General Medical Council

Good medical practice 2024

How we developed the updated professional standards

August 2023

Contents

What is *Good medical practice*?

Our professional standards, including *Good medical practice*, out the principles, values, and standards of care and professional behaviour expected of all medical professionals registered with us.

Good medical practice is an ethical framework, which supports medical professionals to deliver safe care to a good standard, in the interests of patients. We work closely with medical professionals, patients and others to develop *Good medical practice*, so it is a shared agreement of what the professional standards should be.

Good medical practice isn't a set of rules. The medical professionals we regulate need to use their professional judgement to apply the standards to their day to day practice. It informs medical education and training, as well as the advice that medical royal colleges, defence organisations, the British Medical Association and others give to doctors.

The professional standards describe good practice, and not every departure from them will be considered serious. We only take action in the small number of cases where an investigation indicates a doctor's fitness to practise may be impaired, to the point that patient safety, or public confidence in the profession, may be at risk.

About the review

It's been over a decade since the last fundamental review of *Good medical practice*. The 2013 guidance has stood the test of time well, but it is important to ensure the content keeps pace with developments in medical practice and wider society.

One such development is our preparations to become a multi professional regulator. That's why we considered the roles and practice of Physician Associates (PAs) and Anaesthesia Associates (AAs) in this review; *Good medical practice* will apply to PAs and AAs when regulation begins in the future. We were also keen to update the professional standards as part of our preparations for upcoming regulatory reforms to our processes, so we can be confident that they're up to date and representative of modern practice.

We are also taking the opportunity to review some of our more detailed guidance, including:

- Ending a professional relationship with a patient
- Delegation and referral
- Acting as a witness
- Conflicts of interest
- Writing references
- Social media

- Consent to research
- Good practice in research
- Sexual behaviour
- Intimate examinations and chaperones
- Maintaining a professional boundary

The Good medical practice advisory forum

In 2021 we established an advisory forum for this review comprised of twelve experts, independent of the GMC. It was chaired by Professor Emma Cave, a professor of healthcare law at Durham University. The role of the forum was to act as a critical friend and sounding board for key decisions and developments throughout the review. As such it was advisory rather than decision making. The members participated as individuals, rather than as representatives of organisations. Whilst the members reflect a diverse range of perspectives and experiences from across UK healthcare, the forum was not a substitute for direct engagement and consultation.

You can find information about the full membership and meeting notes on our website.

Pre-consultation evidence gathering

Starting in March 2021, we embarked on a range of activities to identify the themes and intelligence that would become the evidence base for the review. Our main three activities are described below.

Desk research

We reviewed material from a range of internal and external sources, including data and insights from:

- enquiries received into the standards team from a wide range of sources over the past five years
- other GMC teams including the Contact Centre, Data, Research and Intelligence (DRIH), Regulation Policy, and Fitness to Practise teams
- other programmes of work within the GMC – for example: *Supporting a profession under pressure* and *Embedding learning from sexual abuse*.

To focus our efforts when conducting scoping we looked for things like:

- recommendations from an official source, such as government inquiries or systems regulators, highlighting gaps in our standards and/or expressing concern that our existing standards were not being applied consistently
- issues or challenges raised by key stakeholders including healthcare leaders, organisations, doctors, and patients where we've needed to clarify/give advice on our standards
- areas where policy or practice has moved on considerably since the last review
- opportunities to promote good practice through inclusion in the standards.

Research

Given that our initial data sources were largely registrant-focused, we commissioned our Data, Research and Insights team to carry out a 'rapid scan' on data around patients' views and needs. This included a review of both primary resources, as well as reports published by other organisations.

We also commissioned three pieces of research to inform the review. These were:

- Regulatory approaches to standards
- Understanding how external users perceive, access and apply GMC professional standards.
- An internal review of how our guidance (and the standards they contain) are used within the GMC.

Targeted stakeholder survey

In August 2021 we ran a targeted online survey for key stakeholders. The purpose of the survey was to give us a sample of responses to help inform the proposals and questions to include in our full public consultation.

We asked questions on issues such as:

- the extent to which our standards meet the diverse needs of patients, public and registrants
- the structure and role of our standards
- the principles we should add, update or remove and the impact of change
- the applicability of standards to the different professionals we regulate

- terminology (such as the use of ‘must’ and ‘should’) and the thresholds for fitness to practise action when standards are not met.

