guidance by format**

In terms of format, most indicated that they had (or would if necessary) use online formats rather than the hard copy. Online formats were preferred for a number of reasons including:

- being able to search for specific content more easily
- being confident that the information is the most up-to-date version
- the information seeming more manageable in that it is broken up into shorter sections online rather than booklets with lots of text.

Few participants (who tended to be older) indicated that they preferred hard copy (also reflecting the findings of the quantitative Guidance Survey<sup>8</sup>).

*“I would want a paper copy, I have to say, when I was writing amendments to the documents last weekend it was very helpful having the hard copy while I’m writing it rather than keep going into the website or the pdf file”* (Manchester group)

However, some indicated that they preferred hard copy because of their negative impressions of the website and the fact that they had previously experienced difficulties with navigating the site.

Whilst there was a general feeling that the hard copy would stay on the shelf and not be referred to, several participants made a point of taking hard copies away after the group.

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<sup>8</sup> Ipsos Mori Guidance Survey 2009: 48% of those aged 56-65 and 55% of those aged over 65 preferred hard copy compared with 39% of the total

A general consensus was that hard copies should not be sent out routinely to everyone but should be available on request. This would have the dual advantages of saving money and also driving more people onto the website.

- One slight issue raised with this, however, was that sending out hard copies was a good way of raising awareness of the guidance and a move away from this practice would need to be in tandem with improved communication by other means.

The use of vignettes was generally welcomed (by those who were aware of this) in that it brought the guidance to life and illustrated the scope of the guidance effectively.

- The inclusion of a number of case studies towards the end of the hard copy bulletin in particular was seen as a good way of providing the information in a way which did not overwhelm in terms of detail

*"I think where people might get into trouble with the GMC is where you didn't realise there was an issue and the vignettes give you just an idea of the scope of the guidance so you might not think that you need research. You know, people always get into trouble with research because they didn't get proper Ethics Committee approval or whatever, that sort of thing, or whether there was a consent issue with a child. But it reminds you...and then your light comes on and you think 'aha, this is something I must check'."*  
(London group)

### **3.2.6 Use and perceptions of the website**

Although most participants indicated that they would prefer the use of online formats in future, the website was not frequently or widely used to view guidance currently. Some participants mentioned that they mainly used it to check whether someone was registered (although others were unaware that this was a possibility).

When given the opportunity at the group to view or search the site, there were mixed views on its accessibility and appearance. Some participants were broadly happy whilst others were extremely critical. It should be noted that there was limited time in the group to review the website as this was not the primary objective of the research but some information has been provided below on participants' impressions.

One participant felt that the site had been improved recently with the addition of more case studies:

*"I went to the GMC website the other night...and it looked like they'd kind of changed it and made it a bit more user friendly."*



*Actually, I think they did have a couple of case studies to illustrate something, I can't exactly remember what it was, but I remember thinking it looks like they've made the website a little bit more helpful, as in putting examples of actual cases of consent and confidentiality. Where that makes it much more real to clinicians, if you can look at real examples and as a guideline it makes it much more helpful." (Edinburgh group)*

Another participant at the Edinburgh group used the GMC website all the time and felt that there were no problems with accessibility, using his mobile to access information.

*"Suppose I want some information about consent because that comes up every time in the Ethical Committee. So if I look at the consent guidelines on the GMC website then at the bottom it says you can email to a friend. Now, I will email that to my Google account and then I will synchronise my mobile with my Google account so I can read that guidance. That's my way of doing it." (Edinburgh group)*

However, several participants indicated spontaneously that they had not been able to find relevant case studies when searching previously and issues relating to difficulties searching the site were raised at the groups:

- One doctor indicated that she tended to do a 'google-type' search to find what she wanted on the GMC site rather than going onto the site in the first instance
- Others pointed out that the search function on the site was not that useful (following surfing the site during the groups). They had typed in '*patient gift*' as a specific issue that they wanted advice on and nothing relevant came up.

