

Good medical practice advisory forum

Meeting 3 – 18 November 2021

Attendees

Advisory forum members

Professor Emma Cave (Chair), Mikaela Carey, Dr Josie Cheetham, Eileen McEaney, Professor Geeta Menon, Lucy Mulvagh, Joan Saddler, Professor Pali Hungin, John Randall, Neil Tester (Deputy Chair)

GMC project team

Sharon Burton, 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

Dr Henrietta Hughes, Dawn Hodgkins

Agenda items

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|----------|--|-----------------|
| 1 | Welcome and introductions, including declarations of conflicts of interest | Prof Emma Cave |
| 2 | Minutes of the last meeting | Prof Emma Cave |
| 3 | Leadership and teamworking | Angela Breingan |
| 4 | Interprofessional boundaries | Harriet Foxwell |
| 5 | Consultation methods | Claire Garcia |
| 6 | Summary and next steps | Prof Emma Cave |

Item 1: Welcome and introductions

- 7 Professor Emma Cave welcomed the group to the meeting and signalled that this was the second of two meetings focusing in on, amongst other things, priority areas for redrafting the guidance.
- 8 Two members took the opportunity to declare potential conflicts of interest ahead of discussion of agenda item 3, if their organisations chose to bid for the research mentioned. This was noted and no information was provided in this item that would give an unfair advantage to any potential bidder for the research.

Item 2: Minutes of the last meeting

- 9 The minutes of the previous meeting were discussed and agreed.

Item 3: Leadership and teamworking

- 10 Angela Breingan, Policy Manager, explained that the role of leadership was a major theme emerging from the reports and other evidence reviewed in the scoping and engagement phase. The discussion paper sets out a range of questions about how we tackle issues of leadership, team working and culture within *Good medical practice* (GMP).

Questions 1 & 2

Should we have a professional duty on leadership in GMP? If so, is the best way to bring together all the related GMP content under one theme, and pull in key principles from the Leadership and management guidance?

Are leadership skills and team-working behaviours relevant to all our registrants ie should all registrants be able to demonstrate leadership and accept leadership by others?

Discussion

- 11 A member asked if the focus of concern is what happens in the clinical environment, since the sources of evidence listed in the discussion paper all seemed to relate to clinical settings. As registrants work in a wide range of contexts, it was suggested that it would be helpful to look at (and signpost clinicians to) the wider evidence base about the impact of leadership behaviours. For example, the work of Michael West and Jeremy Dawson from The Kings Fund which explores the impact of compassionate, inclusive leadership on organisational and team cultures.
- 12 A medical member was inclined to agree with the proposals to include leadership duties in GMP. However, they would want this to take account of the organisational

context in which registrants are working. Organisational culture can impact on the ability of registrants to function well as leaders.

- 13** GMP would need to carefully define leadership responsibilities. For example, if senior clinicians aren't available for advice and support, then trainees are very exposed. What would leadership look like for trainees in such a case – is it more than knowing where your competence ends? We shouldn't set expectations on registrants to take action to address problems over which they have no control – as this would be 'heaping burning coals' on staff who are already under pressure.
- 14** A member was struck by the evidence that many clinicians find leadership hard to define and it can be hard to recognise when leadership is required or precisely what it looks like. It may be impactful to highlight to registrants the leadership skills and behaviours that they can demonstrate and make a real difference for patients – a positive approach of this kind could enhance their wellbeing and sense of professional pride.
- 15** A medical member argued that clear definitions of expected leadership skills and behaviours should be accompanied by expectations around equity of access to leadership training. We should also set expectations around teamworking practices that create psychological safety and cultural safety (referring to the concerns of black and minority ethnic registrants) and related leadership training as effective contributions to improving standards of patient care – making clear that relevant training should be given to everyone.
- 16** Another member responded to the question about defining expected leadership skills and behaviours, noting that the Leadership and management guidance has a lot of useful content. However, the guidance is not as clear as it might be that it does not just apply to those in formal leadership roles; that it also describes responsibilities around leading and working well within teams.
- 17** In addition, the member highlighted that the legal requirements around meeting equality, diversity and inclusion responsibilities include ensuring equality of access to leadership training. Secondly, that leaders should be supported to develop their leadership skills and abilities - not just be pressured to do more within their organisation to change the culture and improve services.
- 18** Angela reflected that there was a strong theme around the need to draw out what some people have called 'embedded leadership' - the actions that registrants take every day to influence the way that a team delivers care to patients or their organisation provides a service to patients.
- 19** A medical member commented that highlighting the role of this form of leadership in GMC guidance would bring benefits for registrants. It was striking that after the publication of the [Generic professional capabilities](#) (which require all postgraduate curricula to include training in leadership and management skills), that this is now

becoming a core part of the training offer. The medical member noted that statements in our guidance can support those who are pushing for change and even encourage some disruptive innovation.