We invited responses from over 60 organisations involved in UK healthcare and medicine and received 40 responses (24 full; 16 partial). The range of responding organisations included patient and doctor representative organisations, medical royal colleges, health regulators, and education and quality improvement bodies.

Inclusion criteria

To assess whether issues identified in our scoping could be expressed as professional duties or not, we set inclusion criteria at the start of the review. The inclusion criteria remind us that standards define what makes a good medical professional as they set out the professional values, knowledge, skills and behaviours required for UK practice. To meet the inclusion criteria, new professional standards must be:

- within our remit - i.e. a matter to do with professional standards, not clinical, technical, legal or other matters outside our expertise
- relevant to the practice of individual medical professionals, not an action for employers, educators, government
- relevant to most if not all registrants
- demonstrable by individuals in practice – and capable of being evidenced - eg through appraisal and revalidation
- if breached - seriously or persistently - would bring registration into question.

The inclusion criteria helped us to separate the obvious new duties from areas, which although relevant, may not be a good fit when expressed as a duty.

Key findings

As a result of our initial data analysis, the thematic priorities we identified for new or amended professional standards were:

- tackling bias and discrimination in healthcare
- patient centred care, decision making and communication
- team working, including working in multi-disciplinary teams

- leadership and interprofessional behaviours, including civility and sexual misconduct between colleagues.

The key findings in relation to the tone, style and structure of the guidance were:

- strong support for keeping four domain structure of *Good medical practice*
- desire for us to retain 'you must' and 'you should', with the potential to add 'I will' statements
- support for current level of detail in *Good medical practice*, but with more explanatory text to contextualise duties
- calls for us to clarify the interaction between professional standards, fitness to practise and local processes and to say more about what we mean by 'professional judgement'.

One of the key findings from the research we commissioned into how audiences use and perceive the guidance was that most registrants look to *Good medical practice* and not to our more detailed guidance to understand their professional duties. It also found that awareness of our more detailed guidance could be improved. Promoting important duties from more detailed guidance into *Good medical practice*, whilst taking care not to significantly increase the overall length, was suggested as a solution for some of the gaps identified.

Overall, the message from the stakeholder survey and other scoping and engagement activities was that we should be taking an approach of 'evolution rather than revolution'. That is, we should be updating and adapting *Good medical practice* to make sure it's relevant and realistic for the future, but we were starting from a good place, with a well-regarded product.

Equality, diversity, and inclusion

A key objective of the scoping phase was to identify issues around equality diversity and inclusion (EDI) that would, in turn, feed into the Equality Impact Assessment (EQIA). To ensure that all the staff working on the review had the requisite understanding from day one, we briefed them about the protected characteristics as defined by the Equality Act 2010 and other characteristics which are not fully protected by law, but which can result in bias and discrimination. For example, socio-economic background/location of a registrant's primary medical qualification.

We sought out reports and data related to EDI, featuring registrants or patients with protected characteristics. We also commissioned internal research into areas where we needed to know more.

As we progressed through the review, several important themes began to surface, including leadership, boundaries, and climate change. We made sure to scrutinise the EDI considerations

for both patients and registrants of each theme as we went along. This approach means we had EDI at the centre of our scoping activities and running through every aspect of the work. The responsibility for understanding and capturing the EDI information has been a collective one.

We have published a fuller account of how we considered EDI throughout the project in our equality analyses. Part 1 covers activities leading up to consultation; Part 2 covers the redrafting of *Good medical practice* following consultation and Part 3 covers our implementation planning. Future additions will cover the development of more detailed guidance in scope for review.

Public consultation

A public consultation on the updated draft guidance ran from 27 April to 20 July 2022.

Alongside questions about the overall style and structure of the document we asked for views on four key themes:

- Tackling discrimination, and promoting fairness and inclusion
- Working in partnership with patients
- Working effectively with colleagues
- Leadership and organisational culture.

Seeking diverse views

We sought views from the people who will be expected to follow our guidance (doctors, physician associates and anaesthesia associates), alongside patients and the public and key stakeholders such as health organisations and representative bodies.

We invited responses to our public consultation via three surveys tailored for different audiences.

- A main stakeholder survey intended for large organisations, which received 410 responses including 365 from individuals and 47 organisations.
- A survey for individual healthcare professionals, which received 3241 responses including 2899 doctors, 55 medical students, 75 physician associates and students, 20 anaesthesia associates and students, and 37 other healthcare professionals.
- A survey of patients, members of the public and patient groups, which received 1028 responses including 582 patients, 264 members of the public, 57 relatives, 27 patient advocates, 21 carers.

