

Good medical practice advisory forum

Meeting 4 – 15 December 2021

MS Teams

Attendees

Advisory forum members

Professor Emma Cave (Chair), Neil Tester (Deputy Chair), Mikaela Carey, Dr Josie Cheetham, Dawn Hodgkins, Dr Henrietta Hughes, Lucy Mulvagh, Joan Saddler, Professor Pali Hungin, John Randall,

GMC project team

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

Apologies

Eileen McEaney, Professor Geeta Menon

Agenda items

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| 1 | Welcome and introductions, including declarations of conflicts of interest and notes of last meeting | Prof Emma Cave |
| 2 | Review of redrafted duties | Emily Phillips |
| 3 | Implementation strategy | Faye Cranfield (Chair: Neil Tester) |
| 4 | Summary and next steps | Prof Emma Cave |

Item 1: Welcome and introductions

- 1** Professor Emma Cave welcomed the group to the meeting and explained that for this meeting she would be sharing the chairing responsibilities with Neil Tester, who would facilitate item 3.
- 2** Professor Emma Cave signalled that this would be the final meeting of the forum ahead of the consultation on draft guidance, although members would have another opportunity to review the draft in the new year.
- 3** The notes of the last meeting were agreed with no amendments. No conflicts of interest were declared relating to items under discussion.
- 4** Three members offered overarching comments ahead of the substantive discussion of the meeting.
 - One member said it was important for the review team to bear in mind the rapidly changing context in which medical professionals are working, with new technologies, democratisation of knowledge, and changing relationships with patients. The member also flagged the corporate and commodified structures medical professionals work in, where local protocols may conflict with professional values, and said that the new professional standards need to acknowledge this context and describe a set of value that work for the future of medicine, and not the past.
 - Another member added that it was important that the professional standards reflect the complexity of patient pathways, and the reality that patients are usually cared for by multiple clinicians.
 - A third member cautioned that this forum is not likely to be reflective of the wide range of views in medicine and wider society about what is/isn't acceptable practice, and we will need to elicit a diverse range of views during consultation.

Item 2: Review of redrafted duties

- 5** Mark introduced this item by reminding the group of the parameters of the redraft. Based on our findings from scoping and pre-consultation engagement, these were:
 - 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
 - approval of the succinctness of the current document, and a steer not to overload it with detail

- a desire to shift the guidance tonally to make it more empathic, to recognise the context medical professionals are working in, and to position the guidance as empowering and supporting medical professionals to practise well in the interests of patients.

Emily then gave an overview of the redrafted guidance.

Structure and ordering

- 6** Professor Cave opened the discussion by asking for views on the revised structure and order of the draft.
- 7** One member agreed with the proposal that without a good working environment, patient care suffers, but raised the question of how it would land with patients and the public if patient care is seen as subordinate to team working in the draft?
- 8** Another suggested this could be addressed by making clear in the title and preamble to domain 1 that the purpose of good team working is to facilitate patient care. The introductory text could also say something about how the domains fit together, and make clear there is no hierarchy implied by the order. This could also be shown visually. Another member welcomed this, as a way of showing how these themes are integrated and cohesive in the draft.
- 9** Another member highlighted the importance of thinking about how the new standards will translate into appraisal, and how registrants will evidence meeting the duties, with the reminder that not all doctors work with patients. The member also expressed a desire to see continuous learning as a theme throughout the document.
- 10** Another flagged the universality of human rights, and suggested this should be reflected through all the domains, with explicit mention of registrant and well as patient rights. Another cautioned against the use of the word 'bias' when actually what we were talking about was behaviour that results in inferior treatment. There needs to be a clear and specific focus on tackling discrimination and inequality in all its guises.
- 11** One member emphasised that this document must not be a stick to beat doctors with, and must not set unrealistic expectations that patients will expect medical professionals to be held to account against. Registrants needs to feel valued and respected by the GMC, and the professional standards need to resonate with how registrants feel. The recent message to the profession from Dame Carrie MacEwen, wishing doctors well in a time of extreme duress, was an example of supportive and welcome messaging from the GMC.

