

**Thursday 14 October 2021**

**10:00 to 12:30**

MS Teams

## Good medical practice advisory forum Meeting two

### Key discussion points

#### Advisory forum members

Professor Emma Cave (Chair), Mikaela Carey, Dr Josie Cheetham, Dawn Hodgkins, Dr Henrietta Hughes, Eileen McEaney, Professor Geeta Menon, Lucy Mulvagh, Joan Saddler

#### GMC project team

Sharon Burton, Angela Breingan, Faye Cranfield, Rose Clout, Fionnula Flannery, Claire Garcia, Angela Hernandez, Farkhanda Maqbool, John Paul Mattar, Sophie Maycock, Emily Phillips, David Round, Rosalind Springer, Mark Swindells, Laura Tivey

#### Apologies

Professor Pali Hungin, John Randall, Neil Tester (Deputy Chair)

This note attributes comments to members of the Advisory Forum simply as 'members' unless there appear to be different perspectives of individuals who are registered medical professionals ('medical members') and those from a non-medical background ('lay members'). We refer to members of the GMC team as 'team members'.

### Item 1: Welcome and introductions

- 1 Professor Emma Cave welcomed the group to the meeting and noted that this was the first of two meetings focusing on priority areas for redrafting the guidance. Professor Cave acknowledged that this work is taking place in the ongoing pressures of the pandemic, which she recognised had been a tough time for everyone.

### Item 2: Equality, diversity and inclusion (ED&I)

- 2 In relation to GMC corporate commitments, Sharon highlighted:

- that our approach to ED&I goes beyond achieving representative numbers of people with legally protected characteristics, within the profession, healthcare sector or the GMC. For us, a commitment to equality includes, for example, fairness in terms of fitness to practise case outcomes. Our commitment to inclusion is about making sure that people of diverse backgrounds, with different ways of thinking about or doing things, are respected and valued for their particular insights and contributions;
  - the corporate statements of intent that underpin all the internal and external GMC ED&I activity. For example, the intention to partner with employers in the healthcare system to improve workplace environments and cultures. These statements show the GMC recognises how longstanding and serious a problem there is with discrimination, bias and inequalities in our society and how this plays out in healthcare;
  - that our determination to help drive meaningful change underpins our decision to publish specific targets for eliminating bias, discrimination and disadvantage;
  - the internal and external mechanisms for holding the GMC to account against its statements, commitments and targets. This includes accountability to parliament for our regulatory performance; and the enhanced arrangements for scrutiny of ED&I issues by the Executive Board and Council, in place since September 2020.
- 3** Sharon then set out some of the key challenges for setting what we call 'normative' professional standards. She highlighted the inherent tension between the goal of setting common standards - applying across the UK and the medical profession - and the concern to make sure that the diverse backgrounds, perspectives and interests of registrants themselves are represented in the standards.
- 4** She drew attention to the British Association of Physicians of Indian Origin's report, *Bridging the gap*, which has prompted questions around whether GMP standards:
- can reasonably be said to represent 'white norms' of professional conduct and practice? Or 'common norms' drawn out of multiple perspectives?
  - when viewed through the lens of biased attitudes towards ethnic minority professionals and those who qualified outside the UK (international medical graduates or IMGs), lead white colleagues to judge the actions and decisions of ethnic minority and IMG registrants negatively and unfairly?
  - can be framed in such a way that different cultural expressions of professionalism will be equally valued in practice?
- 5** The team are exploring these questions and will return to Forum members on this in future meetings and in the public consultation.