Overall, we received over 4,600 written responses across the three surveys, which is significantly higher than any of our previous consultation on professional standards. However, we are mindful that the majority of medical professionals do not engage in consultation exercises and respondents to surveys are self-selecting. We therefore also gathered feedback via online collaborative software in over 200 engagement events attended by 3,800 medical professionals delivered by our outreach team, of which 49% were doctors from ethnic minority backgrounds.

Events and specialist workshops

We held specialist workshops with experts and thought leaders on patients' rights, research, environmental sustainability, digital technology and artificial intelligence. The purpose of these workshops was to identify potential gaps, risks and ethical challenges in these areas and understand how they might affect how medical professionals will practise in the future. We also held stakeholder events in Northern Ireland, Scotland and Wales.

Consultation responses

Healthcare professionals

Healthcare professionals across the UK engaged positively with the consultation. We received responses from 2291 individual doctors in England, 264 in Scotland, 131 in Wales and 50 in Northern Ireland. Although doctors in England form the biggest proportion of respondents to the consultation, they were slightly under-represented in relation to the proportion on our medical register.

We received responses from healthcare professionals working in a range of fields across the UK including 957 consultants, 667 doctors in training, 510 specialty and associate specialist and locally employed doctors, 446 general practitioners, 137 locums working across primary and secondary care, 75 physician associates and students, 55 medical students, 53 responsible officers/medical directors, 20 anaesthesia associates and students, and 37 other healthcare professionals. We also received 167 responses from doctors practising outside the UK.

Patient engagement and bespoke research

We promoted our short patient survey via national patient organisations in the UK including the Patients Association, Healthwatch England, Wales Council for Voluntary Action, Board of Community Health Councils in Wales, Health and Social Care Alliance in Scotland and Patient Client Council (PCC) in Northern Ireland. As a result, the proportion of respondents to the patient survey in the four nations is broadly in proportion to size of population, with slightly fewer patients in Scotland engaging. We received responses to the patient survey from 787 people in England, 67 in Scotland, 67 in Wales and 23 in Northern Ireland. The PCC also co-hosted user-

involvement sessions.

In addition, we commissioned ICE Creates behavioural insights agency to hold six dedicated focus groups for patients with lived experience of the healthcare system in the four nations, at the beginning and end of the consultation period. Participants were recruited to broadly reflect population demographics including protected characteristics and socio-economic status.

ICE Creates also held focus groups and telephone interviews with patients from 22 seldom heard groups including ex-offenders, travellers, people undergoing gender reassignment, domestic abuse survivors, people with physical, mental and sensory disabilities, refugees and asylum seekers, homeless people, people with additional communication needs, people with low literacy and other groups. A total of 159 patients participated in the first phase of this research.

Following the consultation. ICE Creates undertook further patient focus groups to explore some of the principles and issues identified in the consultation in more detail. We also took the opportunity to explore issues raised by healthcare professionals about time and resources and asked patients participating in the focus groups to consider what's most important to them during a time-limited appointment. Six focus groups were held, including sessions for patients living in England, Wales, Scotland and Northern Ireland, a men-only group, and patients accessing independent care.

Themes

This review of *Good medical practice* has taken place in the context of a medical profession which is striving to recover from a pandemic with workforce shortages across all staff groups in the healthcare system. Many doctors are understandably exhausted and are dealing with record backlogs of people waiting for care.

It's also the first time we've updated the guidance with a forward look to the future regulation of physician associates and anaesthesia associates, subject to new legislation being introduced by the UK government.

These factors are evident in the responses we received from medical professionals, patients and other stakeholders. In analysing them, we were mindful of this context, while also recognising that the final version of the guidance needs to be relevant to the medical professionals we regulate into the next decade.

In general, the vision we set out in the updated the standards was supported by stakeholders, individual medical professionals and patients. For each of the questions we posed on individual changes to *Good medical practice* the proportion of responses expressing support ranged between 70% and 84% in the main survey, between 63% and 87% in the healthcare professionals survey, and between 64% and 93% in the patient survey.

Several respondents, including the British Medical Association (BMA) and medical defence organisations, were supportive of individual principles and our aim to improve fairness and inclusivity in the workplace, but expressed concern about the collective impact of the updated standards.

