

Understanding how external
users perceive, access and apply
GMC professional standards

Research report
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Bringing the voices of communities into the heart of organisations



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1. Executive summary

Background and approach

In order to inform its review of *Good medical practice*, the General Medical Council commissioned Community Research to conduct research to explore how its professional standards are perceived, accessed and applied by users.

The research consisted of: an online forum with 50 doctors and medical students; 12 telephone interviews with doctors and medical students who had recently used ethical guidance; 6 telephone interviews with doctors who may find it challenging to access guidance; an online survey completed by 36 Responsible Officers, and 30 telephone interviews with stakeholders including organisations providing advice and information to doctors; employers and educators.

Main findings

Use of professional and ethical guidance

The research found that it was relatively rare that doctors and medical students found themselves in situations where they felt they needed actively to consult ethical guidance. When they did encounter situations that they couldn't deal with themselves, they tended to rely primarily on their colleagues for advice or support, turning to online resources as well, if necessary.

Unsurprisingly, stakeholders used ethical and professional guidance in a direct way more frequently than most practising doctors. It was primarily used to inform the development of guidelines and teaching materials for doctors and medical students, and as a reference tool when it came to making judgements about a doctor's revalidation and appraisal process. However, stakeholders who were also practising doctors said that they rarely used the guidance themselves in that capacity.

Landscape for ethical guidance and resources

When ethical guidance was required, doctors and medical students initially looked to their colleagues, typically other doctors; if they were not able to help, they turned to other sources, most commonly their defence unions. The GMC guidance tended to be used less 'in the moment' and more in a formal capacity, for example as part of reflective practice, when cross checking the 'rules', or in exam/interview preparation. By contrast, stakeholders often relied most heavily on the GMC's guidance, but also sought input from other regulators or specialist organisations.

Use of GMC guidance

Most doctors and medical students engaged with the GMC guidance relatively infrequently for a number of reasons. In addition to preferring to use other sources of guidance, some doctors simply didn't think to refer to GMC guidance when ethical



issues arose. Many felt that they applied the core principles instinctively and as such, had no need to refer directly to the written guidance.

Most users accessed the guidance online in order to be confident they were reviewing the most up-to-date versions; however, there was a sense amongst some that, by no longer engaging with hard copies, doctors may read the guidance less than they previously did.

Understanding and awareness of GMC guidance

While most doctors felt confident in their knowledge of *Good medical practice*, there was less awareness of the explanatory guidance and very few knew about the supplementary materials provided. When prompted, most doctors and medical students said that they did not know the difference between the types of guidance. While stakeholders had a better understanding of how the different pieces of guidance fitted together, they had some sympathy with doctors' lack of awareness, given the extent of what was available and the infrequency with which it was accessed.

Views of GMC guidance

Most doctors and medical students were positive about GMC's ethical guidance in terms of both its content and style. They found it clear and comprehensive, and at first glance, easy to navigate. The main criticisms were that it seemed overly open to interpretation (although by contrast, a minority welcomed the guidance not being overly prescriptive), and that it didn't take into account the context in which most doctors operate.

Stakeholders similarly felt that the guidance was well written and covered off most issues. Some expressed frustrations in relation to the search function on the website, but for many, the main problem with the guidance was that doctors weren't making enough use of it. While the guidance was generally seen as accessible for users with special visual or language needs, a small group of stakeholders thought that doctors who had not trained in the UK may find it particularly difficult to interpret.

Suggested improvements

Users in both phases of the research identified similar ways in which the guidance could be improved to make it more useful including: more examples to help bring it to life; more alternative formats, better dissemination and improved navigability.

Differences by audience

By and large there were few major differences by doctor or stakeholder type. Attitudes towards the guidance amongst doctors and medical students seemed to vary more by personality type than by specialty, career stage or setting. Similarly, doctors with protected characteristics did not appear to use or view the guidance differently from others. Whilst stakeholders understandably used the guidance for



different purposes depending on their role, they likewise shared (largely) positive views towards the guidance.

Conclusions

Although users do highlight criticisms of the guidance, particularly in relation to navigation of the website and a perception that it can be hard to interpret, most are positive about the overall provision. The relatively low levels of usage amongst practising doctors appear to stem more from a lack of awareness of the extent of support available (they may not realise how much it can help them) and / or not fully comprehending its importance (they may not recognise the implications of not being fully abreast of its content.) Some feel that they do not require ethical or professional guidance to conduct most of their daily tasks. The pressure of their working environment also means that doctors have limited time to refer to external guidance. Raising awareness of, and providing easier and better access to, the guidance, directly and in partnership with others, may help to address this.

Most doctors and medical students do currently feel catered for in terms of the sources of guidance they do access. Where organisations providing advice (for example, medical defence unions or Royal Colleges) are interpreting GMC guidance on their behalf, there is arguably no cause for concern. However, when doctors and medical students are relying on the advice of their colleagues (who may themselves be less up to date with official guidance) the need for better dissemination becomes more apparent.



2. Background and method

2.1 Research background and objectives

The General Medical Council (GMC) is responsible for setting the standards of good medical practice that all doctors in the UK should follow. The organisation is in the process of undertaking a review of [Good medical practice](#) and wished to conduct research with external users of the guidance to inform decision making throughout this review. Community Research was commissioned to undertake this research in Spring 2021.

The overall research objectives were to understand how external users perceive, access and apply the GMC's professional standards. The research sought to answer the following questions:

- What does the current landscape for ethical guidance look like?
- What are external users' views on how the GMC's suite of guidance and supporting materials are structured conceptually?
- What are external users' views on how the guidance is disseminated?
- What are external users' views on the accessibility and navigation of the guidance?
- What do external users expect the GMC to provide guidance on, and what is better provided by others?
- How do external users apply GMC guidance in their work?

2.2 Research approach

An overview of the research method can be found in the appendices of this report. The fieldwork consisted of two phases (further detail on the sample is provided at Section 2.4 below):

- Phase One (late May / early June 2021):
 - A 2-week online forum with 50 doctors and medical students.
 - 18 x telephone depth interviews with doctors and medical students (comprising 12 'in the moment' interviews with participants who had recently used ethical guidance and 6 interviews with 'seldom heard' participants).
 - An online survey with 36 Responsible Officers (ROs).
- Phase Two (June / July 2021):
 - 30 x telephone depth interviews with stakeholders (comprising 12 each with 'advisers' (organisations providing information and advice to doctors) and 'employers' and 6 with 'educators').



2.3 Discussion areas

Online Forum

The online forum consisted of a range of sequenced tasks and activities that participants could complete at convenient times. These included some quantitative-style tasks (questions where participants could choose from fixed responses) but comprised primarily open-ended questions, giving participants the opportunity to provide detailed responses. Upon completion of each exercise, participants were able to see the (anonymised) responses of their fellow participants in order that they could see feedback from their peers, and how it compared to their own answers.

The discussion areas in the forum focussed initially on doctors' and medical students' own experiences of addressing ethical and professional issues and the guidance that was used in these situations, before going on to explore views of the GMC's guidance specifically. Participants were also given one of a number of ethical dilemma scenarios and asked what they would do in that situation. They were then asked to look at the GMC's own guidance to address it. The full transcript of activities can be found in the appendices of this report.

Interviews

In-depth telephone interviews with doctors, medical students and stakeholders followed a similar format to the forum in that participants were asked about the situations in which they used ethical and professional guidance, and then asked specifically about their views on the GMC's guidance. Interviews were tailored to the participant to ensure sufficient focus on their area of expertise.

2.4 Sample and recruitment

Phase One

Forum

Doctors and medical students were purposively recruited on behalf of Community Research by Acumen Fieldwork. Quotas were set to ensure that participants in the forum represented a range of doctors and students, in terms of gender, ethnicity, career stage, setting, location and country of qualification. The final spread of forum participants is shown in the appendix of the report.

Depth interviews

There were no quotas set for participants who took part in the 'in the moment' interviews beyond that they had encountered an ethical dilemma for which they had used guidance in the past two months. Similarly, for 'seldom heard' participants, the only fixed criteria were that participants may have challenges in accessing the guidance (this included a mix of people with visual impairments, mild learning difficulties and people who did not speak English as a first language). Across the 18



interviews a good spread of career level and settings were represented (also outlined in the appendix of the report).

Responsible Officer (RO) survey

ROs were invited to take part in a short online survey via a link in a news bulletin sent to all ROs. In total, 34 completed the survey.

Phase Two

A list of potential stakeholder organisations was compiled, with participants approached and invited to take part by Community Research so that the GMC did not know who took part. The 30 depth interviews were made up of:

- 12 'advisers', comprising Royal Colleges, medical defence unions and other sources of information and advice used by practising doctors.
- 12 'employers', comprising Responsible Officers (who had completed the survey and expressed an interest in taking part in a follow up interview) and Medical Directors.
- 6 'educators', comprising Directors of Medical Education and post and undergraduate teaching fellows.