- 20** In addition to supporting the idea of 'embedded' leadership skills, there might be value in exploring the Faculty of Medical Leadership and Management model which describes leadership responsibilities at the individual, team, and organisation and system level.
- 21** Another member highlighted that many NHS organisations have recognised that leadership is not only about the formal roles at the top of the organisation's hierarchy - some of the best leadership is demonstrated by porters and cleaning staff particularly attending to issues around patient safety and experience. They are moving towards a quality improvement culture, with many postgraduate training opportunities focused on quality improvement initiatives. Our guidance could support this shift.
- 22** The same member reiterated the earlier concern that the review needs to be sensitive to the challenges for registrants of showing leadership in workplace environments where there are deep rooted issues around poor team or organisational culture. Making the development and application of quality improvement skills a mainstream expectation on all registrants would help towards addressing the issue.
- 23** A medical member asked the group to consider possible unintended consequences of new leadership duties, such as doctors who find themselves in a difficult situation where there is no room to manoeuvre, and then feel that a duty around showing leadership is another stick to beat them with. There are organisations where the corporate structure limits the room for autonomous action and leadership responsibilities could be one more weight to be carried that a doctor can't easily discharge. The team will therefore need to think hard about adding context to any leadership duties, and carefully consider how duties will play out in the real world and affect fitness to practise decisions.
- 24** Mark Swindells, Assistant Director for Standards, offered reassurance that we are alive to the issues raised about the realities within different healthcare organisations. We're also conscious of the importance of setting expectations that take account of the context in which registrants are practising.
- 25** A member highlighted that the public inquiries into service failures identified the leadership culture 'at the top' as the key to other issues in the organisation. It wasn't clear whether the proposals around all registrants demonstrating leadership skills and behaviours were intended to fix the sort of problems identified in public inquiries, and if so whether we were confident that they would have this effect?
- 26** Professor Emma Cave drew together the points raised so far, noting that there was general support for the proposed duties, with clear definitions, expressed in a way

that manages expectations about what may be possible in different environments, and a requirement for appropriate support to be provided for registrants to meet the standards. The existing Leadership and management guidance was a good starting point to draft GMP duties along these lines. However, members were invited to consider whether there are any elements of Leadership and management guidance that didn't sufficiently cover the points - looking for gaps to attend to in the drafting.

- 27** A medical member stressed the need for the drafting to avoid a tone that suggests that a failure to demonstrate leadership behaviours would be an 'offence' leading to fitness to practise action. The duties should be expressed as something empowering to registrants – supporting them to take action to improve local services.
- 28** In response, another member stressed the need to consider both issues together. The public inquiry reports focus on the role of hierarchical, formal leadership as a key influencer on the safety and quality of care. We also know that no profession is free of individuals who behave in problematic ways that impact on the quality of care provided to service users. In setting out expected leadership skills and behaviours, can the team be clear if the standards are intended to drive out bad practice – such as the hierarchical and other behaviours that underpin service failures - or to set positive requirements for the benefit of patients?
- 29** A member noted the change of focus from asking registrants to 'show leadership' to promoting the importance and benefits of leadership skills and behaviours, and the need for mechanism to be in place to support development of these practices. However, if a specific standalone duty is included in GMP around leadership practice, would some registrants breeze past, if the evidence is that they do not see themselves as leaders?
- 30** Professor Emma Cave reflected on the concerns raised, and suggested that one option for covering the issues without significantly expanding GMP might be to revise the Leadership and management guidance. In doing so, the team could also make clearer that this guidance is about the leadership role that everyone can play in the course of their work – it might be helpful to change title.

What are the behaviours that underpin good teamworking?

- 31** Angela summarised the issues behind question 3 of the paper. She asked the group to consider:
- If GMP does include leadership duties, should it also include something about duties that fall on 'doctors with extra responsibilities'? This might seem outdated now and perhaps unnecessary if we are emphasising that all doctors are expected to demonstrate leadership skills and behaviours.