## Item 3: Key themes from scoping

- 6** Mark explained that the team are in the guidance development phase. Mark also described how the team have worked to make sure the ED&I approach outlined by Sharon’s earlier presentation gets translated into reality. For example, looking for evidence that any of the current standards could lead to differential impacts on individuals with protected characteristics and other characteristics such as having an overseas qualification or being from a lower socioeconomic class (noting that social class is a protected characteristic in Wales). These issues are now being worked up as part of a formal Equality Impact Assessment.
- 7** Mark moved on to share the headline messages from the scoping stage:

  - strong support for retaining four domain structure, but potential to rename the domains and move content around;
  - support to retain ‘you must’ and ‘you should’ to express duties – but interest in exploring some form of ‘I will’ statements, and whether GMP can be restricted to ‘must’ statements;
  - level of detail in the guidance is about right – but potential to include more explanatory text to contextualise duties and to acknowledge the operational environment;
  - need to make clearer the interaction between the professional standards and fitness to practise/local processes;
  - potential to say more about what we mean by ‘professional judgement’. This was a challenge set out by Deborah Bowman in her recent paper for the Professional Standards Authority on regulation in the context of the pandemic.
- 8** He went on to note the five themes that have been identified for redrafting: (a) tackling bias and discrimination in healthcare; (b) patient centred care, decision making and communication (both of which were being discussed at today’s meeting as part of agenda item 4); (c) team working (including civility and behaviours in the multidisciplinary team); (d) leadership; and (e) interprofessional boundaries (the last three themes will be discussed at November’s meeting).

### *Discussion*

- 9** Members welcomed the focus on human rights and equality issues. It was recommended that we do further work to consult with bodies such as the Equalities and Human Rights Commission and the Scottish Human Rights Commission to deepen understanding of the issues and ensure that whatever approach we take to reflecting rights in GMP is consistent with the law across the four UK nations.

- 10** We should also consider the expectation, set at the international level, that states will progressively implement into national law the full range of individual rights set out in UN Conventions. This is particularly relevant to people with disabilities where the UK has been slower than some other nations, in terms of adopting the UN Convention on the Rights of Persons with Disabilities into our legal framework.

## **Item 4: Priority areas for redrafting (part 1)**

### **Bias and discrimination in healthcare**

- 11** Angela proceeded to take the group members through each of the five discussion questions as set out in the pre circulated paper.

*How could the guidance set stronger expectations in terms of registrants challenging racism and discrimination?*

- 12** There was clear support from the group for the proposals presented, though several comments were made around being mindful of the complexities these issues raised.
- 13** Several members agreed that if we're going to use the guidance to set duties to tackle discrimination in settings where they may be institutional racism and inequality, then we have to give clear descriptions of what is expected. We also have to be clear on why it is important that professionals respond in this way, to help dismantle these forms of power.
- 14** A medical member reflected on the empowering nature of positive statements to help the profession(s) tackle discrimination in its different forms. Different dynamics of power in healthcare environments were discussed, and it was noted that movements such as Civility Saves Lives and Speaking Up were real world models to learn from.
- 15** There was agreement between members of the importance of the use of proactive, affirmative language rather than simply using negative statements in the guidance alone. Language used by Scottish Social Services and international human rights legislation were both pointed to as good examples that we could learn from.
- 16** A member cautioned against conflating racism and other forms of discrimination. It is important that we are clear what we mean when describing racism and other forms of discrimination which are all distinct forms of power operating in insidious ways.

*Should there be a specific requirement for registrants to consider the impacts on their practice of their own values, beliefs, personal biases?*

- 17** A medical member reiterated the importance of doctors acting as role models in society and how important it is for them to attend to their own values and beliefs so that they are able to act as positive influencers. It was felt that this was an important

part of medical education and training that should be core to progression rather than simply addressed in 'bolt on' training courses. This should run through a medical professional's career, demonstrated and evidenced at annual appraisal etc.

- 18** Another member cautioned the group about being attentive to the types of behavioural norms that we may or may not be asking healthcare professionals to demonstrate. Whose norms are they and how can we guard against applying simple right/wrong ideas of acceptable behaviour in tackling bias and discrimination?
- 19** It was agreed that the consultation would be a good place to explore the challenges further. A note of caution was also sounded that we should not overcomplicate what we are trying to achieve in terms of behavioural norms.
- 20** A member commented on the now extensive literature around the concept of unconscious bias. It was discussed that we need to ensure that we've learned from this literature regarding the reality and effects of unconscious biases, but also be clear with regards to the evidence now emerging of the lack of efficacy of many of the training courses that have attempted to equip learners to tackle these issues.