2.5 Context

The research took place in May/June 2021, over a year into the Covid 19 pandemic. Doctors have been at the forefront of increasingly difficult ethical decision making across a wide range of issues when it comes to delivering patient care during this period. (Deborah Bowman's report for the Professional Standards Authority¹ discusses this and the role of guidance to support difficult decisions and the ensuing moral distress.) In this piece of research doctors and stakeholders reflected on ethics in light of the pandemic, as well as in relation to their pre-Covid practice.

2.6 Note on reporting / caveats

For the sake of clarity, throughout this report we have used the term 'doctors and medical students' to indicate participants who took part in Phase One (either the online forum or the depth interviews) and described participants in Phase Two as 'stakeholders'. Where there are points specific to sub groups as, 'doctors', 'medical students', 'advisers', 'employers' or 'educators', this is made clear.

A qualitative method was chosen for this piece of research in order to achieve the greater depth of insight required than would be possible with a purely quantitative approach. However, some quantitative elements were incorporated in the forum; these results are shown in the report for illustrative purposes but should not be extrapolated or considered indicative of the wider doctor population. Likewise, the

¹ <https://www.professionalstandards.org.uk/publications/detail/ethics-in-extraordinary-times-practitioner-experiences-during-the-pandemic>



responses from the RO survey are shown in chart form in the report, but should only be used for indicative purposes.

Verbatim quotes have been included throughout the report to illustrate particular viewpoints and bring participants' thoughts to life, using their own words. It is important to remember that the views expressed do not always represent the views of all who participated. In general, however, quotes have been included to indicate where there was particular strength of feeling about a topic.



3. Main findings

3.1 Use of professional and ethical guidance

Summary

It was relatively rare that doctors and medical students found themselves in situations where they felt they needed to actively consult ethical guidance. When they did encounter situations that they couldn't deal with themselves, they tended to rely initially on their colleagues for advice or support, before turning to online resources.

Unsurprisingly stakeholders used ethical and professional guidance in a direct way more frequently than most practising doctors. It was primarily used to inform the development of guidelines and teaching materials for doctors and medical students, and as a reference tool when it came to making judgements about a doctor's revalidation and appraisal process. However, stakeholders who were also practising doctors said that they rarely used the guidance themselves in that capacity.

Doctors and medical students

For most practising doctors and medical students it was not a routine situation to consult ethical guidance. That is not to say that ethical issues did not arise; rather that doctors usually felt confident to address them when they did (and medical students knew who to ask/how to find out). There did not seem to be a pattern where doctors in certain settings or specialisms encountered more ethical dilemmas (that they could not address) than others. Many doctors commented that they were very used to dealing with ethical issues but (as a result of this familiarity) it was rare that they came across situations that they did not feel equipped to handle. Some reflected on the additional ethical challenges that had come with Covid, for example, resource allocation and remote consultations.

"My practice is brimming with ethical dilemmas." Doctor, Male, Consultant, Independent, Scotland

"The old adage "common things are common" means that most scenarios encountered in practice occur frequently and hence don't require reference to guidance. It's only the rare, unfamiliar things that require reference to the guidance." Doctor, Male, Consultant, Independent, Northern Ireland



“Covid has affected the way that things run normally and meant that everyone has had to work in new and unfamiliar roles or settings which lends itself to feeling uncertain of ethicolegal perspectives.” Medical Student, Female, England

In the research, participants were asked to think of a situation in which they had found themselves with an ethical or professional dilemma and were unable to proceed. Most of the examples given related to issues with patients or colleagues:

- Patients
 - Most of the situations that doctors and medical students found themselves in involved patients. These were either issues requiring immediate decision making, or ongoing issues about longer-term patients. While there was a very broad range of dilemmas overall, many of them related either to consent or confidentiality.
- Colleagues
 - A number of participants found themselves in situations where they felt that a supervisor or colleague had behaved unprofessionally, or they were concerned about the way a patient was treated by others.

Only when prompted did doctors and medical students also identify other instances where they had consulted ethical guidance outside of their day-to-day working lives, for example when studying / preparing for an exam or interview. A handful had used it in appraisals, but this was relatively rare.

The types of dilemmas that were foremost in participants’ minds tended to be those issues with patients or colleagues that were encountered in the workplace. In these situations, they often followed a similar journey, illustrated in Figure 1, which shows the typical journey for doctors and medical students when encountering ethical dilemmas.

Most doctors, particularly those who were advanced in their careers, were used to dealing with ethical issues and confident in their ability to address them. (By contrast, medical students were rarely exposed to ethical dilemmas without senior support available.) Doctors therefore tended to make decisions based on their own knowledge and experience, particularly when they were in a time pressured situation. If an ethical dilemma was particularly unusual or serious, they might turn to other sources of help, in which case, they would most commonly call upon their colleagues for advice. Only if they were unable to find an answer there (or in some instances if they could not or did not want to talk to a colleague) would they then move to other sources of information or guidance. Sometimes, they might return to their colleagues armed with said information to help to make a decision on the best course of action.



“My first points of contact are my current colleagues at the practice. The next step is usually the documents available online through my defence union and the GMC website.” Doctor, Female, GP, Primary, England

Figure 1: Typical journey when encountering an ethical dilemma



Stakeholders

Stakeholders were much more likely to use ethical guidance on a regular basis. The main reasons for using guidance tended to align with their roles (although there was some crossover – for example, some of the stakeholders who were recruited as ‘advisers’ were also the Responsible Officer at their organisations). This fell into three broad categories:

- As advisers, to inform the advice and guidelines that was provided to members, for example, to provide greater detail or tailor guidance to a specific specialty.
- As employers, primarily in relation to investigating complaints, but also in relation to appraisals / revalidation.
- As educators, designing and delivering ethics-based curricula.

A number of stakeholders who were also practising doctors highlighted the fact that while they used ethical guidance in the above roles, they rarely used it in their patient-facing roles. They also felt that practising doctors rarely consulted ethical guidance in their day-to-day work.

3.2 Landscape for ethical guidance and resources

Summary

When ethical guidance was required, doctors and medical students initially looked to their colleagues, typically other doctors; if they were not able to help, they turned to other sources, most commonly their defence unions. The GMC guidance tended to be used less ‘in the moment’ and more in a



formal capacity, for example as part of reflective practice, when cross checking the 'rules' or in exam/interview preparation.

Stakeholders often relied most heavily on the GMC's guidance, but also sought input from other regulators or specialist organisations.

Doctors and medical students

There was no sense from doctors or medical students that there was any lack of ethical guidance available – when they needed it, it was there. As discussed above, they generally tended to turn to colleagues as their first source of information or guidance when they could not address an issue themselves, but after this, the sources most commonly cited were the defence unions and the GMC's written guidance. Other sources, including the BMA, the Royal Colleges and social media forums were also used by doctors, albeit to a lesser degree. Doctors and medical students also used a combination of sources, for example, cross checking different sources of guidance against each other. Each source is explored in turn, below:

Colleagues

As outlined above, colleagues (most commonly, other doctors) were the go-to source for most doctors and medical students initially, for a number of reasons:

- Immediacy of advice
 - In situations where a decision was needed straight away, there was often no time to go away and refer to external guidance, so the only option was to ask the advice of a peer in order to get an immediate answer.
- Specificity of advice
 - Talking to a colleague allowed them to talk about the intricacies and nuances of a specific case (they would never find the exact same situation in written guidance, no matter how many case studies exist).
- Trusted source
 - Doctors and medical students alike were often confident in the experience of senior colleagues and that they would know the 'right' thing to do. They also felt that their colleagues and peers would have theirs and their patients' best interests at heart and so could trust the advice they gave.
- Opportunity for discussion
 - Sometimes doctors simply wanted the opportunity to talk through a particularly thorny issue and get different viewpoints to help them to decide upon the best course of action. They also found it useful being able to debate different interpretations of GMC guidance, and use each other as sounding boards.



“I always ask my consultants. I have been fortunate to have worked with some extremely approachable and supportive consultants throughout my training and have always gone to them for advice on professional issues.” Doctor, Male, Specialty Trainee, Secondary, Wales

“Talking to my supervisor has been a preferred source, however I think that is because it allows the intricacies of the case to be discussed and allows for some more thinking around the area about how to apply the guidance.” Doctor, Female, Consultant, Mental Health, England

“I went to the doctor just senior to me to ask for advice and support, as she was also unsure about how to proceed, we went to the registrar with the team. It was easy to find support but only as I felt comfortable in my team otherwise it may have been difficult.” Medical student, Female, Wales

“I think ethics is an interesting area and one we all feel more comfortable discussing and agreeing as a team in numbers. It is perhaps harder to justify your actions based on "written guidance" than it may be if you have MDT discussion or GP team meeting backing which can equally be documented.” Doctor, Male, Specialty Trainee, Primary, England

Unsurprisingly medical students and doctors at an earlier stage in their career were likely to turn to more senior colleagues. They had the experience and they trusted their judgment. However, many more experienced doctors would also turn to their peers, particularly for grey-area dilemmas. They liked being able to work collaboratively and share different perspectives. Ethical issues were sometimes discussed as part of a multi-disciplinary team (MDT) review, and some hospitals had formal forums for such discussions, while others were more informal, for example, just quick check-ins for reassurance.