- Should GMP set expectations around the behaviours and skills that underpin effective teamworking? This could be achieved by drawing on the descriptions set out in [Outcomes for graduates](#) and bringing relevant content into GMP.
- Another approach would be to bring relevant Leadership and management guidance content into GMP.

Discussion

- 32** Professor Emma Cave noted that there is a lot of content in our Leadership and management guidance on expected behaviours within teams. Members might want to focus on whether there is anything key missing from the guidance. For example, would it be helpful to include guidance on forming effective teams; when to draw in people with different expertise to support the delivery of care to patients; how to determine who should take a leadership role; how to deal with team dynamics, culture, and ethical dilemmas.
- 33** A member commented that it seems that formally constituted teams are well-served by the existing guidance on multi-disciplinary working. The experiences of people with multiple long term health conditions throws a different light on teamworking challenges. Their care is more likely to be delivered by 'informal' teams, involving different staff who are not structured and managed as a team. Informal teams need to work collaboratively to meet the needs of a patient who is moving through, for example, 6 different clinics and using different services. These informal teams might benefit from guidance that supports them in thinking about how to work together to support patients through these complex care pathways.
- 34** A medical member pointed out that in hospital settings doctors no longer belong to a 'firm' – a single multi-disciplinary team with stable membership that works together over many months. Teams can form for only one day, to meet the needs of an individual patient. To promote inter-connectivity between team members and across teams, our guidance would need to make clear how we expect registrants to develop the skills to work in any team (with 'norming, forming, performing' needing to happen within weeks or even minutes).
- 35** A member noted that good team work should also incorporate a patient's transition through primary and secondary care.
- 36** A medical member pointed out that there is a big gap in the Leadership and management guidance from the GP perspective, given the changing structure of general practice and the fact that a significant part of the workforce consists of locum/sessional doctors. There are challenges in ensuring continuity of care for patients, for example where a locum/sessional doctor has ordered blood tests and there is no guarantee that this will be picked up by another doctor taking over the patient's care. It would help to have guidance around personal responsibility for

patient care and ways of working in teams within primary care to reduce the risks to patient safety.

- 37** Another medical member supported the need to recognise that registrants might work in 'true teams' and 'transient teams' – for example the latter is really important in emergency situations such as responding to a cardiac arrest. In their view, trainee doctors would appreciate guidance on what is expected of them in these different teams especially given their shift working arrangements. It would also be helpful to have advice on dealing with the ethical challenges and team dynamics that they might encounter when working in different teams as a transient member.
- 38** Professor Emma Cave reflected that it would be a challenge to address all of the points made by members within GMP without significantly expanding the content and this was in tension with the emerging view that GMP should remain short and succinct. In considering what elements of the Leadership and management guidance could be brought into GMP to address the points and concerns, Professor Emma Cave's initial view was that this might focus on the content around effective team communication, responsiveness to patients and colleagues, and responsibility for decisions and the quality of patient care.
- 39** A member agreed with this summary, arguing that many of the issues raised were about 'relational' challenges and responsibilities. They suggests that perhaps there would be value in explaining this briefly within GMP for simplicity's sake, and then unpacking the detail in the Leadership and management guidance.

How can GMP support a more compassionate working environment?

Should we include specific duties to provide equality of leadership opportunities?

- 40** Angela summarised the questions presented in the paper which were about setting clear responsibilities and expectations around creating a compassionate and supportive working environment.

Discussion

- 41** A medical member expressed enthusiasm about the Civility Saves Lives (CSL) work, and explained that there is evidence to show that civility not only saves lives, it has a positive impact on learning and retention. There are different ideas about what 'civility' means – it's not only about politeness or kindness. It's also about respect for differences in perspective, experience and background. Including some of language and ideas from CSL in GMP could prompt a wider discussion about the value and potential impact of the concept within different healthcare settings.
- 42** A member felt that if we are going to use terms like civility and kindness in GMP, it would be important to discuss what the team intends the words to mean, and to pay

attention to the fact that the concept may be understood differently in different cultural contexts.