*Should we set any specific requirements in relation to cultural competence?*

- 21** Angela explained that although the concept of cultural competence had come out as an important theme in the scoping, the team were not yet clear on whether, and if so how, this could be framed as a specific duty aimed at individual professionals. This is something that will be asked about as part of consultation.
- 22** The work of Professor David Williams\*, Harvard University on cultural issues in healthcare was pointed to as an example to learn from in terms of clear descriptors and principles.
- 23** Gender competence was highlighted by a couple of members of the forum as being a particularly live and developing issue across the different countries of the UK. It was noted that in medicine, there is a growing evidence base to suggest women face substantial challenges not just formally e.g. in academia, medical leadership and recruitment processes, but also access to informal sponsorship and opportunities.

*Should we address discrimination by patients in GMP?*

- 24** One member cautioned that we need to consider whose behavioural norms we have in mind when talking about unacceptable behaviour from patients. Again, there needs to be careful consideration of the complexities here.

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\* Prof Williams interviewed by the Kings Fund in 2019 <https://www.kingsfund.org.uk/audio-video/podcast/david-williams-racism-discrimination-health>.

- 25** A medical member reflected on the challenge of witnessing poor behaviour by patients or their family or friends while coping with what might be intense workplace pressures. In a stressful situation, it can be hard to know how to respond appropriately in the moment. It would be helpful for the GMC to give some guidance on this, so professionals can know what's expected and be well-prepared ahead of such situations arising. Although the member acknowledged that professional standards are by their nature high level, they queried whether there are other ways in which we could give more specific, practically focussed information that supports medical staff to respond appropriately? For example, what action might be acceptable when weighed against the duties around ensuring continuity of care for a patient, and what role might those in medical leadership positions play in supporting staff in responding to these situations?
- 26** Another member wondered whether it was a case of having a separate section on discrimination from patients in the guidance, or whether it was most appropriate to weave these issues into a more general section on acceptable behaviours and tackling poor behaviours. They also noted that there might be communication barriers between patients and professionals that contribute to creating these situations and can make them especially difficult to deal with.

*Should we include specific duties in relation to fairness in providing training/mentoring opportunities?*

- 27** Angela explained to the members that the team were deliberating whether this was an issue that belonged in GMP, or whether it would be better dealt with at local level via employment and training policies.
- 28** A medical member commented that we should be aiming to use GMP to strengthen and support local level policies by setting the principle and then signposting appropriately.
- 29** Another member agreed, and ventured that we could consider adding wording to paragraph 42 to the effect that registrants need to be aware of explicit and implicit bias around the availability of training opportunities.
- 30** A medical member noted the consideration that Physician Associates (PAs) have a lack of formal progression post qualification which has both been beneficial and indeed a barrier to accessing opportunities. Although it was felt that this has been managed well on a local level to date, as the PA membership is growing, a more robust system would be welcomed.

## Patient centred care, communication and shared decision making

*Does GMP focus sufficiently on patients' rights?*

- 31** Fionnula explained that stakeholder feedback suggested that GMP could take a more explicitly rights based approach. This is something that the team are keen to explore, however, at present it's unclear how far the current version is from this goal. She asked the group: what would a rights based approach, addressed to individual registrants, describing demonstrable behaviours, look like in the guidance?
- 32** Professor Cave began the feedback by echoing comments made earlier in the meeting about the importance of GMP not just stating high level principles, but translating what the principle means in the context of different areas of practice. She highlighted the Medical Council of New Zealand as being particularly impressive as an example of this kind of approach.
- 33** The Cumberlege review was pointed to as providing evidence that we can learn from about attending to patients' rights - especially the experiences of women patients.
- 34** Another member suggested that we not only consider using more explicitly rights based language, but also the language of jurisprudence. The World Health Organisation was suggested as one place where the team can look for good examples of how rights based service delivery principles might be formulated.
- 35** It was noted that Alliance in Scotland has good networks and can act as an intermediary, introducing the team at GMC to a range of organisations that can support development here.
- 36** A medical member noted that it was important to consider the different understandings of rights. Patients can sometimes see rights in a consumerist way, for example as a right to receive a certain drug on demand which is not helpful or constructive.
- 37** It was also recognised that health inequalities impact on different groups of patients in different ways. There was agreement that GMP should aim to support medical professionals to navigate these differential impacts so that they might uphold and fulfil the rights of their patients in ways that were sensitive to these factors.
- 38** Another member highlighted the different meanings of the terms 'patient centred care' and 'shared decision making'. Although these concepts are interlinked, they are also distinct, and it was suggested that the former term is more widely understood than the latter. Fionnula clarified that although we had used the term shared decision making in this paper, it doesn't appear in the guidance itself and that there is not an intention to do this.