Preambles

12 Professor Cave sought views on the new preambles to each of the domains.

13 In relation to the preamble to domain 1, the following comments were made:

- It would be helpful to be clear when we refer to patient needs that this is the full range of needs, not narrow clinical needs determined by clinicians.
- We could add reference to rights here, although one member said it was important to be specific about which rights we have in mind.
- In relation to working with 'all' colleagues – was this too wide? Are we implying colleagues the person doesn't even work with? One member reflected that colleagues won't always be in the health service, and the team confirmed it was intended to convey that colleagues includes all the people the registrant works with, including non-clinical ones. Another member suggested referring to diversity of colleagues.

14 In relation to the preamble to domain 2, the following comments were made.

- Should the text say 'respect, protect and fulfil' patient rights? These are terms from human rights law. Another member endorsed this, given that medical professionals are duty bearers under international law, but said if we add these terms we should also define what they mean.

15 In relation to the preamble to domain 3, the following comments were made.

- One member asked whether it is too onerous to require registrants to 'understand themselves'? Would it be better to say they should be reflective?
- Another responded that self-awareness is difficult to generate without input from others, and it is important that medical professionals are open to giving and receiving feedback. These should be expectations throughout registrants' careers – it is no good selecting people for interpersonal skills and situational judgement if those skills are not supported by the working environment.
- Another member suggested that we could reflect the changing nature of medical practice here, and say something about medical professionals keeping pace with change. Another suggested that we use the term 'inclusive leadership'.

16 In relation to the preamble to domain 4, the only comment was that the current text focuses on public trust, whereas duties that follow are mostly about individual trust. The importance of trust in individual registrants should be reflected in the preamble.

Revised duties

17 New and revised duties were discussed by theme, with Emily giving a brief overview of the redraft for each theme.

Leadership

18 Professor Cave reminded the group of its previous steers in relation to embedded leadership, equitable access to training, emphasis on leadership skills, and articulation of what leadership means. She highlighted how these had influenced the draft and asked for views on the text.

19 Comments and suggestions from members in relation to this section were as follows.

- Should there be something in relation to offering support to others, which mirrors the duty to seek support?
- Could we reflect more clearly how expansive leadership can be – for example through sponsorship, coaching, reverse mentoring?
- We should be as explicit as possible about what kind of leadership we mean to drive a culture that supports and nurtures others – so inclusive or collaborative leadership, not heroic.
- We need to avoid setting people up to fail, and not put responsibilities on people that the environment doesn't support. This is connected with how we engage other stakeholders – for example, do the job descriptions of CEOs include a requirement to make sure registrants can fulfil their professional obligations?
- Could we be clearer about the difference between formal and embedded leadership – for example, when we refer to being competent, do we mean in relation to formal leadership roles?
- In relation to quality improvement, it is important that people are prompted to draw on evidence from patient and community groups – not just traditional patient experience measures.
- Could we expand on the duty in relation to quality improvement to make clear that registrants should take action when quality is not sufficient? Or link more clearly this paragraph to existing duties to take action in relation to patient safety risks.
- Putting the burden on the registrant to speak up is focusing on the wrong end. People in leadership roles also need to be responsible for listening up and following up.

- 20** Mark reminded the group that while the current discussion is about GMP, we still have the explanatory guidance to consider and some of the detailed issues discussed at this meeting might be better placed in more detailed guidance.

Team working

- 21** Professor Cave reminded the group of its previous steers in relation to recognition of different sorts of teams, behaviours when working within and between teams, and the importance of civility in teamwork.

- 22** Comments and suggestions in relation to this section were as follows.

- The draft text currently refers to listening respectfully to colleagues' contributions. But what if the contributions don't command respect – for example if they are discriminatory?
- Should we separate out how registrants treat each other (civily, with respect) from how they communicate (providing information, listening)?
- The text could be clearer that where supervision of colleagues is delegated, the colleagues providing that supervision need to be suitably skilled and confident in that role.
- Should we mention 'attitude' as well as 'behaviour' in the duty to act compassionately within teams?