“Our trust runs monthly/fortnightly (depending on Covid!) ethics discussions where cases are discussed, and the morality and ethics of a case is discussed in detail with reference to legal precedents.” Doctor, Male, FY, Secondary, England

“My first port of call would be my colleagues. We discuss difficult cases and have set up a WhatsApp group for nine of us. Consensus can then be documented in the patient notes.” Doctor, Male, Consultant, Independent, Northern Ireland (NI)

Not all doctors were able to talk to their peers or colleagues that easily. For example, some GPs envied their hospital colleagues this opportunity which they were not able to access themselves.

“As a fully fledged GP, I need to work more independently and am often the only doctor in the clinic. It is often impossible (or not helpful) for me to contact



colleagues, hence the need for me to contact the MDO.” Doctor, Female, GP, Independent, England

“It seems to me that working in a team and discussing with colleagues who possibly have more experience seems to be a common pattern. It actually is somewhat surprising as we as GPs often are working very isolated. It seems a lot of the people responding to this research are in hospital medicine so have the comfort of a team behind them.” Doctor, Female, GP, Primary, England

Defence unions

Where doctors or medical students were unable to, or chose not to, seek out colleagues’ advice (for example, if there was no one around to ask or if their ethical query related to a colleague), defence unions were the next most commonly used source of information and guidance. Sometimes they simply went online to look at their guidance but often they would make use of their helplines. Defence unions tended to be in the forefront of people’s minds compared to other potential sources for doctors.

The main reasons that participants chose to use defence unions were:

- Practical advice
 - Doctors and medical students felt that the defence unions would actually tell them what to do i.e. interpret the GMC guidance for them and instruct them as to the most suitable course of action. It was also valued specifically as a source of medical legal advice.
- On their side
 - Participants felt that, unlike the GMC, the defence unions were likely to have their best interests at heart and so would give advice accordingly. As such, they were particularly likely to go to them in situations where they thought there was a risk that they might get in trouble (for example, if a patient had complained).
- Ease of access
 - The fact that they could easily access advice (for example, from their helplines) made the defence unions an attractive prospect in situations requiring a timely response. Helplines were also valued for the opportunity to speak to a real person and discuss the specifics of a particular situation.

“I really find the Defence Union, their website’s usually quite helpful. They always publish their really scary journals once a quarter of things that have gone wrong, they’re quite useful.” Doctor, Female, Specialty Trainee, Primary, England

“My MDO [medical defence organisation]. It is truly wonderful to be able to speak to an expert any time of the day or night.” Doctor, Female, GP, Independent, England



“The Defence Union instinctively, I’d say, is more if there’s a question about something being wrong, having made a mistake or having some question about a complaint or legal action, that sort of thing, as opposed to trying to know the correct course of action.” Doctor, Male, Consultant, Secondary, NI

GMC

The GMC did come up as a source of guidance for many participants – but often in slightly different circumstances than when they went to colleagues or defence unions for advice or information. Section 3.5 explores views of GMC guidance in full, but the main reasons for choosing GMC guidance are summarised below:

- As part of reflective practice
 - Some doctors and medical students found it useful to refer back to GMC guidance after an incident had occurred as part of reflective practice or when writing up a case discussion. It may not have been realistic to look at the guidance in the moment, but it was felt useful to look back on it after the event.
- To check ‘rules’
 - Related to this, some doctors referred to GMC guidance to back up or validate decisions they had made to reassure themselves they had made the right call. It was also used as a tool to cross reference against. Doctors would be more likely to check GMC standards when situations were more serious and / or there was a greater risk of getting into trouble.
- For ‘official’ purposes
 - Some doctors and medical students felt that while other sources of guidance were better suited to ‘in the moment’ ethical dilemmas, it was necessary to refer to the GMC guidance for more formal or official purposes, for example, when studying for exams, preparing for interviews or to use as a teacher or examiner.

“I’m very likely to use it when I have to write a case discussion/academic piece that involves ethical or professional themes. This is because it is a useful reference to draw upon if I need to make a point in my writing - I think this is because the GMC guidance appears to be the gold standard for how to conduct oneself. I would only occasionally use it when I wasn’t sure about something that I had encountered in a clinical setting.” Medical Student, Male, Scotland

“For revalidation/ appraisal and for raising a concern I am more likely to use advice from the GMC. In terms of involving a patient I ask the advice of colleagues and medical defence union as patients’ cases are often much more complex than generalised guidance can help with.” Doctor, Female, GP, Primary, England



"I am mostly likely to review the GMC guidance after I have faced a situation that has made me feel less confident in managing ethically or when I am reflecting on how I would approach a challenging scenario differently in future. This would usually be informally, and after discussing it with a junior doctor. We also have to read the GMC guidance at the start of medical school, and when revising for the SJT this year I reviewed the guidance again to ensure I was familiar with it prior to taking the exam." Medical Student, Female, England

"I would consider using the guidance if I felt that I needed some more legal guidance I think, or if my judgement around an ethical decision was called into question. I imagine if someone told me they would "report me to the GMC" - I may well look at the specific guidance around GMC to see whether I have done something acceptable or not. I would consider using it for interview and exam preparation, as well as an adjunct for ethics teaching for medical students. I have no doubt that it would give the right information for those situations." Doctor, Male, Specialty Trainee, Primary, England

"Depending on how 'serious' the situation is... if there is an extremely delicate context in which you anticipate you may have to explain your actions and defend your position then I would be more compressive in my research and link back to published GMC guidance..... it would provide a strong foundation upon which to base and defend my own ethical position." Doctor, Male, Specialty Trainee, Secondary, Scotland

Figure 2 offers a high-level summary of the main sources of guidance used by doctors and the reasons for and against each type.

Fig 2: Sources of guidance

Source	Most likely to use when...	Pros	Cons
Colleagues	They need an immediate answer	They're an immediate and trusted source	They're not always appropriate / may not have the answers
Defence unions	They might be in trouble	They're accessible and offer practical support	Not the official source
GMC	To check 'official' guidance	They're the official source	It's not always clear what to do next

Other sources

Doctors and medical students did also use other sources when faced with ethical or professional dilemmas, albeit not to the same degree as those discussed above:

- BMA



- Similarly, to defence unions, some chose to refer to BMA guidance because they perceived the organisation to be for them (as opposed to the GMC which was not). They also felt that the BMA guidance simplified jargon and provided more examples.

“I would go to the BMA if I thought my employer might throw me under the bus.” Doctor, Male, Specialty Trainee, Secondary, Scotland

- Royal Colleges
 - Doctors chose to seek guidance from the Royal Colleges when they were looking for more specific advice relating to their specialty.

“I used this [RCPsych learning modules] frequently during my psychiatry placement as I would frequently be faced with ethical dilemmas largely relating to capacity and it was difficult to understand the mental health law.” Doctor, Male, Specialty Trainee, Primary, England

“The AAGBI and RCoA offer comprehensive specialty specific advice to anaesthetists. This tends to flesh out the principles provided by the GMC.” Doctor, Male, Consultant, Independent, NI

- Social media
 - A number of doctors sought advice on social media forums, sometimes posting questions themselves or looking to see if others had experienced similar issues. These tended to be informal closed groups (e.g. on Facebook or Whatsapp) where doctors would be able to access both advice and support for difficult situations.

“Increasingly I find many social media closed groups of doctors have facilities to discuss difficult cases /scenarios – there is usually a wide range of responses including support / links for further specific advice. Some of them also offer kind words of support for the clinician which is helpful when we are all becoming increasingly isolated in our own workplace.” Doctor, Female, GP, Primary, England

A small number of doctors also used guidance provided by their Trusts.

Stakeholders

Stakeholders likewise used a range of different ethical guidance, with some overlap, for example using Royal College guidance for the specificity of its advice, or the BMA for providing more detail.

Stakeholders working in advisory roles also drew upon and / or compared GMC’s guidance to ethical guidance from other regulators, be they for other professions (for example, the General Dental Council or the Nursing and Midwifery Council) or for doctors in other countries (for example, the Irish Medical Council or the Medical



Council of Canada). However, most felt that the guidance provided by the GMC was more comprehensive than that of its peers. Advisers focussed on particular specialties also looked at more specialist relevant organisations to help inform some of their guidelines.

“We might even look at other countries, we may go to Australia and say, “What are they doing there and what have they put together and can we nick some of that?” There’s never any point in reinventing the wheel and so you can look wider in the UK for that sort of ethical guidance around some of those difficult clinical dilemmas but it’s often the people who are working within specialist societies that can help guide some of that thinking around what are the pitfalls.” Adviser

Employers generally defaulted to the GMC as they felt that it was safest to use the guidance published by the regulator.

“Although I might be able to find other things, I would imagine that a lawyer would jump all over me for using that because that’s not the professional standard. So, I feel sort of tied to using whatever the GMC put out because they are the people that get to tell us what the standards are.” Employer

While the Trust may have its own disciplinary policies, there was a sense amongst some employers that doctors would be more likely to take GMC guidance seriously.