- 43** Professor Emma Cave reflected that there was broad agreement on including relevant duties in GMP and the need for some softening of the language of existing principles that relate to leadership and workplace cultures. It would be important to choose words carefully for example 'civility' and consider how - if the team creates duties around such behaviours – this might impact on people who have cognitive impairments or are neuro-diverse and understand social cues in different ways (such as people with autism).
- 44** A medical member returned to the question about creating a duty around equality of leadership opportunities. They suggested that it might be helpful to look at, and add to the evidence base, the findings relating to ethnic minority doctors in the recent report from BAPIO 'Bridging the gap'.
- 45** Professor Emma Cave observed that in setting any duty to promote equality of leadership opportunities, we need to be clear that this is about career progression, and that elsewhere we are focusing on equality of opportunity to develop leadership skills and attributes.
- 46** Lastly on this topic, a member expressed support for the proposed wording of the principles about EDI and leadership (and access to opportunities) as presented in the paper. They noted that it is important in terms of 'future proofing'- that the team bear in mind that there may be disadvantaged or marginalised groups with no voice that we are currently unaware of. There is also the complexity of intersectionality to consider (and the protected characteristics within Wales are legally a little different to the rest of the UK).

Item 4: Interprofessional boundaries

- 47** Harriet summarised the key issues in the paper. She highlighted that the focus of the proposals for new or enhanced GMP duties was inappropriate sexual behaviours towards colleagues..
- 48** There are some relevant principles in GMP for example about treating colleagues with respect, and in the explanatory guidance on sexual behaviours towards patients. However, the guidance doesn't specifically draw out the issues of inappropriate sexual behaviours and incivility between colleagues. The team has taken the view that they should try to address the issues by setting out high level duties in GMP supported by new explanatory guidance, using the consultation to test whether this would have wide support.
- 49** Harriet invited attendees to consider three discussion questions.

Should there be professional standards in relation to inappropriate sexual behaviour between colleagues?

Discussion

- 50** A medical member expressed support around the inclusion of duties requiring registrants to actively promote a respectful workplace culture and emphasised that this would be particularly valuable from a trainee's perspective, especially in workplace settings and medical specialisms where there's a known problem.
- 51** The BMA's sexism in medicine report highlights a key issue around sexual boundaries and the need for clear expectations about behaviour that is and isn't acceptable. Taking action, through GMP, to bring about culture change in this area would help build patient confidence in health services.
- 52** Another member agreed with the proposed strengthening of professional duties in relation to tackling inappropriate behaviours. When reflecting on the experiences of LGBTQ and transgender professionals (for example the transgender chair of a group being subject to unacceptable 'banter'), they noted it would be helpful to make clear that the issue of inappropriate sexual behaviours is not just about male and female interactions.
- 53** Professor Emma Cave expressed support for the Australian regulator's approach to describing relevant duties, noting it is very straightforward and clear, and might therefore be a good starting point. This point was supported by other members.
- 54** There was general agreement within the group about the importance of not overlooking marginalised groups and added that guidance should make clear our positive expectations include behaviours toward people who identify as non-binary.
- 55** A member noted that it would also be important to draw out the issue of different power dynamics and how they influence these behaviours. The member agreed that a broad, inclusive approach to any new duties in this area will be helpful. But they also stressed the importance of acknowledging that the way sexual harassment and incivility is experienced can be specific to a person's gender identity. For this reason, there may be additional need for tailored guidance that recognises the different gendered dimensions of the power imbalances and sexual behaviours in medicine, as described in recently published reports.
- 56** It might be helpful to ask groups who are active in tackling violence against women and girls, and LGBTQ groups, whether they would see a benefit in setting out not only broad inclusive principles and tailored advice that addresses the specific experiences and concerns of different groups.

Do the professional standards say enough about supportive behaviour between health professionals with regards to inappropriate sexual behaviour?

- 57** Harriet introduced the discussion by outlining that it's well-established that workplace culture can make it difficult for individuals to challenge someone who behaves inappropriately or sexually harasses a member of staff.
- 58** She noted that GMP explanatory guidance (eg *Leadership and management* and *Raising and acting on concerns about patient safety*) contain a number of principles around taking action where patient care may be compromised. But there is no explicit advice on tackling inappropriate sexual behaviour towards colleagues. Even in positive working cultures we know that individuals who want to help a colleague on the receiving end of poor behaviour may be unwilling to call it out. Including a duty in GMP may help create clear expectations to be proactive.