Other issues relating to the site included:

- Interactive case studies on a specific subject were not easy to find as they were felt to be poorly labelled (parts 1 – 5 do not mean anything and there is no list of exactly what scenarios are included within each)

*"It sounds like they group them together as and when they've done them so that everyone will release this as a new bulletin. It should be based around specific topics because, if you want to look for a specific piece of information, will it be in Part 1, Part 2? They could have a list of topics..." (Manchester group)*

- Some participants were under the mistaken impression and guidance was only available in html rather than pdf and they saw this as a barrier to using it.
- A perception that there is too much information on the site and it is difficult to find. The site was described as being 'jumbled' at one of the groups:

*"...immediately you just think information overload, I cannot take this, I'll have to get the information in another format. If you compare it to say the Royal college of Psychiatrist's website, for example...it's fairly user friendly, it's easy to see the information you want to get. So the GMC website you're likely just to go back to Google to find some other way of getting information"*  
(Edinburgh group)

*"In one corner you're seeing some case of a doctor up in Court, in another corner there making reference to new guidance on this and in another corner it's about something else and you just look at it and say 'what am I looking for again, I can't even remember now because I've been bombarded by all these different things."*  
(Edinburgh group)

A perception that the GMC website (rather than the guidance section specifically) is not balanced in that it presents just negative things about doctors:

*"If you go on the GMC website it exposes you to lots of negative things about doctors rather than positive things. So you feel that you just don't want to hear that."* (Edinburgh group)

*"It's definitely more for the public, isn't it? If you look at all the tabs, they've got one. 'Concerns for Doctors – how to make a complaint'.....there's none that says for doctors how to, I don't know, contact the GMC for support or something. (Manchester group)*

### **3.2.7 Perceptions of the design of the hard copy booklets**

The design of the hard copy booklets was well received generally although there was some criticism of the front cover of the 0 – 18 guidance which some felt was aimed at the public rather than them:

*"I appreciated that it might be sort of a childish, maybe it's part of a competition [for children] to design a really good doctor, but I*

*was looking at two listening devices, eye to eye contact, flexi legs, it didn't really enthuse me" (Manchester group)*

### **3.3 Suggested improvements**

#### ***3.3.1 Spontaneous suggestions***

Participants were asked for their spontaneous suggestions on how the GMC could improve communication about or access to the guidance and associated resources.

#### ***Encourage doctors to engage with the GMC***

Several participants noted that their attendance at the discussion group had made them feel differently (and more positively) about the GMC as it was the first time that they had had any meaningful contact with them other than administrative.

Key suggestions focused around 'humanising' the organisation so that doctors would be more willing to engage with them, log onto the site and access the guidance and learning materials, for example:

- Running roadshows and other face-to-face activities
- Giving talks at medical schools (outside of inspection visits)
- Providing more information on proceedings to remove the 'mystery'
- Providing more information on what support the GMC gives to doctors who go through a fitness to practise process
- More promotion of situations when doctors are absolved
- Presenting a more positive face of doctors (for example, establishing a system of awards for achievement).

*"If GMC was to come and have a road show in Edinburgh, Manchester, Birmingham, London and invite two hundred doctors and tell them about Good Medical Practice, appraisal and revalidation, what we are supposed to do, what we are not supposed to do, I think that will register more in our mind that reading a book." (Edinburgh group)*

#### ***Increased personalisation of the website***

It was suggested that the website could be more personalised so that relevant case studies or other information would come up once a doctor signs in.

- The creation of online communities was also suggested as a way of encouraging doctors onto the site.

*"Imagine if you had like every doctor had an account where if they searched for a particular topic it brought up case studies, it brought up like interactive examples, it brought up maybe that particular topic, a forum where you can discuss with other people and then you could save it. So you can build up a library of different rules and regulations, things that actually were relevant to you in your practice and then every time you log on you'd be able to refer to one of these particular areas and maybe discuss with other people." (Manchester group)*

*"You've got to think as well that, if you log onto the GMC website, can you do that, can you type in your number and then it says 'you're an Orthopaedic trainee, these are the things that apply to you'....Doesn't doctors.net do that, whatever your profile says you have these educational things that you do and you get points, a sort of reward system where you get website points." (Edinburgh group)*

### ***Encouraging / mandating doctors to review the guidance:***

Participants at all of the groups suggested a more explicit link to the guidance at appraisal and linking the guidance to continuous professional development (CPD) credits:

- Ensuring that the GMP follows the same structure as the appraisal system to ensure that it can be mapped across effectively. It was felt that it used to do this but recent changes have meant that it is more difficult to read across the two:

*"GPs have appraisals and certainly where I work it's more rigid than that but it's definitely linked to this. But GPs are not necessarily aware that it's linked to that subconsciously. But it would be helpful, because it's going to become electronic in the future, the Encarta GP website, that actually at the start they say are you aware of these guidelines and then there's a link saying tick here to see the guidelines before you even start. And I think that will inspire people" (Manchester group)*

- Linking completion of the interactive case studies to CPD through the development of a certification process ie the doctor receives a certificate for completing a module of online training (with the case studies being packaged up into a module). It was mentioned that BMA and doctors.net both do this already.