“I might say, 'In the Trust’s view, as an employer, this is unacceptable' but doctors’ prime loyalty is to being a doctor...it is a much more powerful thing to say, 'This is the behaviour expected of all doctors, of which you are one, and therefore this is what you must do'. That is something that’s very difficult to argue with and, of course, now the GMC have the ability to withdraw their licence to practice so they lose their livelihood. So, it’s an area that is very clear.” Employer

Educators used a variety of guidance sources in their teaching, but needed to ensure that the GMC guidance was integrated throughout and the importance of its position as the regulator emphasised.

“In the lectures I have I will have a single sort of stop point with a slide with the cover of say confidentiality on it. I will frame it and, again, there’s slides with big red writing that the GMC is the only statutory body in the UK providing this sort of guidance, so regardless of what the BMC Ethics Committee or any other society Ethics Committee is saying, this is the statutory guidance.” Educator



3.3 Use of GMC guidance

Summary

Most doctors and medical students engaged with the GMC guidance relatively infrequently for a number of reasons. In addition to preferring to use other sources of guidance, some doctors simply didn't think to refer to GMC guidance when ethical issues arose.

Most users accessed the guidance online in order to be confident they were reviewing the most up-to-date versions; however, there was a sense amongst some that, by no longer engaging with hard copies, doctors may read the guidance less than they previously did.

Doctors and medical students

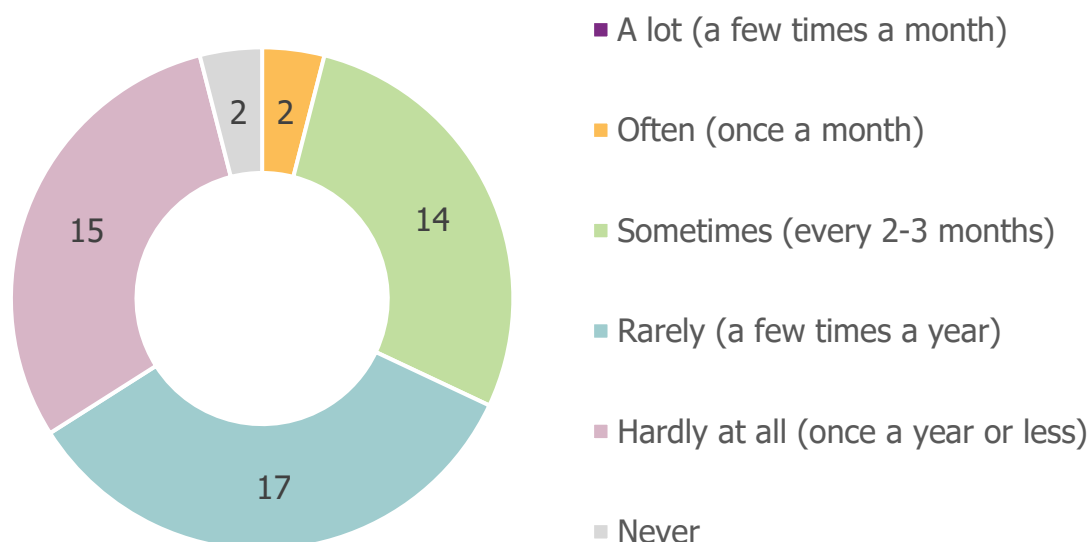
Frequency of use

Doctors and medical students in the online forum were asked how often they engaged directly with GMC guidance e.g. via hard copy, the website or downloaded publications. Figure 3 shows there is a range of engagement; however only a couple were engaging with it once a month (and none more than this). Around two thirds of participants said they engaged with it rarely or hardly at all².

² This compares to [Corporate Strategy and Perceptions tracking 2020](#) showing that 72% of doctors say that in the past year they had used GMC professionals standards and ethics guidance to help them determine what course of action to take.



Figure 3: How much do you typically engage with the GMC guidance directly e.g. via hard copy, the website or downloaded publications?



Base: All doctors/medical students from forum (50)

"I do not know anyone who has used the guidance for anything except SJT prep." Medical Student, Female, Wales

"I am involved in curriculum design for the University at a hospital level... We probably would have referred [to *Good medical practice*] when we were looking at how we set up the curriculum. That probably would have been the last time, and that would have been 3 or 4 years ago." Doctor, Male, Consultant, Secondary, NI

"I use it when I have an exam, interview or challenge. When I do use it, it's better and more useful than I thought but there is just so little time." Doctor, Male, Consultant, Tertiary, Wales

Medical students in the forum were also asked how often they used the guidance tailored to students (*Achieving good medical practice*³ outlines the standards expected of medical students and shows how the principles and values of *Good medical practice* apply to students). Again, there was a spread across the sample, but most used it infrequently.

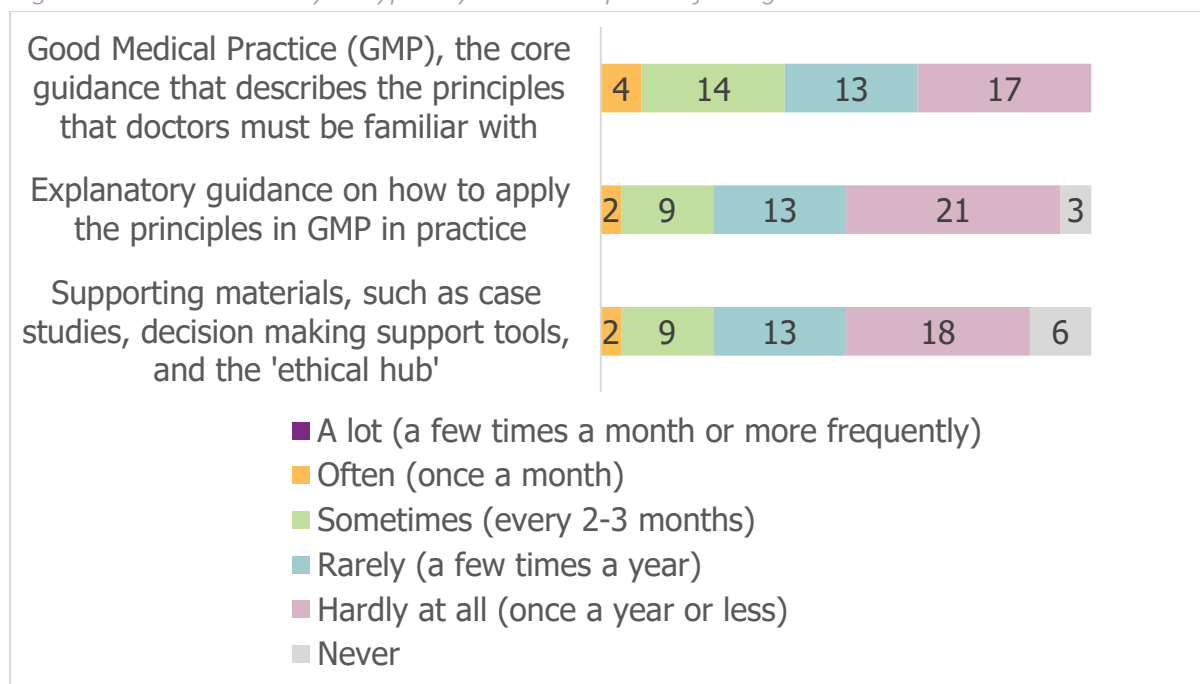
Participants were also asked about the different parts of the guidance and how often they engaged with them. Again, as Figure 4 shows, engagement levels were

³ [Achieving Good Medical Practice: guidance for medical students](#)



relatively low; doctors and medical students were more likely to say they engaged with *Good medical practice* (as discussed in Section 3.4, for many this was the only guidance they thought of in relation to the GMC) than the explanatory guidance or supporting materials, but most used them rarely or hardly at all.

Figure 4: How much do you typically use these parts of the guidance?