Many respondents, including those who supported the principles within the guidance, cited lack of time and resources, abuse towards doctors, stress and burn-out within the profession as potential barriers to implementation. Some respondents called for the GMC to take a more visible stance in challenging others to ensure resources are in place to support medical professionals enact their personal duty to provide a good standard of care.

Some interpreted the guidance as a list of things which need to be done in every patient interaction rather than a range of principles to be broadly applied. Others predicted the fear of complaints will drive defensive practice and that additional time would be needed to document how the standards had been followed as evidence to protect themselves against potential allegations.

We heard concerns that an increase of 'must' statements may create unrealistic expectations and result in an increased number of complaints. We also heard concerns that medical professionals may be held to account for system failings, such as a lack of systems in place to support patients' language and communication needs. Where medical professionals are unable to do everything that's expected of them this can cause stress, moral injury, and low morale with some respondents suggesting this will drive more people to leave the profession.

We also received feedback about our fitness to practise processes, including a lack of confidence that concerns are handled fairly and proportionately, with a particular impact on international medical graduates and medical professionals from ethnic minority backgrounds.

A perceived lack of transparency about when a failure to meet the standards in our guidance is likely to trigger a GMC investigation, or conclude in action on registration, is also fuelling fear within the medical profession. Several key stakeholders, including the BMA and medical defence organisations highlighted the importance of a clear, concise statement to help medical professionals understand the relationship between standards guidance and fitness to practise procedures.

The 2013 version of the guidance has a statement explaining that "Only serious or persistent failure to follow our guidance that poses a risk to patient safety or public trust in doctors will put your registration at risk". We tried to make this clearer in consultation draft by providing a more detailed explanation of the contextual factors that are taken into account when assessing complaints. However, this had the unintended consequence of some stakeholders feeling the statement was less clear and raised fears that we were lowering our threshold for action.

We reflected on these points carefully and amended the description of how *Good medical practice* relates to fitness to practice, detailed in the next section of this document. We considered the overall feedback very carefully when reviewing individual duties following the consultation closing, in determining the final text.

What's changed and what's new?

Structure and tone

There was support in the scoping and consultation for the overall format of *Good medical practice*, and for there to be one document spanning all the medical professionals we will regulate. There was support too for our efforts to make the tone more supportive to our registrants, and to add some limited introductory text at the start of each of the domains to explain how each, contributes to the overall vision of *Good medical practice*. We have renamed and re-ordered the domains as follows:

- Knowledge, skills and development
- Patients, partnership and communication
- Colleagues, culture and safety
- Trust and professionalism

As in previous versions of *Good medical practice*, the order of the domains does not denote priority: each domain has equal weight and importance.

Duties of a doctor

We tested whether the current 'duties of a doctor' summary statement should be amended to read 'I will', giving those registered with us more ownership of the behaviours it describes. While the headline statistics suggested support for this change there were some strong and persuasive opposing views that these are duties and expectations, not just behaviours; that the GMC rightly owns these expectations and should be clear about that; and that it is not legitimate for us to put words in the mouths of registrants.

The conclusion we have reached is that this section functions best as an executive summary of *Good medical practice*, so has been returned to the second person "you must". We have also retained the word 'duties' as this word reflects the fact that there are actual duties on medical

professionals, both legal and ethical, that underpin the expectations set out in *Good medical practice*.

New duties

This table summarises the most significant new duties in the updated version of *Good medical practice*.

New or updated duties	Explanation
New: sexual harassment	This is a new duty driven by evidence considered around poor inter-professional behaviour, power differentials and sexual harassment. It is drafted broadly, to capture the nuances in this kind of behaviour, including where it happens online.
New: bystander action in response to bullying, harassment, discrimination	This new duty builds on the duty in our guidance on leadership and management for doctors to 'tackle discrimination'. It prompts medical professionals to take action without being prescriptive about what kind of action. We discussed concerns about putting junior members of staff in difficult positions, for example 'forcing' them to call out poor behaviour of those above them; encouraging an adversarial response; the possibility of making things worse by escalating an issue without consent from the victim. We've tried not to be prescriptive but have given examples of the kinds of action that could be taken – for example it could simply mean checking in with and offering support to the person who experienced the bullying, harassment or discrimination.
New: sustainability	The evidence of risks to public health as a result of the climate crisis is clear. We have faced a number of calls from doctors and their representatives that we should incorporate sustainability into *Good medical practice*. But we also heard concerns in terms of what can reasonably expected of individuals, and whether medical professionals could be held to account for matters that they don't have agency over. We have balanced our expectations that medical professionals should choose sustainable solutions when they are able to, provided these don't compromise care standards, against the fact that many factors about the environmental impact of healthcare are beyond an individual practitioner's control. We add that medical professionals