*"I think one way to get people going into this is a portfolio credit or something like that, it makes that connection because I'm filling out boxes and talking about these sorts of things does actually fill the boxes but having it like endorsed by the GMC that I've got four credits in this." (Manchester group)*

*"One of the chapters that we have to do for our appraisal folder is probity and that's where almost all of this stuff sits, and we all go "oh, I don't know what to put in my Probity section" because you don't really want to have issues of probity but you want to show that you're, you know, and this would fantastic. If they said 'here's a certificate saying you've done the confidentially module on the GMC website, you can put that in your Probity folder, the Probity section in your appraisal folder.'" (London group)*

- Some broached the idea of mandating doctors to review the guidance or complete training programmes using the case studies:

*"I'm not saying that you should force somebody to be this in a dogmatic way but you want them to learn, you want them to maintain being good doctors then provide it in an interesting way and ensure that they've done that as a requirement for them to get their revalidation and their registration. (Manchester group)*

### **Changing content**

Suggestions included:

- Greater use of case studies as these focus the mind and are easier to digest than the guidance itself:

*"It's scary but you read it and you think okay, I'll never forget....a kid with abdominal pain, always rule out appendicitis, you never forget that. And a ten year wasn't told when he had some lesion excised that he could be left with a scar and when he's a grown up adult he develops a cavoid as well as some sensory problem and it sticks in your mind that even ten year old, you should be informing them consent. So it brings it to light, it brings the concept to life" (Manchester group)*

- Integrating the case studies into the core guidance in order to better illustrate the points and bring it to life.
- Ensuring that all the guidance is as concise as possible.

## *Collaboration with other organisations*

Suggestions included:

- Liaising with others providing guidance on similar subjects (Royal Colleges and others) to ensure that the guidance is standardised where possible
  - There was some acknowledgement that this has happened recently with training materials.
- The GMC working with the Royal Colleges and others to provide case studies that are relevant and realistic

*“What I would find really helpful is some kind of a book on GMC guidance specifically for psychiatrists with a couple of useful cases that you might think, ‘oh right, if I was in that situation what would I have done’ and they might show me an example of where it wasn’t ideal and they could illustrate the points, why that would be useful.” (Edinburgh group)*

## *Promotion of the guidance*

Suggestions included:

- Explain what guidance is available and how it inter-relates ie what is in the confidentiality supplementary guidance which is missing from the core guidance:

*“That framework needs to be provided, we’re not even aware of all the guidance that is available. Okay, what does the confidentiality one have and what’s the supplementary one, what are the key aspects that that has that are not in the main document. We need to have two or three bullet points, don’t we, on what we need so if necessary we can go in and read the details.” (Manchester group)*

- Send a regular ‘friendly’ email with brief information on recent interesting cases or giving information on the number of cases related to a specific issue and that they needed to be aware of the relevant guidance:

*“I think just send major cases, recent cases and saying exactly where that question was in breach of these guidelines, you can see it in paragraph 3, whatever.” (Manchester group)*

- Promote the guidance and resources more to doctors at Medical School as this is a time when they could be more receptive to this type of information
- More promotion of the learning materials to those who are responsible for teaching
- Online links to the GMC website from other trusted sources of information, for example Pulse for GPs
- Communication of the helpline number given low levels of awareness
- Tailor communication options i.e. allow doctors to select if they want to be contacted by post or email

### ***3.3.2 Response to prompted improvements***

A number of suggestions were provided by the GMC in order to test doctors' response, including the provision of the following:

- Online or printed versions of the following: case studies, answers to a list of common enquiries, presentations with discussion notes
- Articles in E-Bulletin
- More innovative means of sharing or disseminating information through podcasts, webinars and a mobile version of the GMC website.

Responses were fairly similar to those in the quantitative survey<sup>9</sup> where the most popular learning materials were a series of online case studies and the publication of a list of answers to common queries.

There was a consensus that the idea of producing a **list of answers to common questions** (referred to by participants as FAQs) was a very good idea and there was an immediate positive response to this. The response to the suggestion of **producing presentations with discussion notes** was more muted but seen by some as being of potential benefit when teaching.

*“Downloadable presentations have the advantage particularly for use either in training, whether that's medical students, doctors in training or we all have practice meetings sort of periodically and it wouldn't be beyond comprehension that we might have one once a year that said right, okay, we're going to discuss probity issues and a downloadable thing that you could then discuss like a ready made teaching session.” (London group)*

The idea of producing more **case studies or articles** in the E-Bulletin was welcomed generally. Participants generally felt that few doctors would have the

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<sup>9</sup> GMC Guidance Survey: Online survey of 997 doctors December 2009, Ipsos Mori

time or inclination to look at **podcasts or participate in webinars**. Lack of easy internet access for some clinicians was mentioned as a barrier in Edinburgh.