*How can GMP be more explicit about the role of the registrant in facilitating patients' decision making?*

- 39** Fionnula explained that the recently reviewed *Decision making and consent* guidance had been well received and that there was an opportunity to align the core guidance in GMP with the principles set out in the explanatory guidance.
- 40** A member noted that human rights principles had influenced the progression from 'shared decision making' as a goal, towards the goal of 'supported decision making' where the role of the professional is to support patients to make their own decisions. But widespread adoption of the 'supported decision making' model is going to take time to achieve and embed across healthcare, in the UK as in a number of other countries. It was suggested that the next GMP would be an opportunity to facilitate this change. For example, GMP could incorporate the sort of concrete language that is used in international law around the right to participate in decisions about care and access to information to support this. In this formulation, the duty lies on individual professionals to proactively provide information and to make themselves understood rather than on the patient as the receiver of information to press for information and involvement.
- 41** This was linked to discussion about decision making based on a patient's 'will and preference' rather than the concept of 'benefit' to the patient. The former concept is socially progressive and it may be subject to differential commitment across UK countries. The review might also be an opportunity for GMP to push the envelope in a way that supports progressive realisation of this aspect of international law.
- 42** One member reminded the group that GMP can set a standard that goes further than what is required by the law (and has done so in the past). They also suggested that the lack of reference to rights was a current weakness in domain three. They also offered wording along the lines of: patients' rights to make informed decisions about viable treatment options (as opposed to the right to simply demand treatment).

*Can GMP say more about what good communication with patients looks like?*

- 43** Fionnula noted that the current guidance did address various facets of communication, but that the content was dispersed and work could be done to bring it together. The group supported the idea of some restructuring work to emphasise principles of communication and clarify expectations of registrants.
- 44** A member suggested that if GMP is going to include requirements on good communications it would be helpful to give more detail on what that looks like, e.g. active listening. There will also be the need to ensure that relevant training and continued professional development is undertaken.
- 45** It was suggested that GMP paragraph 35 could be amended to articulate more clearly the purpose of collaboration being about the interests of patient care, and paragraph 31 could lay down a duty to be aware of and counter structural biases.

*Should GMP refer to mental capacity, and is there enough focus on children and young people in GMP?*

- 46** Fionnula explained that the challenge with GMP is that principles are set at a high level so as to be widely applicable. The current version doesn't expressly mention capacity, but we know that there can be a good deal of anxiety around this subject from users of the guidance. Although GMP is not the place to give detailed advice about this, could more be done in GMP to highlight expectations of registrants and do some signposting?
- 47** Fionnula told members that although it would be problematic to begin subdividing GMP by categories of patients, some stakeholders had said we should bring children to the fore within the core guidance so it's clear it applies to them.
- 48** A member recognised that the issues of 'capacity' and children and young people were linked. It was suggested that the team might look across the whole of the guidance for opportunities to make appropriate and relevant references to children and to people who lack capacity.
- 49** It was noted that there isn't a single test for capacity across all jurisdictions of the UK- whether for adults, children, young people or those experiencing mental ill health - and this can make things very complicated in terms of drafting. One suggestion was that we could refer to capacity and children in the context of existing duties set out in paragraph 31. The first and seventh principles of the *Decision making and consent* guidance were pointed to as an existing example of this approach. It is about conveying that everyone has a right to be involved in decision making about their care, while recognising that there are complexities in law that might affect how that looks in practice in individual cases.