	should consider supporting initiatives to minimise the negative environmental effects of healthcare.
New: kindness	There is a new paragraph about treating patients with kindness, courtesy and respect. The proposal to include the word 'kindness' attracted significant debate during the consultation period. Our intent is to capture what we know many consider to be the essential components that underpin the relationship of trust between patients and medical professionals. And we were influenced by reports such as the investigation into maternity and neonatal services in East Kent which cited a repeated lack of kindness and compassion in the list of failings. Some of the points we include in *Good medical practice* are: • listening to patients, recognising their knowledge and experience of their health, and acknowledging their concerns • being willing to explain your reasons for the options you offer (and the options you don't) and any recommendations you make • recognising patients' right to choose whether to accept your advice, and recognising their right to seek a second opinion • not making assumptions about what a patient might consider significant or the importance they may attach to different outcomes. We are clear however that being kind in this context doesn't mean agreeing to every request or withholding information that may be upsetting or unwelcome. It means trying to alleviate or prevent suffering, and taking steps to understand patients, and make them feel valued, respected and cared for.
New and amended: feedback, reflection and bias	The revised guidance includes a new component that medical professionals should be aware of the risk of bias, and consider how their own life experience, culture and beliefs influence their interactions with others, and may impact on the decisions they make.
New and amended: leadership	We have enhanced what we say about leadership in the latest version of *Good medical practice*, bringing in some of the established principles from our guidance on leadership and management for doctors. We say that all medical professionals must help to create a culture that is respectful, fair, supportive, and compassionate by role modelling behaviours consistent with these values. For those in a leadership or management role we include expectations that they will

	take steps to create an environment in which people can talk about errors and concerns safely. We also say they must be satisfied that any discriminatory or bullying behaviour or harassment they are aware of is adequately addressed.

The interaction between professional standards and fitness to practise

The 2013 version of *Good medical practice* contains the following description of the link between *Good medical practice* and our fitness to practice processes at paragraph 6:

> *To maintain your licence to practise, you must demonstrate, through the revalidation process, that you work in line with the principles and values set out in this guidance. Only serious or persistent failure to follow our guidance that poses a risk to patient safety or public trust in doctors will put your registration at risk.*

Whilst this "serious or persistent" terminology is well-established, it isn't strictly accurate. Some failures to meet the expected standard may never reach the level of seriousness that would justify action on registration, even if persistent. So, working closely with colleagues in our fitness to practise directorate, we have updated the language, so it more accurately describes the *Good medical practice* and fitness to practise relationship, as follows.

> The professional standards describe good practice, and not every departure from them will be considered serious.
>
> When a concern is raised with us about a medical professional, we must assess if that medical professional poses any current and ongoing risk to one or more of the three parts of public protection:
>
> - protecting, promoting and maintaining the health, safety and wellbeing of the public
> - promoting and maintaining public confidence in the medical professions, and
> - promoting and maintaining proper professional standards and conduct for members of those professions.
>
> We do this by considering the following.
>
> a How **serious** the concern is. This includes looking at the extent of the medical professional's departure from the professional standards and/or the impact of a health condition on their behaviour or performance. It also includes other **factors that may impact on seriousness**, such as premeditated or persistent behaviour, abuse of power,

and whether the behaviour or poor performance the concern relates to is an isolated incident or has been repeated.

b Any **relevant context** that may impact on risk, for example systems factors and interpersonal factors in the medical professional's working environment or their role and level of experience.

c How the medical professional **responded** to the concern, including evidence of insight and remediation.

Once we've assessed the risk, we'll need to consider if **regulatory action** may be required in response to the concern. You can read more about our procedures and the types of action we might need to take on our Fitness to practise webpages.

This new language will be mirrored in the guidance we provide for GMC and Medical Practitioner Tribunal Service (MPTS) decision makers, aligning these two important documents. We hope it will provide more assurance to medical professionals registered with us about the careful considerations we make when a concern is raised with us.