*"With regard to things like podcasts and things like that, I would probably say that's probably not a great thing to do because generally I wouldn't look at these kind at work and I can't imagine very often sitting at home and doing that kind of thing in my spare time. And things like podcasts wouldn't work on the average NHS computer, it has to be simple stuff because generally computers, certainly wherever I've worked, don't tend to cope with videos or streaming files..." (Edinburgh group)*

There was a somewhat mixed response to the development of a **mobile version of the GMC website**. A minority view at each of the groups was that technology is moving on and that as it is becoming more usual for information to be accessed in this way, the GMC needs to ensure that their website is future proofed. One doctor was under the impression that the BMA is developing this functionality at the moment.

*"If they said we're releasing some kind of mobile site where two touches of a phone screen and you're into your guidance for a certain scenario, it would be difficult to beat because no-one else does it at the moment." (Edinburgh group)*

Some also felt that it could be seen as a positive and presented as a way of the GMC investing in technology for the benefit of doctors. It was also felt by one doctor in London that it could be appropriate to develop this functionality to encourage public access to the website (but others felt that they did not want doctors' subscriptions to pay for something that would only be of benefit to the wider public).

However, the majority were not convinced that this was a good use of resources:

- As they did not tend to look at the website regularly, they did not feel it important to have a mobile application.
- Some felt that the website would need to be improved before this would be useful.
- It was also pointed out that the vast majority of doctors have easy access to computers (particularly GPs who are sat in front of a screen for most of the day) and that they, therefore, would not need to access to information on a handheld device.



## 4. Conclusions and Recommendations

The overarching objective of this programme of qualitative research was to supplement the findings of the quantitative online survey conducted in 2010 and better understand how, why and in what circumstances and formats the GMC guidance is used. A key requirement was to explore any barriers to using the guidance and to understand what would help doctors access it more readily.

As in the quantitative survey, most doctors were aware of the guidance and had some familiarity with the GMP. Other core guidance was less well known, with the guidance on confidentiality and consent most associated with the GMC. Most participants were not particularly confident about the relationship between the GMP and the other core guidance and were not aware of some of the specifics, e.g. that some of the other core guidance has its own supplementary guidance. However, when asked, doctors intuitively felt that the supplementary guidance would expand upon the high level principles in GMP. There was an overall lack of awareness of the learning materials, with a number of participants at each of the groups suggesting that the GMC should produce case studies to help bring the guidance to life (not realising that this was already available).

Most of the participants could recall at least one instance during their careers that they had used the guidance. It was striking that some indicated at the start of the discussion that they had not used the guidance and then, prompted by discussion, recalled a number of times that they had, in fact, used the resources.

It was also notable that most instances of use of GMC guidance were related to training, appraisals or preparation for job interviews. Participants did not tend to use the guidance in relation to clinical practice. The small number of participants who had been prompted to review the guidance because of a specific clinical issue, tended to do so after the event to check that they had operated within the guidelines.

A raft of other sources of information and guidance were mentioned, with the medical defence unions being top of mind for many. It was apparent that the GMC was not a natural first port of call for most participants although a few participants were aware that the information from other sources was, in fact, based upon GMC guidance.

Although it was generally felt that the GMC fulfilled a necessary function by providing overarching, supra-collegiate guidance and there was a need for the provision of a 'gold' standard, participants identified a number of barriers to using the GMC guidance at all or more frequently. These have been grouped into the following themes:

- A general lack of time.
- Lack of awareness of the scope.
- A perception that it is not necessary (belief that they know the content because have read other sources or that they have read the guidance in the past).
- Negative perceptions of the GMC (detering participants from engaging with the organisation or using the materials).
- Negative perceptions of the guidance itself (caused by a lack of a definitive response when used previously, perception that the guidance is not for them or written in the wrong tone / style).

Positively, participants were also able to identify a number of possible ways that the barriers could be overcome. Less helpfully, in some instances their responses were inherently contradictory. Some participants felt strongly that the GMC should be doing more to fulfil its role to foster good medical practice through providing more learning materials and improving communication to doctors about the existence of its guidance and supporting materials. Others felt that this was not the GMC's main role and that other organisations were better placed to deliver on this educative and supportive function. They, therefore, felt that resources should be directed elsewhere or that their registration and other fees should be reduced. Some appeared to hold both views (that the GMC should do more and less) simultaneously which may indicate that most participants had not considered GMC's role previously and were expressing a desire to have both more support and lower fees.