Partnership and decision making

- 23** The group generally welcomed how far this section of the draft had moved on from the current edition of GMP. Comments and suggestions in relation to this section were as follows.

- Should we add a duty to 'check understanding' to the duties around sharing information patients want or need? An insight from recent work with patients, including those from marginalised communities, was that people do not always understand what medical professionals have told them.
- In addition to the list of factors clinicians should consider when giving clinical care, medical professionals should actively think about the range of medicines a person is taking and whether the benefits outweigh the risks. This is particularly relevant for people with multiple conditions, where there can be a burden in terms of being able to adhere to medication, and complex side effects from polypharmacy.
- In relation to modality of care (i.e., whether face to face or online) should we add something about not making assumptions, and assessing preferences on an ongoing basis? It was also recognised that service provision is not solely a matter

of matching patient preferences, or always in the control of individual registrants, so should we add 'where appropriate' into the text?

- In relation to empowering and supporting patients to care for themselves, could we be clearer that information needs to be tailored and not generic? And is there a way of framing the duty in a more positive pro-self-management language, not just steering patients away from harmful behaviours. This is to recognise that patients spend a small proportion of their lives with medical professionals, so medical professionals should work with patients to understand and support what they are already doing to manage their own health. The Scotland strategy for self-management was offered as a model.
- In relation to patient rights, the group discussed the range of perceptions about what this term means (for example human rights, consumer rights, rights summarised in the NHS constitution). A member suggested that it is better for the document to talk about specific rights rather than generic ones that can raise questions of interpretation.
- In relation to safeguarding duties, this seemed to be drawn very wide as drafted, and potentially impossible to meet.
- In relation to the duty to provide help in emergencies, should we make clear this is advice for the UK as different laws and expectations will apply elsewhere?
- In relation to patients posing risks to medical professionals, what do we mean by taking 'available steps' to minimise risk? What happens if 'available steps' do not eliminate the risks?
- In relation to patients making decisions, the current draft is misleading in suggesting patients always have a right to choose whether or not to have treatment or care. It should also refer to 'available' options and be clarified in terms of what support is needed after a decision is made.

Maintaining trust

24 Comments and suggestions in relation to this section were as follows.

- There was a discussion of whether the duty in relation to communicating in public (which includes social media) was too broad as drafted and intruded too far into medical professionals' private lives. While standards need to be high, they can't be prohibitive.
- Members gave examples of behaviours that can bring individuals or the profession into disrepute, such as misuse of their professional status to pursue private interests; abusive or discriminatory language in open forums; abusive or discriminatory language in private messages or closed groups (which can later

become public and raise questions of trust). A member suggested these may be matters to pick up in explanatory guidance.

- In relation to trust, one member highlighted the link between civility and patient safety and suggested adding something about colleagues being able to trust one another.
- In relation to advertising, the text should make clear that information must not be misleading and if medical professionals enter into contracts the terms must be fair and transparent.
- In relation to cooperating with formal inquiries, we should add in 'investigations' to reflect the role of the Healthcare Safety Investigation Branch.

Equality, diversity and inclusion (ED&I) and other overarching comments

- 25** Professor Cave invited any further overarching comments on the document, in particular in relation to how it engages with ED&I issues.
- 26** One member commented that there were specific duties in relation to tackling discrimination and inequality in all domains except domain 4. Could we add something there?
- 27** Another member reiterated the worry that in trying to create a document that supports good practice, we will nevertheless create unrealistic expectations against which medical professionals will be held unfairly to account. The GMC team acknowledged this risk and said it would be something that they would take into account when drafting the opening sections of the document, which would set expectations for its use and interpretation.

Item 3: implementation strategy

- 28** Faye Cranfield introduced the paper and gave a brief overview of what the GMC means by the term 'implementation' and how we distinguish between 'direct' and 'indirect' methods.
- 29** Neil Tester asked if there were any questions or comments on the paper generally. One member commended the rigour of the paper but cautioned about being too rigid, and locking ideas down before they have been tested. Are we leaving sufficient room for what we don't know?
- 30** Neil Tester then facilitated discussion of the three questions in the paper.