Must and Should

The feedback we had during the consultation strongly supported the continuing use of 'musts' and 'shoulds' in *Good medical practice* as a well understood signal about the expectations for each specific duty. We have, however, taken the opportunity to improve our description of what those expectations are, as follows.

We use the terms 'you must' and 'you should' in the following ways:

'You must' is used for a legal or ethical duty you're expected to meet (or be able to justify why you didn't).

'You should' is used for duties or principles that either:

- may not apply to you or to the situation you're currently in, or
- you may not be able to comply with because of factors outside your control.

Terminology

One of the objectives of this review is to streamline and improve users' navigation of the guidance on professional standards and supporting content. As part of this, we have considered the terminology we use to describe *Good medical practice*, our other guidance statements and the advice on our ethical hub. It was clear from our scoping that there is much greater awareness of *Good medical practice* than our more detailed guidance, for example, our formal guidance on

confidentiality, consent, and end of life care. Yet these documents have the same status as formal professional standards we set.

To help make this clear we will now describe the other professional standards documents that sit alongside *Good medical practice* as 'more detailed guidance', rather than the previous term 'explanatory guidance'. The new nomenclature is:

- Professional standards – this comprises **GMP** and the associated **more detailed guidance.** Together, this is the guidance on professional standards, which our registrants are expected to follow.
- Ethical hub – advice and supporting information on ethical topics. This is a collection of resources exploring how to apply our guidance in practice, focusing on areas doctors often ask us about, or have told us they find challenging. It does not set new professional standards and is not intended to replace the formal guidance.
- Learning materials – case studies, videos, decision tools. These are learning aids, again not intended to replace the formal guidance.

The distinction between 'guidance' and 'advice' is not one that is clear to our customers, and this has caused some difficulties, for example in understanding the status of hub content and the extent to which doctors can be held to account. We are therefore going to stop using the term 'ethical guidance' to describe the guidance on professional standards, and instead to use the term 'professional standards' to collectively describe *Good medical practice* and the more detailed guidance on professional standards. Other material such as the ethical hub will continue to be described as 'advice'.

While changing our terminology in this way will not change the status of *Good medical practice* and the other formal, more detailed guidance, we think it will more clearly differentiate the content that has regulatory weight from content that doesn't. It will also better align with the terminology used by other professional regulators.

More detailed guidance

We are also reviewing the following pieces of more detailed guidance, alongside the core *Good medical practice*:

- Ending a professional relationship with a patient
- Delegation and referral
- Acting as a witness

- Conflicts of interest
- Writing references
- Social media
- Consent to research
- Good practice in research
- Sexual behaviour
- Intimate examinations and chaperones
- Maintaining a professional boundary

As these pieces of guidance expand upon core principles and duties in *Good medical practice* , we have taken a targeted approach to testing views on our proposed updates. The updated versions of these pieces of guidance will come into effect at the same time as *Good medical practice* on 30 January 2024.

Implementing *Good medical practice* 2024

Scoping and developing an implementation framework

Implementation is the process of putting our professional standards into practice. This means going beyond just publishing and launching new or updated professional standards, by making sure:

- our registrants are both aware of and understand the standards
- patients are aware of what is expected from registrants
- our staff (and others) who use the standards in a regulatory or formal advisory and educational role, have a good understanding of them, and the intended effect of the standards.

For this review, our aim has been to use an evidence-based approach to inform implementation activity and to create a general implementation framework which can guide future reviews of our standards.

We started by identifying different types of implementation activity. Firstly, activity undertaken directly by us (where we have direct links to registrants and within our own regulatory functions) or indirectly (where our professional standards are used by external stakeholders or by registrants themselves), as captured in the following table.

Direct (by the GMC)	Indirect (external)
• Comms to registrants • Outreach – delivering teaching and improvement interventions & supporting Responsible Officers • GMC website • Revalidation • Education policy and QA • Fitness to Practise	• Medical school and postgraduate curricula (exams) • Medical Defence Organisations • BMA • College/specialty organisations' teaching/guidelines • Employers/Trusts/Boards' policies • Hidden curriculum - informal advice/ training between doctor colleagues • Journals • Appraisal/CPD/LLL • Semi-formal doctor groups designed to knowledge share, Facebook, Whatsapp • Other memberships and networks • MPTS

We looked at examples of implementation activity from other projects, such as the updated Decision Making and Consent guidance (2020) , and we reviewed some previous helpful internal research on developing interventions to change doctors' behaviour. This internal literature review highlighted what methods of interventions, related to behaviour change theory, are most effective. It also sought to establish whether there was an existing framework we could use and apply to the implementation of professional standards. In addition, we commissioned independent research so we could understand how external users perceive, access and apply GMC professional standards.