#### **4.1 Recommendations**

Recommendations are grouped into five main themes and are as follows:

##### ***Convincing doctors that the GMC and its guidance is for them as doctors and as individuals***

It was apparent at the groups that many participants had used the guidance but did not see it as a first port of call, preferring other sources. There appears to be an issue of trust, with some doctors not wanting to engage with the GMC as they prefer to have as little contact as possible with an organisation that they perceive to be a punitive regulator. This perception of the organisation as a whole extends to their usage of the guidance and acts as a barrier to greater levels of engagement. Associated recommendations are, therefore, as follows:

1. Explore how the GMC could 'humanised' and demonstrate that it is there to support good medical practice.
2. Content could be more personalised, for example producing and disseminating more information by specialty through more links with

relevant Royal Colleges and Societies or through the personalisation of content on the website.

3. Review the content, design and tone of the learning materials to ensure that they are not viewed as being too simplistic or patronising

### ***Improving the promotion and accessibility of the guidance***

The guidance currently is not felt to be particularly user-friendly and the following actions could be considered in order to ensure that the guidance is easier to use:

4. Make improvements to the website design, layout and search function.
  - 4.1. One possibility is to consider conducting some accompanied web surfs with doctors to gain greater insight into perceptions of the website and exactly how it could be improved.
5. Integrate the case studies into the guidance where possible to ensure that it is less dryly written and to raise awareness of the case studies (which were popular with participants).
6. Provide 'bite-sized' pieces of information (for example emails with information on specific cases and links to the relevant guidance).
7. Ensure that there are online links to GMC guidance from other sources.
8. Produce online frequently asked questions.
9. Ensure that the guidance is written as concisely as possible.
10. Explain what guidance is available and how it fits together i.e. how the supplementary guidance relates to the core guidance.
11. Promote the existence of the GMC helpline.

### ***Encouraging usage by persuading doctors there is something in it for them***

It was clear that some participants would only use the guidance if they were persuaded that there was 'something in it for them'. Possible ways to sell the benefits of reviewing the guidance are:

12. To promote the fact that the guidance and learning materials are useful in a number of contexts but particularly for job interviews, appraisals and training.
13. Ensure that there is an explicit link to CPD through the development of a certification process for the completion of online training modules.
14. Demonstrate better that doctors need to know the content of the guidance to provide good care and to avoid others' mistakes.

### ***Managing expectations***

Some participants were negative about the content of the guidance because they had not been provided with a definitive answer in the past. Others were unclear about the role of the GMC and why they were spending resources on the development of learning materials and a mobile website. Recommendations, therefore, include:

15. Managing doctors' expectations about the guidance i.e. that it won't necessarily provide a definitive answer but will provide the parameters or a guide of what they need to consider
16. Some participants felt that the 'grey areas' relating to ethical questions where there are no black or white answers could be better communicated on the website for both doctors and to educate the public
17. Communicate the GMC's role and the rationale for investing in the provision of learning materials and new formats of information

### ***Reviewing the automatic provision of hard copy guidance***

18. There was a general consensus that hard copies of the guidance should not be sent to everyone automatically but should be available on request for those who preferred this format. If this is done, then communication to doctors would need to be improved in tandem to ensure that the current high levels of awareness of the guidance are maintained.

## Appendix A: Participant Profile

	<i>London</i>	<i>Manchester</i>	<i>Edinburgh</i>
<b>Gender</b>			
Male	2	4	5
Female	4	4	3
<b>Current grade</b>			
Foundation Yr1 / 2		2	
Specialty Registrar			5
GP Specialty Registrar		2	
Specialty Doctor	2	1	
Consultant		2	
GP	4	1	2
Other			1
<i>Length working as qualified doctor in the UK</i>			
Less than 1 year	1	1	
More than 1 year, less than 5		2	1
More than 5, less than 10	2	2	4
More than 10 years	3	3	3
<i>Where completed primary medical qualification</i>			
UK	3	5	5
EU/EEA	2	2	1
Other	1	1	2
<i>Ethnicity</i>			
White	4	6	5
Other	2	2	3