*Question 1 - Based on our scoping and evidence, as well as using our conclusions to date, we believe we should be advocating for the GMC to prioritise indirect implementation - **Do you agree with this approach?***

31 Points made in response were as follows.

- Physician associates (PA) don't have access to a lot of the direct and indirect activities that are noted, such as education policy, and may need a more 'direct' approach.
- If the policy is to shift to indirect implementation, who bears the cost? Mark responded that it is not about the GMC passing over the responsibility/cost to others (Welcome to UK Practice is an example of significant investment by the GMC) but working more intelligently with others to align and amplify efforts.
- We need to be realistic about the 'ask' of stakeholders, what they can contribute and what's in it for them. There are well-tested methodologies for mapping routes of influence and identifying actions. This lends itself to tailored messaging but also clarifies what the ask is, for example whether you're asking influencers to deliver messages direct or repackage. We also need to be realistic about resources – large organisations may be well resourced, but small ones won't be.
- May be worth thinking more creatively about other potential intermediaries – third sector can help with that – e.g. celebrities
- The GMC has a good link through responsible officer (RO) training – for example we could add a module on GMP. It is in ROs' interests to be upskilled. We should also engage with appraisal system providers' appraiser development days. Also consider creating material for reflection – e.g. videos to watch on the way to work – this becomes evidence for appraisal. Could be supported by a big communications campaign.
- We need to be sensitive to the fact that not all key stakeholders will want to be intermediaries for the GMC.

Question 2 - Noting the hidden curriculum and how doctors learn, a major challenge for us is how could we effectively 'influence the professional influencers' – such as doctors in senior positions – or those who can affect change at employer level - **Do you have views on who we should prioritise the 'professional influencers' and how we might collaborate? Do you have good practice examples we might learn from?**

32 Points made in response were as follows.

- Key influencers include the BMA, speciality colleges, and organisations such as Health Education England. Are we engaging those organisations pre-consultation? Mark briefly summarised our engagement approach.

- Specifically for Anaesthesia associates (AA), the Association of Anaesthesia Associates can cascade to all AA members, in conjunction with the Royal College of Anaesthetists.
- Can we target some of the groups of doctors who may be less likely to engage with the GMC – for example trainees who are less likely to read GMC emails, engage with Facebook or Twitter? There is a medical directors’ group in Wales that has influence. BAPIO, BIDA, DA UK, Melanin medics, Women in Health – very influential vocal critics, can we get them invited and involved?
- We need to think strategically about the ED&I approach: 1) the whole agenda 2) discrimination for particular groups.

*Question 3 - It is essential that our direct and indirect implementation activity reaches a diverse range of people and organisations - **What are members’ views on the considerations we should keep in mind to make sure our implementation work reaches a diverse range of people?***

33 Points made in response were as follows.

- We should make sure everything is accessible, recognise people learn in different ways – so multimodal approaches – visual, audio, large text, Welsh language (see the work done by the work psychology group).
- We need to think of diversity and inclusion more widely than protected characteristics. For example, in terms of how junior someone is.
- Include PA and AA ambassadors. Good example was the sharing of the interim guidance for AAs; this worked and landed well.
- Aim to get every community to have conversations about this and interpreting this themselves.
- One member asked how, when engaging patient groups, do we engage with people who are representative of the public at large and not just individuals with particular agendas? Mark summarised the patient research currently out to tender, which will look to get views from a range of patients. Another member highlighted the work of Healthwatch, which can work through community groups.

Summary and next steps

34 Professor Cave wrapped up the meeting by thanking the team for the excellent papers, and for translating the views of the group so clearly through to the new draft.

- 35** While this would be the last meeting of the group ahead of the launch of the consultation, there would be another opportunity for members to review the draft in early January 2022.
- 36** Professor Cave closed the meeting with thanks to Neil Tester for his assistance in chairing this meeting, to the team for making the process so easy to engage with, and to members for their important contributions. Members thanked Professor Cave for her skilled chairing of the meetings.