Base: All doctors/medical students who are using guidance directly (48)

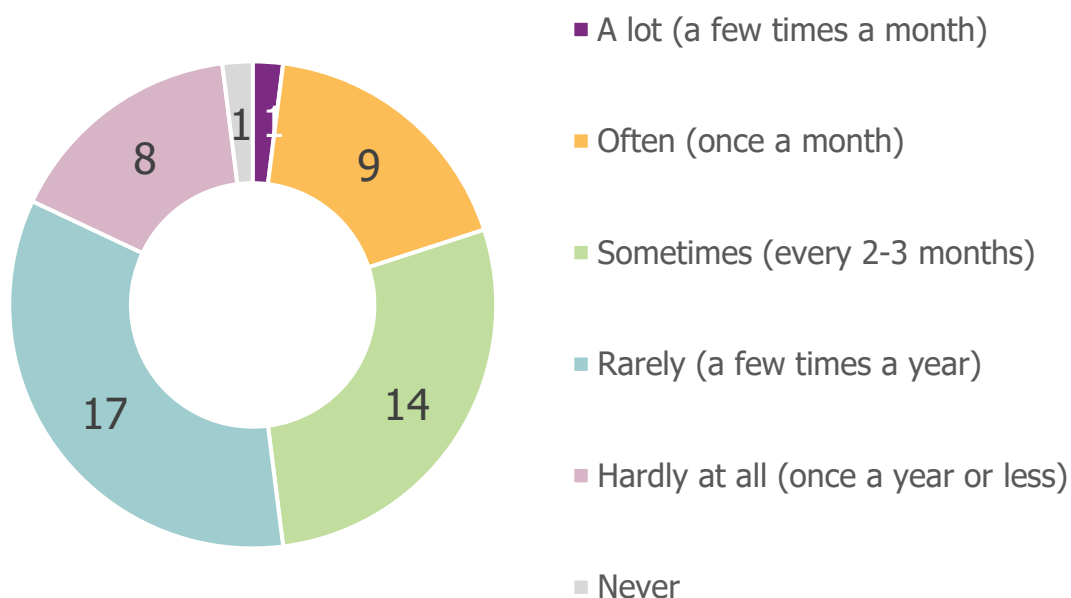
“I normally just use the core guidance and I have almost never used the explanatory guidance/supporting materials.” Medical student, Male, Scotland

“Core guidance would be the first guidance I would usually look at and given the time and if I am interested in a particular topic I would look through the supporting materials as well.” Doctor, Male, FY, Secondary, Scotland

Participants were also asked how often they used GMC guidance indirectly, for example, via delivered teaching or workshops conducted by GMC staff or other organisations, e-learning/course material/ CPD activity, conferences or journal articles or through GMC materials customised by other professional bodies (i.e. local and national guidance from other providers on the topic of ethical enquiries). While still relatively infrequent, participants did appear to use the guidance indirectly more than they did directly, with around half saying they engaged every 2-3 months or more frequently via these sources (see Figure 5).



Figure 5: How much do you typically engage with the GMC guidance indirectly?

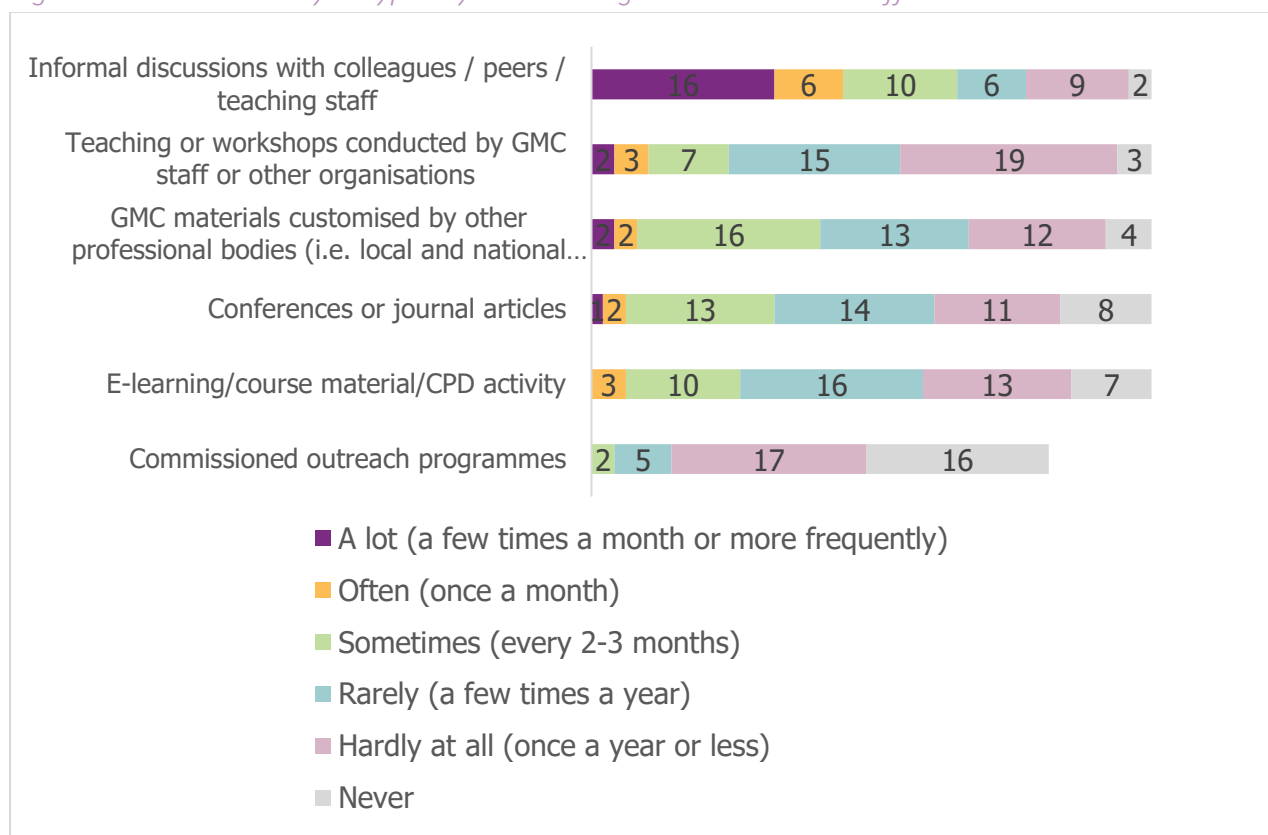


Base: All doctors/medical students from forum (50)

When asked how they typically accessed the guidance via these indirect routes, tying in with earlier findings, 'informal discussions with colleagues / peers / teaching staff' was the route most commonly used by doctors and medical students. Figure 6 shows the responses.



Figure 6: How much do you typically access the guidance via these different routes?



Base: All doctors/medical students using guidance indirectly (49)

Users of guidance

There was no strong sense that GMC guidance was used by any particular group of doctors more or less than others. Those working in secondary care appeared to engage with the guidance slightly more than those in other settings based on answers in the forum; however there was a general sense that there were a number of variables feeding into whether or not a doctor would access the guidance. Some felt it could simply come down to personality type.

“I suspect those working in areas with lots of medico-legal issues, or areas with a lot of queries around capacity and consent are more likely to use the guidance. This may overlap with safeguarding. I would imagine those working in memory clinic, those working with adults with learning disabilities and those working with adolescents for example may have a higher need, as well as GPs potentially.” Doctor, Male, Specialty Trainee, Primary, England

“I think it depends on speciality. For example, intensivists have a very good handle in my experience on ethical and professional issues but often their CPD and conferences include such topics and they are frequently required to justify their decisions in the coroner's court... I'm not sure that the behaviour of colleagues is affected so much by career grade. Some FDs check frequently



whilst others are confident of recent medical school coverage and recall. Even some doctors who encounter issues regularly check the guidance. I wonder if it is more to do with personality type, risk involved and first-/second- hand experience of complaints, investigations, proceeding involvement?" Doctor, Female, Specialty Trainee, Primary, Wales

There was a divergence of views when it came to the career stage at which doctors would be more or less likely to use GMC guidance. Some felt that the more senior you were, the less likely you would be to need it, as you would be able to rely on experience. In contrast, those at an earlier stage in their career might need to refer to the guidance more as they would be less familiar with ethical dilemmas and may also be more likely to refer to it when interviewing for jobs. However, others felt that those in senior positions would be more likely to need to refer to guidance because of the degree of responsibility they would have and the complexity of the problems they would be likely to encounter (whereas medical students or doctors at an earlier stage in their career would have supervisors they could turn to). Essentially, many more junior doctors felt that they did not need the guidance *yet*, while more senior doctors felt that they did not need the guidance *any more*.

"GMC advice gives the basic principles to follow so as a junior doctor I went back over their advice more often. As I am familiar with it now, being more experienced, I tend to use other methods of information finding although I do read new guidance as it is published." Doctor, Female, GP, Primary, England

"I think the guidance is used more by more senior doctors. They're more likely to be the ones making core decisions that affect patients. Junior doctors and students are less involved in the decisions for patients care so are less likely to be making key decisions in ethical dilemmas." Medical Student, Male, England

"It is interesting - on the one hand it could be the case that doctors face more challenging ethical situations by nature of their roles and need to consult guidance more. But it also may be the case that they have more experience and exposure to managing these situations and therefore do not consult guidance as much." Medical Student, Female, England

Why doctors and medical students are not using the guidance more

There were a number of (often overlapping) reasons that doctors and medical students were not using GMC guidance that often:

- Not recognising the need
 - Many doctors did not feel that they needed to refer to GMC guidance. They were confident in their own knowledge and experience, and felt that they knew the basic principles instinctively. Some of them said that they had used it more often earlier in their careers, but felt that they had less need now that they had more experience. There was a general sense amongst many that the



principles had been internalised and following *Good medical practice* was a case of following one's own common sense / moral compass. Some also recognised that while they may not be seeking out the guidance directly, they were likely to have absorbed the principles indirectly, for example, when discussing cases with more senior colleagues or in articles. This was also the case for some medical students – they did not feel they needed to consult the guidance themselves as others, senior to them, would be doing so if required.