## Appendix B: Research Instruments

### GMC – Follow up qualitative research to the 2010 Guidance Survey Final discussion guide 4.4.11

#### Objectives

- The overarching objective is to supplement the findings of the 2010 Guidance Survey by exploring doctors' current use of the guidance and learning materials and their preferences in terms of possible changes
- There will be a specific focus on:
  - Levels of familiarity with the guidance, including understanding the relationship between the core and supplementary guidance
  - Exploring use of learning materials
  - Understanding preferences in terms of format
  - Exploring triggers and barriers to use of GMC guidance and learning materials
  - Exploring the response to possible changes in format

#### 1. Welcome (5 mins)

- Introduce self and Community Research
- Explain the purpose of the discussion group briefly – to get their views on the access to and format of GMC guidance and learning materials
- Outline ground rules
  - No right or wrong answers – importance of honesty
  - One speaker at a time
  - Mobile phones off / silent
  - Have a lot to get through so may move on at times
- Explain analysis and reporting process
  - Remind participants that comments will not be attributed to individuals in the report

#### 2. Introductions and Warm Up (10 mins)

*Purpose: to get to know the group and their experiences. To help participants feel at ease in the group*

- Individuals introduce themselves to the rest of the group
  - Giving brief details (name, place of work, current job, how long working in the UK)

### 3. Current levels of familiarity (15 mins)

*Purpose: to understand where participants are at the moment in terms of general perceptions and levels of understanding*

- HOW FAMILIAR WOULD YOU SAY THAT YOU ARE WITH GOOD MEDICAL PRACTICE – THE CORE GUIDANCE PRODUCED BY THE GMC?
  - Note how participants refer to the guidance ie any references to Duties of a Doctor or other titles?
  - Why do you say that?
  - When did you first become aware of the guidance?
  - If relatively unfamiliar, why have you not read it in detail? Do you feel that you already know the content or have other information sources that you tend to use?
  
- ARE YOU FAMILIAR WITH THE OTHER CORE GUIDANCE BOOKLETS PRODUCED BY THE GMC? (for example, 'Confidentiality', 'Consent: patients and doctors making decisions together')
  - Why do you say that?
  - When did you first become aware of this guidance?
  - Which of the booklets are you more / less familiar with?
  - If relatively unfamiliar, why have you not read it in detail? Do you feel that you already know the content or access requisite information from information sources that you tend to use?
  
- HOW WOULD YOU DESCRIBE THE RELATIONSHIP BETWEEN THE CORE AND SUPPLEMENTARY GUIDANCE?
  - Why do you say that?
  - Are you aware that some of the other core guidance booklets have their own sets of supplementary guidance (for example 'Confidentiality')
  
- DO YOU KNOW WHERE TO ACCESS THE GUIDANCE ON THE GMC WEBSITE?
  - How easy generally is it to find what you want?
  - Is some information easier to find than other information?
  
- WHICH OTHER SOURCES OF INFORMATION / SUPPORT DO YOU USE? For example, colleagues, BMA, Royal Colleges, medical defence bodies, Department of Health, Scottish Executive, Equality and Human Rights Commission etc
  - In what instances might you use these sources? Please give any recent examples.
  - In what circumstances would you use these sources rather than the GMC?
  - How do you decide which sources to use? What factors influence your decision?
  - Would links to GMC guidance from these sources be helpful?

- WHOSE RESPONSIBILITY IT IS TO ENSURE DOCTORS ARE KEPT ABREAST OF STANDARDS?
  - Probe for where responsibility lies between the individual and the GMC
  - Has your view of this changed recently?
  - Does this change dependent on length of time practising or any other factors?

#### **4. Use of materials (30 mins)**

*Purpose: to understand where participants use of materials by type and format*

##### GMP

- WHEN DID YOU LAST USE GMP?
  - What circumstance?
  - What prompted you to use the GMP rather than other sources? [Note to moderator: explore whether it was a last resort or if they wanted to specifically know GMC's standards relating to that particular query]
  - What format did you use? (e.g. hard copy booklet or online)
  - How helpful did you find GMP? Did you need to refer to any other resources after using GMP? If so, which ones?
  
- HOW FREQUENTLY DO YOU REFER TO GMP?
  - What circumstances would you typically use it?
  - How helpful have you found it when doing so?
  - Which formats have you used? Why did you decide to use these formats in this specific situation?
  
- DO YOU HAVE ANY SENSE OF HOW OR WHEN YOUR COLLEAGUES HAVE USED THE GUIDANCE?
  - Can you give any examples of circumstances they have used it?
  - Have you had any discussions with colleagues about the guidance in the past?
  
- DO YOU THINK THAT THE GUIDANCE IS MORE USEFUL FOR SOME DOCTORS THAN OTHERS?
  - For example, at certain career stages or by type / grade?