Discussion

- 59** Professor Emma Cave asked members to bear in mind in their reflections on the issue that introducing such a duty for registrants could mean that their fitness to practise might be called into question if they persistently or seriously failed to actively support a colleague.
- 60** A member noted it was difficult to see quite how as a regulator the GMC would be able to hold registrants to account, unless they had been 'persistently' unsupportive or had failed to support a colleague and that had led to an adverse outcome. The member expressed a sense of discomfort around the idea, pointing out that there can be many nuances and situational details that affect whether and how a person acts on events at a particular moment in time. However, it's possible to see that where disclosures have been made to a senior member of staff and they have failed to act, that would be more clear-cut in terms of fitness to practise action.
- 61** Another member expressed understanding of the concerns noted above, and suggested that perhaps this issue can be addressed by providing guidance on the sort of steps that staff might be expected to take. This could be supported by advice on what the GMC means by supportive/unsupportive behaviour and 'persistent' failure to meet the expected standard. GMP duties would need to be as clear as possible, and case study examples could help by describing common scenarios and illustrating different options for action and their different outcomes.
- 62** The member noted that victims of sexual harassment will not want to continue working in a culture that stigmatises them when they speak up, and we need to recognise how speaking up can further compound trauma. Therefore, it seems important for the team to include something specific in the guidance to be very clear about the supportive action that we expect from colleagues. The group agreed that guidance should also bear in mind the impact on patients if clinicians are working in an environment where these behaviours are not being addressed.

- 63** Angela observed that existing guidance already says that registrants should challenge colleagues (GMP para 25) and that they must tackle discrimination (Leadership and management para 7). So perhaps the guidance needs to make clear that the focus is on promoting and supporting good practice around speaking up, and less on the likelihood of more cases coming into the FTP process.
- 64** A medical member agreed that in including a duty around being supportive to colleagues, the GMC needs to avoid appearing to be focused on pursuing punitive outcomes and make sure changes are understood as a positive lever for change. The member suggested asking registrants in the consultation to consider how they can support colleagues in situations where offensive 'banter' or micro-aggressions have occurred. The member provided examples such as seeking support from an active ally and using a coffee conversation to call out poor behaviours with compassion.
- 65** The same medical member suggested drawing on learning from practice around child and adult safeguarding – especially where there is a legal expectation on professionals to act in support of the person who may vulnerable. Any duty in the guidance would benefit from more detailed advice and perhaps case studies to bring the issues to life.
- 66** Professor Emma Cave agreed that the points raised by members should be explored in the consultation, including the idea of using case studies as a way to allay registrants' fears about possible FTP consequences.

Should GMP address the role and responsibilities of managers and senior doctors in responding to allegations of inappropriate sexual behaviour?

- 67** Harriet outlined that staff with formal management and leadership roles can play a crucial part in shaping organisational culture around calling out inappropriate sexual behaviours. It may be that setting a clear duty on registrants in these roles - in relation to supportive cultures and role modelling expected behaviours - could encourage more junior staff to speak up.

Discussion

- 68** A member welcomed the proposal to set out expectations of managers and senior leaders but stressed that it will be important to take a nuanced approach. For example, recognising that managers need to take account of confidentiality for people on the receiving end of sexual harassment, and people who speak up about their experiences need to be consulted on and agree with any subsequent actions taken to address the situation.
- 69** If people speak up in a culture which is not supportive, there is the possibility for them to experience more harm if the situation is handled badly by managers. A member emphasised the need to make sure that GMP is in line with other guidance and procedures and suggested that it may be helpful for the team to consult groups

involved in the programme to action to end violence against women and children about good practice within organisational settings. The team should try to align GMC guidance with national policies and any examples of effective guidelines that are already in place.

- 70** Professor Emma Cave concluded the discussion by expressing a need for caution to make sure that the inclusion of a specific duty on leaders and managers isn't understood as suggesting that the responsibility to act and to shape a positive culture rests solely with senior leaders.

Item 5: Consultation methods

- 71** Claire gave a brief overview of the team's consultation methods and the scope to be creative in efforts to reach as wide an audience as possible within the constraints of the consultation timetable.

Summary and next steps

- 72** Professor Emma Cave wrapped up the meeting by thanking members for the richness of their reflections and suggestions throughout the meeting, as well as on the important points to for the GMC team to get right in the approach to public consultation. She summed up with a general observation that the key challenges for those redrafting GMP would be to keep the content short and succinct while including content that sets the context for new duties. We'll also need to focus on using language that clearly explains the nuances that arise in many of the areas discussed today and at the previous GMP advisory forum meetings.