"The more experience I have the more I feel I know the GMC guidance without needing to refer to it as much." Doctor, Female, Consultant, Mental Health, England

"In my head, it's just the Code of Conduct, that's what it always was when I trained 20 years ago. I appreciate it's probably evolved since then but I'm lucky, I've not had much need to refer to it. I'm not somebody who bends the rules anyway, I don't push any boundaries anyway so I don't think I'm doing anything that's going to." Doctor, Female, Specialty Trainee, Primary, England

- Lack of time
 - As discussed earlier in Section 3.1, in many situations doctors simply didn't have the time to refer to GMC guidance in the heat of the moment when they needed to make a quick decision. This barrier applied to all written guidance, not just GMC's, but it did also mean that doctors valued anything that was quick to review e.g. flow charts rather than wordy guidance. Even during 'downtime', as nice as it would be to read through the GMC's and other guidance at their leisure, given its length, realistically many doctors and medical students did not feel they had the available time to do this.

"I think many doctors think they have an overall understanding of GMP and GMC guidance e.g. from medical school training and it is easy to rely on this rather than use time in often very time pressured, sometime chaotic clinical environments or working patterns to refer to guidance (especially when the guidance is lengthy - we often just need a short answer/directive)." Doctor, Female, Specialty Trainee, Primary, Wales

- Lack of awareness
 - For many doctors, the GMC was simply not on their radar as a source of support or information – it was not top of mind in a way that other sources (such as defence unions) were. They thought of the GMC guidance only in terms of *Good medical practice*, which they saw as a set of 'rules', rather than a resource that might help them. Most had little, if any, knowledge of the other learning materials available to them, and so wouldn't turn to it as a practical resource. The GMC was relevant more in terms of checking rules than in aiding decision making.
- Only using reactively



- Most doctors recognised that when they did refer to GMC guidance, they did so reactively i.e. only when they had a problem with a patient/colleague, or when they had an exam/interview – and when they did so, they only referred to the relevant part. They knew it was there if they needed it (albeit most did not realise the extent of what was available to them), but generally they only felt they needed it in response to very specific infrequent situations. This also meant that they did not see it in the whole and therefore weren't aware of the extent of it.
- Mistrust of GMC
 - Some doctors were reluctant to use GMC guidance due to their negative feelings about the organisation as a whole. They didn't see the GMC as a body that was there to help them; rather as a body that might catch them out. This was not a case of mistrusting the accuracy of the guidance; rather, that they might inadvertently expose themselves by turning to the GMC for support.

“It wouldn't cross my mind, rightfully or wrongfully, to go onto the GMC website to look for case scenarios or anything like that to learn. This doesn't sound right but it almost feels like they're the Police Station, or they're the Police, they set the rules. You need to know the rules and all this other support around you that helps you to keep to the rules, so like the MPS and stuff giving you case scenarios and education to help you keep to the rules so you don't get into trouble.” Doctor, Female, Consultant, Secondary, England

- Using alternative sources
 - As discussed above, some doctors and medical students simply preferred to use different sources of guidance – because they found it more helpful in the moment and / or they felt the alternatives were designed with their best interests at heart. At other times this was less of a conscious decision to choose alternative sources over GMC and more a case of what came up when searching online for advice.

How the guidance is accessed

Most doctors and medical students were accessing the guidance online. They preferred to do so for convenience and because it gave them confidence that they were looking at the most up-to-date guidance. The way they found the online ethical guidance varied – some people would go directly to the GMC website and search for topics there. However, many doctors simply 'Googled' their search query and added 'GMC' to their search term as they found this would be more likely to take them to the most relevant piece of guidance. Some participants downloaded PDFs and saved these locally to refer to, sometimes because they found it easier to search terms that way, or because they would be able to access the guidance even if they did not have internet access.



“It’s always been online, yes, and I think that’s where I’d feel most comfortable reading it because I suppose with pretty much any medical guidance, I feel uncomfortable reading hard copies because you don’t know if they’re up to date.” Medical student, Male, England

A minority preferred to refer to hard copies of the guidance, using booklets or printing out the PDFs. They liked being able to annotate and found the paper versions more tangible. A handful of doctors mentioned that they would be more likely to read hard copies and therefore keep abreast of the guidance, for example, you might pick up a booklet in your down time in a way that you were unlikely to do with online versions.

Updates

While most doctors assumed that they were receiving updates to guidance via GMC emails, this does not necessarily mean that they were being read. There was a sense that these emails were likely to get lost amongst the many other emails they received, and there was some sense that doctors could avoid GMC emails altogether.

“I get emails, but GMC emails are usually generic and very long, so needless to say I miss some information they send.” Doctor, Male, Specialty Trainee, Secondary, England

“I used to get letters from the GMC. Not sure I get any now. I think I get GMC emails but even if I do they get drowned out by all the other emails!” Doctor, Male, Consultant, Community, NI

Other doctors received notice of updates via other organisations, and some were not aware of receiving any at all.

“I get emails from my Medical Defence organisation informing me about the new GMC guidance (e.g. Decision making and consent - Nov 2020 and Prescribing - 2021), and I attend their webinars on the new guidance.” Doctor, Female, Locum, Primary, England

Stakeholders

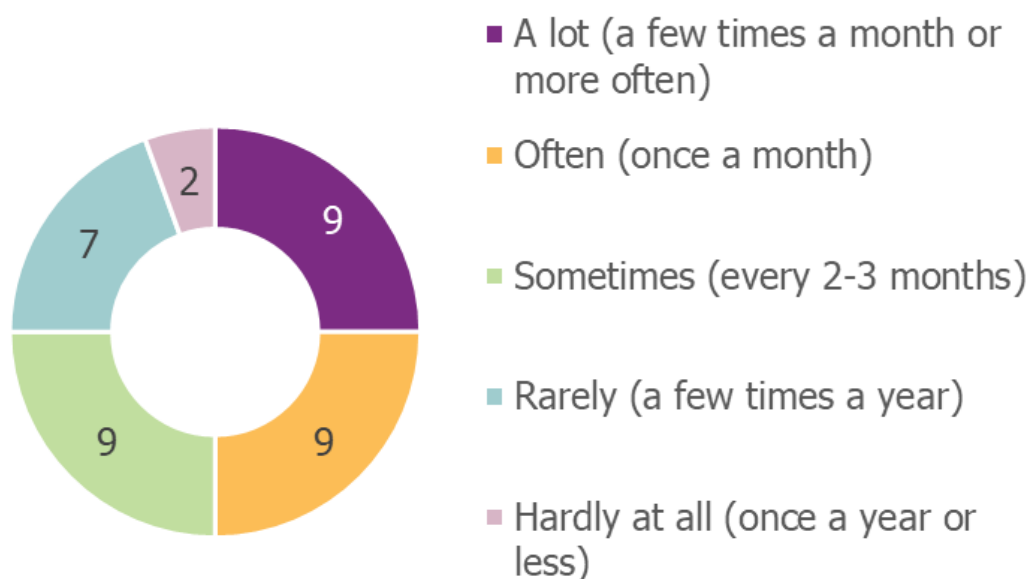
Frequency of use

ROs who took part in the survey were asked the frequency with which they used GMC guidance in their roles. Unsurprisingly they tended to use the guidance more often than doctors, although only half said they used the guidance at least monthly⁴, as Figure 7 shows.

⁴ In [Corporate Strategy and Perceptions tracking 2020](#) 98% of ROs had used the guidance in the past 12 months, and 95% said they would use GMC as a source for ethical or professional guidance.



Figure 7: How often, if at all, do you use the GMC guidance in your role as a responsible officer?



Base: RO survey respondents (36)

Other stakeholders similarly used the guidance fairly frequently in their roles, generally at least a few times a month. Those who were also practising doctors acknowledged that they would rarely use it in their clinical roles, for similar reasons as outlined by doctors.

“I think if the GMC got honest answers to a survey and asked doctors how often they consult the guidance, I suspect they would find it was consulted much less than once a year⁵. Because I wouldn’t contact the GMC’s guidance if I’m in a crisis, I would ring the Medical Protection Society and I would talk to their legal advisors and I would rely on them being experts on the guidance. Because if I’m in a crisis I haven’t got time to go searching for which bit of guidance is relevant.” Educator

Broadly speaking, while doctors tended to use ethical guidance reactively (i.e. when a specific issue arose), most stakeholders were using it more proactively as part of their day-to-day roles. However, some ROs acknowledged that they only used it as and when specific concerns were raised about connected doctors.

⁵ Please note the [Corporate Strategy and Perceptions tracking 2020](#) shows that 72% of doctors say that in the past year they had used GMC professional standards and ethics guidance to help them determine what course of action to take.



There was some sense from stakeholders that practising doctors rarely consulted GMC guidance in their day-to-day roles. Some ROs felt that some doctors might benefit from reviewing it more frequently, particularly older doctors who might not see a need to refer to ethical guidance thanks to their many years of experience. They felt that some doctors might not fully appreciate the societal changes that meant that previously acceptable practice may no longer be ethically / professionally appropriate.