## Supplementary guidance

- WHEN DID YOU LAST USE OTHER CORE BOOKLETS SUCH AS 'CONFIDENTIALITY' AND/OR OTHER SUPPLEMENTARY GUIDANCE SUCH AS 'PERSONAL BELIEFS IN MEDICAL PRACTICE'?
  - Which piece of guidance did you use?
  - Did you use it in conjunction with the GMP?
  - What circumstance?
  - What format did you use?
  - Was it helpful? Why? Did you need to refer to any other resources after using the guidance?

## Learning materials

- HAVE YOU USED ANY OF THE LEARNING MATERIALS DEVELOPED BY THE GMC? [NOTE TO MODERATOR: EXAMPLES ARE ON THE LEARNING MATERIALS LEAFLET AND INCLUDE GOOD MEDICAL PRACTICE, CONFIDENTIALITY END OF LIFE MATERIALS]
  - If yes, which?
  - If no, why not?

GMP HAS BEEN DEVELOPED INTO A SET OF ONLINE INTERACTIVE CASE STUDIES CALLED 'GOOD MEDICAL PRACTICE IN ACTION'

- HAVE YOU USED THE INTERACTIVE CASE STUDIES?
  - Why not?
  - If yes, what prompted you to use them?
  - Which ones can you recall using?
  - What circumstances, if any, are they useful?
- IF YOU HAVE A SPECIFIC QUERY, HOW DO YOU GO ABOUT FINDING WHAT YOU NEED IN THE GUIDANCE?
  - Do you look at a hard copy of the GMP or search online?
  - If online do you do a 'google' or similar type search or do you go straight to the GMC website? On the website do you use the search facility or the online A-Z of ethical guidance?
- GIVE OUT HANDOUT WITH DESCRIPTIONS OF SCENARIOS AND ASK TO READ THROUGH THE SELECTED SCENARIO. DISCUSS IN PAIRS INITIALLY OR AS A GROUP DEPENDING ON TIME AVAILABLE
  - What factors influence your decisions on the source of advice?
  - Would you use GMC guidance? Why/why not?
  - Would you also use any resources from other sources? Why/why not?
  - Probe on what format used and why

- WHAT STOPS YOU USING GMP GUIDANCE MORE THAN YOU DO?
  - Probe for any differences by format (online / hard copy) or type (core, supplementary, learning materials)
  - Specifically, what barriers are there to using the online interactive case studies *[note to moderator, these are often requested and therefore produced and made available online, but appear to be little used]*

## 5. Suggested improvements (25 mins)

*Purpose: to obtain spontaneous responses and explore the reaction to suggested improvements*

- How COULD THE GMC IMPROVE THE PROMOTION OF THE GUIDANCE AND LEARNING MATERIALS?
  - How would you prefer to receive notice of new or updated guidance? (eg email, GMC E-Bulletin, letter, web updates, information via MyGMC web pages, text message, social networking sites, article in trade news)
- HOW COULD THE GMC IMPROVE DOCTORS' ACCESS TO THE MATERIALS?
  - Probe through the website or other means
- DEMONSTRATE WHAT LEARNING MATERIALS ARE AVAILABLE ONLINE. ARE YOU SURPRISED BY THE SCOPE?
  - How could these be communicated to doctors to best demonstrate how they could be used as development opportunities (for example, as part of reflective learning)?

THE GMC INTENDS TO DEVELOP OTHER LEARNING MATERIALS TO HELP DOCTORS UNDERSTAND AND APPLY THE GUIDANCE IN THEIR WORKING LIVES.

- IF THE GMC PRODUCED LEARNING MATERIALS IN ELECTRONIC FORMAT DO YOU THINK THAT YOU WOULD USE THE FOLLOWING?
  - Online case studies (not necessarily interactive), online publication of answers to common enquiries, downloadable presentations with discussion notes, podcasts, webinars?
  - A mobile version of the GMC website, containing all ethical guidance is scheduled to be launched in the summer. If this was available, would you access content on your mobile? Do you do this already in other contexts
  - Why / why not?
  - Anything that GMC needs to bear in mind when developing these materials that would influence you to use them?
- IF THE GMC PRODUCED LEARNING MATERIALS IN HARD COPY FORMAT DO YOU THINK THAT YOU WOULD USE THE FOLLOWING?