This report and other scoping activity drew us to a series of conclusions from which we developed a set of implementation principles:

What does the evidence tell us?

Scoping conclusions

It is necessary we set authoritative professional standards which can be used to underpin the GMC's position when we need to react to issues of the day.

Responsible Officers, employers, educators and organisations rely on our guidance to support and enable good practice.

Awareness and reaction to our guidance varies amongst individual registrants.

Dissemination of our professional standards happens informally between colleagues. The hidden curriculum can affect this.

There are insufficient GMC resources available to talk to each registrant regularly. However, registrants tell us that generic information often "gets lost" amongst other communications. Even with a willingness to engage from stakeholders, co-production and collaboration can be time-consuming with variable scope and impact.

In the past, the GMC has not always followed an evidence-based approach to implementation.

Implementation principles

We need to try a new approach which is targeted, engaging groups who have the most influence on registrants.

Our interventions should be preventative, and support 'course correction'.

Whilst case studies and written advice can be useful at an individual level, we can't rely on these tools alone to shift behaviour.

Our approach should be personalised, and tailored to the environment a doctor works in, their career stage (including key transition points), and their touchpoints with us.

Registrants should be prominent in our implementation activity, helping demonstrate how our guidance can be applied to the reality of current practice.

When we have the opportunity to shape external discussions (e.g. social media), we should use this activity to meet our implementation goals.

Co-production of material can be valuable, provided this work has sufficient impact and reach.

We should evaluate our approach and iterate.

Supporting the profession

We know that the medical defence organisations, the medical royal colleges and the BMA, base much of their advice to their members on our guidance. We welcome this and we have therefore prioritised engagement with these organisations throughout the project. We will support them to update and disseminate information through their networks during the familiarisation period for *Good medical practice*, once it has been published on 22 August 2023 to when it comes into effect on 30 January 2024.

Outreach and national offices

Our Outreach and national office teams work across the UK to improve understanding of our guidance. They explain how our processes work and promote our standards. They also collaborate with the health services to understand the issues faced at local level. Our colleagues in our Outreach and national offices have worked closely with us during the review. We are working together to update the core outreach products so we can boost awareness and engagement with the updated *Good medical practice* across the country.

Learning toolkit

We know that medical professionals are extremely busy and deal with high volumes of information. We also know that they are far more likely to seek advice on ethical issues from colleagues than to consult *Good medical practice* and our more detailed guidance. So we can't assume that all medical professionals will be aware of the updated professional standards.

We also understand the impact of the “hidden curriculum”, by which medical professionals absorb norms, values and beliefs from their learning and working environments, and which can sometimes be in tension with the expectations in professional standards.

We are therefore piloting the delivery of a learning toolkit created specifically for the new *Good medical practice*, which is a set of materials to ‘train the trainer’ and help those whose role it is to train doctors in existing forums such as grand rounds and local primary care training networks. We will evaluate the impact of this pilot and, if it’s successful, will consider a wider rollout of an extended toolkit.

Medical education

Outcomes for graduates sets out what newly qualified doctors must know and be able to do when they graduate from any of the medical schools who award UK primary medical qualifications. It is the basis for medical schools to develop their curricula and programmes of learning. “Professional values and behaviours” is already set out in the document as one of the

three overarching outcomes we expect medical students to achieve. Once we have published the new *Good medical practice* we will review *Outcomes for graduates* and associated learning materials such as Achieving Good medical practice to ensure they capture the new content.

The Medical Licensing Assessment's content map advisory group will also review the updates to *Good medical practice* to consider if any revisions to the content map will be helpful.

Appraisal and revalidation

We have updated the description about how *Good medical practice* relates to Revalidation:

> Revalidation supports you to develop your practice, drives improvements in clinical governance, and gives your patients confidence that you're up to date.
>
> To maintain your licence to practise, you must continuously engage with local clinical governance systems, including annual appraisal. This will demonstrate that you're working in line with the principles, values and standards of care, and behaviour set out in the professional standards.