How the guidance is accessed

As with doctors, most stakeholders were accessing GMC's ethical guidance online, again because this gave them the confidence that they were looking at the most up-to-date versions. Many also preferred to save PDFs as they found them easier to read. ROs liked to cut and paste or send links to the relevant sections in their reports or correspondence with doctors about whom concerns had been raised.

There was concern amongst some that, because doctors no longer received paper versions of the guidance, they would be less likely to read the guidance spontaneously, and only access it when they were in trouble.

Employers and educators often had close relationships with their GMC Employer Liaison Advisor (ELA) and found them a useful source of support to supplement the written guidance, for example, to help them to interpret certain aspects of it.

"They are brilliant in that they know the guidance and they also know how the GMC will handle cases... each Responsible Officer is linked to an ELA and you have regular meetings with your ELA and they will come and say 'we've got these cases on the books at the moment and these are yours and you need to know about it' but equally you can say 'can I talk to you about Dr X' and they're really helpful." Educator

3.4 Understanding and awareness of GMC guidance

Summary

While most doctors felt confident in their knowledge of *Good medical practice*, there was less awareness of the explanatory guidance and very few knew about the supplementary materials provided. When prompted, most doctors and medical students said that they did not know the difference between the types of guidance.

While stakeholders had a better understanding of how the different pieces of guidance fitted together, they had some sympathy with doctors' lack of



awareness, given the extent of what was available and the infrequency with which it was accessed.

Doctors and medical students

Participants were asked what they considered to be the main function of the GMC's ethical and professional guidance. Many focussed on the rules and principles aspect of the guidance, rather than on how they could be applied in practice, possibly illustrating a lack of awareness of the supporting materials provided by the GMC.

"The main function of GMC's ethical and professional guidance is to allow us to have clear boundaries on what it is we are allowed to do, and what we are not allowed, based on the expectations of the general public." Doctor, Male, LED, Secondary, Wales

"To provide a standard for behaviour that doctors and regulators can check their performance against. It gives a framework for holding doctors to account, which is important legally for the GMC." Doctor, Male, Specialty Trainee, Mental Health, England

Others saw it more as a resource for doctors to use to help them to ascertain how best to approach difficult situations.

"I believe the main function of this guidance is to aid the medical profession in daily decisions in healthcare where it is hard to know what to do. Due to the nature of medicine, there is often not a 'correct' way to approach a situation so having the GMC guidance helps to guide with general principles and advice." Medical Student, Male, Scotland

The wordcloud in Figure 8 shows the sorts of words and phrases that came up when participants answered this question (the larger the words, the more commonly they were used):



Figure 8: Wordcloud of doctors' perceptions of the functions of the guidance

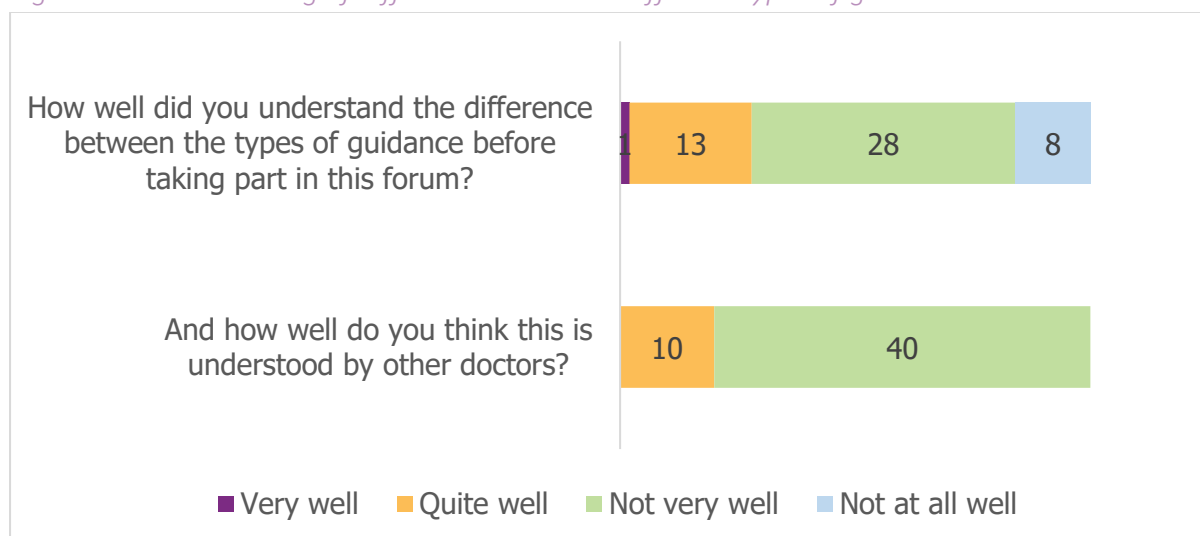


In the forum, participants were provided with a detailed explanation of what the guidance consisted of, and were then asked the extent to which they themselves had understood the resources before taking part, and how well they thought the differences between different types of guidance were understood by other doctors⁶. As shown in Figure 9, when prompted, most said that they had not understood the differences well themselves, and thought it even less likely that other doctors would have understood this. This also came through in the depth interviews, with many participants only realising the extent of the guidance available and the differences between the different elements through taking part in the research.

⁶ Please note that the core and explanatory guidance all carries the same weight, and so should not be treated differently. The distinction lies in the guidance vs the 'advice' which is the supporting materials such as case studies, flow charts, etc. A full description of the different parts of the guidance was provided to doctors and is shown in the appendix of this report as part of the research materials.



Figure 9: Understanding of differences between different types of guidance



Base: all doctors (50)

“I wasn't aware that doctors should treat them differently and would be guessing at the differences between them. I didn't know the guidance was split up in this way.” Medical student, Male, England

“All the different pieces of GMC guidance are inter-related. I do not see much of the difference between core and explanatory guidance and supporting materials.” Doctor, Female, SAS, Secondary, England

“Core guidance sets out what we are expected to do and adhere to and is the minimum that we should refer to. To my understanding, explanatory guidance tells us the rationale for the principles so that we can understand – deepen our learning experiences – but is not absolutely mandatory to read.” Doctor, Female, Speciality Trainee, Primary, Wales

Doctors' and medical students' comments in the forum and the depth interviews indicated that understanding and awareness of the guidance was quite superficial. Doctors tended to refer largely to *Good medical practice* when discussing the guidance, and there were very few references to the supporting materials provided by the GMC.

“I am actually not sure what the difference between these items are - from nomenclature however core is the main document which would be easier to access and would lead to further information in explanatory guidance. However explanatory materials may not necessarily be quoted in law would be my impression.” Doctor, Male, SAS, Secondary, England

“I don't understand the difference between the core and explanatory guidance, but I assume that the supporting materials are more specific further reading



available to doctors. It is also worth clarifying what guidance means specifically - is this just an aide for doctors, or rules that they should follow?" Medical Student, Female, England

The most obvious explanation for this low understanding and awareness is the infrequency with which most participants refer to the guidance. When they do use it, they tend to be searching for specific topics, rather than exploring the guidance as a whole. Furthermore, because many participants find what they are looking for via search engines (as opposed to via the GMC website), they are often taken straight to the relevant section, and so do not see the guidance in its entirety and how it all fits together. This was also exacerbated by the fact that people no longer tended to look at hard copies of the guidance, where the links between the different elements might be more apparent.

"I normally just use the core guidance and I have almost never used the explanatory guidance/supporting materials. This is because most of the time, I just need to find the guidance that GMC is offering on a particular topic. However, if I wanted to explore the topic in more detail (e.g. for an essay or project) I can see how these other materials could be very helpful. I think that is the main purpose of these other materials [is] to supplement and provide additional information for those who want to explore ethical topics in more detail. I'm not sure if doctors should treat them differently because I guess it is useful to have a good understanding of why to act in a certain way. However, in practice, it's easier to just quickly read the core guidance to get an overview." Medical Student, Male, Scotland

"If you just search GMC Guidance, it takes you to that generic duties of a doctor or whatever it is. You have to probe it a bit further, like ethical guidance, paediatric guidance, children's guidance, social media guidance, whatever it is. You can end up just going to the default, you know the general stuff instead of this more specific stuff if you don't look for it." Doctor, Male, Specialty Trainee, Secondary, England

"In recent years I've looked at it on the internet so I've kind of just clicked the relevant links where I've needed to. But I know back in my earlier career days in medical school when we used to rely much more on the harder copies, it was much easier to sort of distinguish because you had to physically go through it a bit more." Doctor, Female, Specialty Trainee, Primary, England

Stakeholders

Stakeholders' familiarity with and understanding of GMC's ethical guidance was unsurprisingly much deeper than most doctors. They were using it more frequently and were confident in their knowledge of how the different pieces of guidance fit together.



Whilst most stakeholders had a much better understanding of the breadth of guidance available, most still concentrated on *Good medical practice* and a few were not aware of the supplementary materials provided. They acknowledged that they themselves couldn't necessarily hope to know it all, and that therefore they believed the average doctor would struggle to do so.