- Articles in GMC E-Bulletin, printed case studies with discussion notes, printed answers to a list of common enquiries, printed presentations with discussion notes?
  - Why / why not?
  - Anything that GMC needs to bear in mind when developing these materials that would influence you to use them?
- IF TIME IN SESSION, ASK PARTICIPANTS TO HAVE A LOOK AT THE WEBSITE AND GIVE COMMENTS
    - How easy is it to navigate the site?
    - Views on the GMC landing page and 'Good medical practice' home page
    - How easy is it to find case studies, supplementary guidance?
    - General comments about the look and feel

## **6. Summary session (5 mins)**

*Purpose: To draw together key findings. To give participants a chance to express any further views.*

- Recap on key issues coming out of group
- Is there anything else that you think is important to add?

THANK FOR PARTICIPATION.

MENTION THAT THEY CAN FORWARD FURTHER INFORMATION / THOUGHTS BY EMAIL FOLLOWING THE GROUP IF THEY WISH

GIVE OUT FURTHER INFORMATION SHEET ON THE GMC STANDARDS TEAM / LIVE CONSULTATIONS

RECAP ON WHAT WILL BE HAPPENING NEXT IN TERMS OF REPORTING

HAND OUT VOUCHERS (IF APPLICABLE) AND EXPENSE CLAIM FORMS

### **Scenario 1 – Answer to an urgent/immediate query**

- You are a GP and a police officer has arrived in reception asking you to hand over the medical records of two of your patients who left the practice around the time a burglary was committed at the shop next door. It is thought that one of them might have been involved. You are unsure of whether to hand over the records of both patients – where would you go for advice on what to do?

AND/OR:

- You are a doctor in a busy A&E ward and a patient who is suspected of having being assaulted by her partner has been brought in. She does not want the police to be notified even though she believes that her partner is likely to attack her when she returns home. Where would you go for advice on what to do?

### **Scenario 2 – Seeking advice when writing an organisational policy or report**

- You are writing a policy for the organisation which sets how to raise and act upon concerns about patient safety, for example if patient safety is or may be seriously compromised by inadequate premises, equipment, or other resources, policies or systems. Where might you seek advice about what to say?

### **Scenario 3 – Seeking advice in order to answer a junior colleague’s query**

- You are asked by a junior colleague who is responsible for seeking consent in the case of a complicated procedure which will be undertaken by another senior doctor in the hospital. How would you find out the answer to this question or where would you advise the colleague to go in order to find out?

### **Scenario 4 - Preparing for a job interview**

- You are applying for a post which involves management responsibilities and have been asked to prepare a short presentation for the interview which talks about a doctor’s role in management – where would you find out about what to cover?

AND/OR:

- As part of the interview process, you have been asked to prepare a short presentation or summary of the key factors to take into account when making best interest decisions about patients who lack capacity including relevant legal references. Where would you go to find out about what to include in your presentation?

## Appendix C: Invitation to participate

Date

Dear Doctor,

### ***Have your say about how the GMC can improve your access to Good Medical Practice and other guidance***

The GMC is currently reviewing the content and format of *Good Medical Practice* (2006) and the supplementary guidance and learning materials that support it. As part of the review we want to find out more about doctors' preferences for accessing and using our guidance and learning materials so we can make sure they fit the needs of doctors.

We have commissioned an independent research company, Community Research, to run some discussion groups with doctors on our behalf. They are holding a group at GMC offices in central London at 7pm on 3<sup>rd</sup> May 2011 [central Manchester on 9<sup>th</sup> May, central Edinburgh on 11<sup>th</sup> May]. You do not need to do any specific preparation for the group, as we are simply interested in your opinions.

The group will last for around 90 minutes and refreshments will be provided. As a thank you for attending, you will receive gift vouchers to the value of £75 in addition to reasonable travel expenses. Given GMC's charitable status, you can make a donation to a charity of your choice rather than receive the vouchers if that is preferable.

The GMC will not be told at any stage who is taking part in these groups, to ensure you can express your views freely. Community Research will produce a

report of key findings which will summarise the findings of all groups conducted. Comments made in the groups will not be attributed to any individuals.

If you are able to attend, please could you register your interest directly with Community Research (link to online survey). You will then receive further information. We have asked Community Research to ensure that doctors from different specialities and at different stages in their careers are involved, and this means that not everyone who registers an interest will be able to attend.

If you are not able to take part in this session, we hope that you will take part in the review in other ways (see [www.gmc-uk.org/gmp2012](http://www.gmc-uk.org/gmp2012) for information). If you have any queries about the research, please contact us by email at [gmpfocusgroup@gmc-uk.org](mailto:gmpfocusgroup@gmc-uk.org).

Thank you for your help with this important piece of research.

Yours faithfully,

Jane O'Brien  
Assistant Director  
Standards & Fitness to Practise  
General Medical Council