We have engaged appraisal software providers to ensure appraisal systems are updated to reflect the new structure and domains of *Good medical practice*. Doctors have an annual appraisal, part of which is to document their successes during the previous year on the entirety of practice with *Good medical practice* as a reference. So, although the new edition of *Good medical practice* is being published in August 2023, we know that many doctors will be appraised on portfolios based on the 2013 edition for some time.

Thank you

We're very grateful to the thousands of medical professionals, patients and others that took the time to share their views on the draft version of *Good medical practice* or took part in the consultation in other ways. The final standards really are the product of the feedback we received throughout the review, as well as the research and data we considered.

The 2021 – 2023 review project was a true team and cross GMC effort. It's not possible to thank everyone involved across the GMC at different points here but particular credit is due to the core review team.

Photograph of the core review team, April 2023.

Annex A

Organisations that responded to the *Good medical practice* consultation

Association of the British Pharmaceutical Industry (ABPI)
Academy of Medical Educators
Academy of Medical Educators
Academy of Medical Royal Colleges
Action against Medical Accidents (AvMA)
Anscombe Bioethics Centre
Association for the Study of Medical Education (ASME)
Association of Anaesthesia Associates
Association of Anaesthetists
Autistic Doctors International
British Association of Physicians of Indian Origin (BAPIO) Institute for Health Research
BAPIO Wales
Bios Centre
Board of Community Health Councils in Wales
British and Irish Association of Stroke Physicians
British Association of Dermatologists (B.A.D.)
British Medical Association
British Medical Association Academic Staff Committee
British Orthopaedic Association
Cambridge ME Support Group
Care Quality Commission
Castle Medical Group Practice Patient Voice

Centre for Sustainable Health
Compassion in Dying
Dorset County Hospital
Faculty of Medical Leadership and Management
Faculty of Pharmaceutical Medicine
Faculty of Physician Associates
Faculty of Intensive Care Medicine
Gallagher
General Osteopathic Council
Greener NHS National Programme, NHS England
Greener Practice
HCSA - the hospital doctors' union
Health Education and Improvement Wales
Health Research Authority
Healthcare Improvement Scotland
HealthSense
Healthwatch England
Independent Healthcare Providers Network
ITT Improve Thyroid Treatment group
Kent Branch Catholic Medical Association (UK)
King Edward VII Hospital
Lay Advisory Committee of the Royal College of Physicians of Edinburgh
Liverpool foundation NHS trust
Londonwide LMC
Medical and Dental Defence Union of Scotland (MDDUS)
Medical Defence Union (MDU)
Medical Ethics Alliance

Medical Protection Society (MPS)
Medical Schools Council
Medical Women's Federation
National Institute for Health and Care Excellence (NICE)
National Institute for Health and Care Research (NIHR)
NHS Blood & Transplant
NHS Education for Scotland
NHS England
NHS Resolution
Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC)
Nuffield Council on Bioethics
Nursing and Midwifery Council
Organisation for the Review of Care and Health Apps (ORCHA)
Parkinson's UK
Patients Association
Physician Associate Schools Council
Private Healthcare Information Network (PHIN)
Professional Standards Authority
Quinolone Toxicity Support UK
Race Equality First
Redburn Loughview Community Forum
Royal National Institute of Blind People (RNIB)
Royal College of Anaesthetists
Royal College of Emergency Medicine
Royal College of General Practitioners
Royal College of General Practitioners Northern Ireland
Royal College of Obstetricians and Gynaecologists
Royal College of Ophthalmologists
Royal College of Paediatrics and Child Health

Royal College of Pathologists
Royal College of Physicians
Royal College of Physicians of Edinburgh
Royal College of Physicians and Surgeons of Glasgow
Royal College of Radiologists
Royal College of Surgeons of England
SAVE US NOW
Scottish Public Services Ombudsman
Scottish Government Regulatory Team
South West Yorkshire Partnership NHS Foundation Trust
Southwark Travellers Action Group (STAG)
St George's University of London
St Helens and Knowsley Teaching Hospitals NHS Trust
Tal y Coed Associates
The Academy of Medical Sciences
The Royal College of Surgeons of Edinburgh
UK Health Alliance on Climate Change
University of Leicester
University of Leicester, Medical School
University of Liverpool School of Medicine
Versus Arthritis
Village Health Group, PPG , Rushcliffe, Notts,
Wessex Local Medical Committees
West London NHS Trust
Women’s Institute