Some stakeholders also raised the same issue as doctors – that because they found it easier to find guidance on some topics through search engines than via the GMC website, they thought others would be less likely to see the overall hierarchy and how it was structured. There was a sense that the visual hierarchy could be made clearer on the website so that it would be more apparent that *Good medical practice* was the starting point and that everything flowed from there.

“The main problem I have is knowing what guidance there is. I have just had a look on the GMC website, and there is a tab for ethical guidance, but finding other guidance documents is not easy unless you know what you are looking for.” RO

“It can be easier to find by Googling than through the menus.” RO

“The rest of guidance [apart from GMP] can be hard to search and find on the internet. Forms in particular I have had trouble finding when I know they are there and this year needed advice on gender [affirmation] and ended up using my ELA to source it.” RO

3.5 Views of GMC guidance

Summary

Most doctors and medical students were positive about GMC's ethical guidance in terms of both its content and style. They found it clear and comprehensive, and at first glance, easy to navigate. The main criticisms were that it seemed overly open to interpretation (although by contrast, a minority welcomed the guidance not being overly prescriptive), and that it didn't take into account the context in which most doctors operate.

Stakeholders similarly felt that the guidance was well written and covered off most issues. Some expressed frustrations in relation to the search function on the website, but for many, the main problem with the guidance was that doctors weren't making enough use of it. While the guidance was generally seen as accessible to users with special visual or language needs, there was some concern amongst a small group of stakeholders (who worked with overseas doctors) that doctors who had not trained in the UK might find it particularly difficult to interpret.

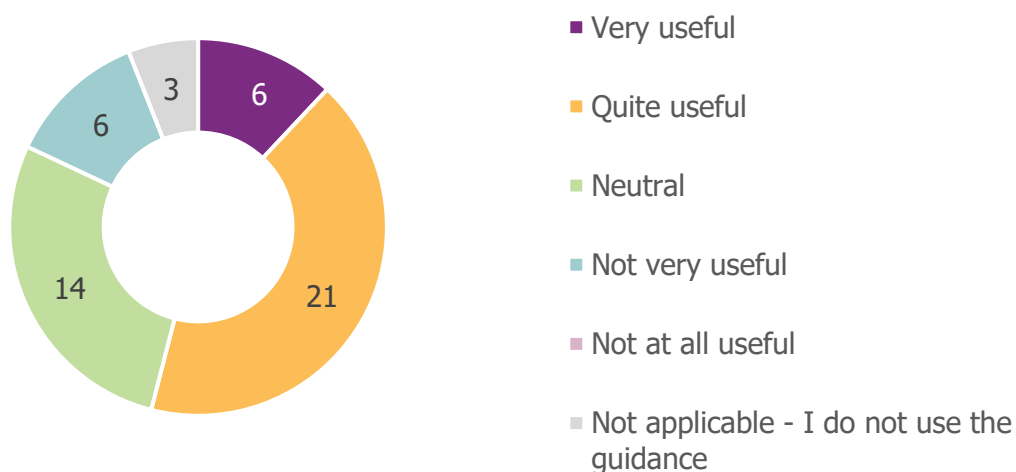


Doctors and medical students

Overall views

Despite using it fairly infrequently and despite often choosing to use alternative sources of guidance, doctors and medical students alike were broadly positive about the GMC's ethical and professional guidance overall. Early in the forum, participants were asked how useful they found the GMC guidance, and most said that they did find it useful or were neutral (indicating a general lack of knowledge amongst some). Responses are shown in Figure 10.

Figure 10 Overall, how useful do you find the guidance?

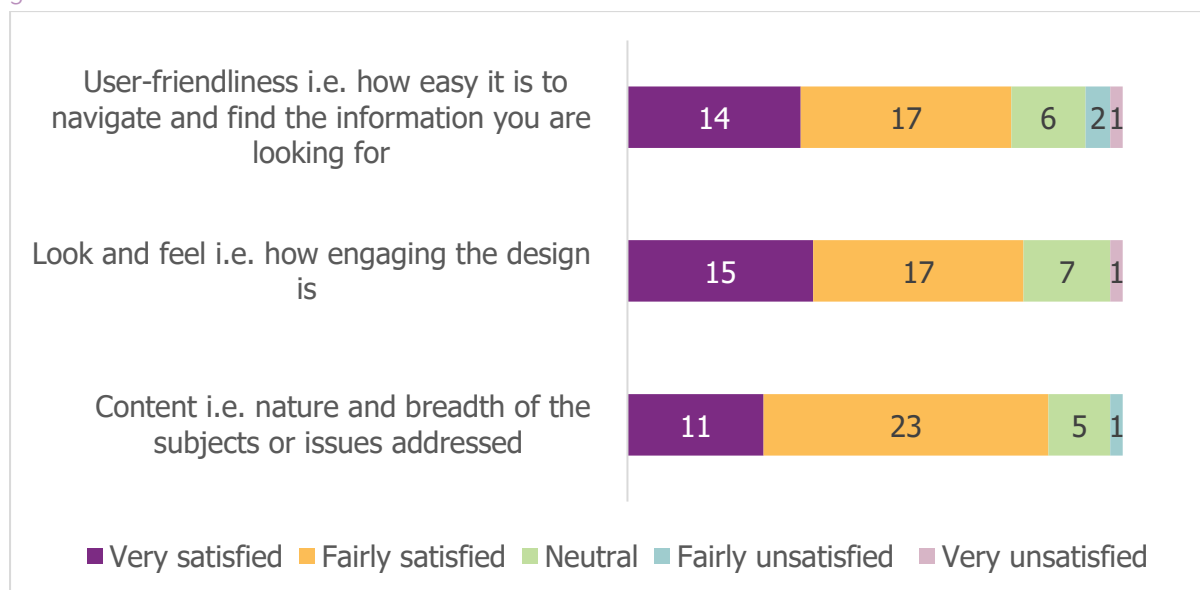


Base: All forum doctors/medical students (50)

Later in the forum, when participants had been tasked with reviewing it in more detail, they were asked how satisfied they were with different aspects of the guidance. Again, feedback was broadly positive, with most saying that they were satisfied with the how user friendly it was, its look and feel, and its content (see Figure 11).



Figure 11: Overall, how satisfied are you in relation to each of the following aspects of the guidance?



Base: All forum doctors/medical students (50)

Tensions

Doctors and medical students do recognise the inherent tensions in the guidance (namely, the need to be both setting clear standards and seeking to provide help and support), and the potential conflicts this can result in. However, by and large they feel that the GMC guidance mostly strikes the right balance. There are two main areas identified by doctors where there are potentially conflicting demands:

- The overall amount of guidance provided
 - Participants often described the guidance as ‘comprehensive’ and felt that it covered off most of what they would expect. This was generally seen as a good thing; however, there were some who felt that there was just too much of it. By and large, although many doctors and medical students recognised that they were unlikely to make use of all the guidance that was available, they felt that it was better that it was there in case they needed it one day.

“Some of the guidance can be extremely lengthy / comprehensive – which is good – but in a busy clinical environment it isn’t always possible to access the information you require easily.” Doctor, Male, Specialty Trainee, Secondary, Scotland

“I cannot see that there is anything missing - there is a great breadth of information available.” Doctor, Male, Specialty Trainee, Primary, England

- The level of ‘instruction’ provided



- Some participants praised the guidance for not being overly prescriptive, and welcomed the fact that it could be applied flexibly. However, many felt frustrated that it was too general to be useful.

“It leaves room for interpretation which is good and bad. It often doesn’t give a clear answer in a moral dilemma but it facilitates the decision making process and provides back up if questioned why I decided a certain way.” Doctor, Female, GP, Primary, England

“I think it's fine to be vague, but needs to be accepted and reasonable people might act differently and feel they are following the guidance.” Doctor, Male, Specialty Trainee, Mental Health, England

Likes

As discussed above, doctors and medical students were generally positive about the guidance, albeit this was sometimes based on relatively superficial or narrow experience, rather than in depth knowledge. Over the course of the forum, having discovered more about what was available, some doctors expressed a pleasant surprise in relation to the extent of the guidance – they found that there was more content and resources provided than they had initially realised. Doctors and medical students liked the guidance for the following reasons:

- Clear and concise.
 - Participants felt that the guidance was well laid out, it was written in plain, simple English and it was easy to understand and navigate.
- Comprehensive.
 - Most doctors and medical students felt that the guidance covered all the areas that they could think of.
- Learning resources
 - Once they discovered these (through taking part in the research), doctors and medical students were impressed by the range of tools available to them.

“I have not used the guidance a lot - though I feel it is easily accessible and I would always know where to look. I feel it is thorough and contains the areas and information I would like.” Doctor, Male, Specialty Trainee, Primary, England

“The topics are very relevant and topical. The language used was simple and easy to understand. The flow charts used, like in remote consultation, was very informative and practical.” Doctor, Female, SAS, Secondary, England

“I think that it is a very easy site to navigate with good heading and section choice. There isn’t too much information on any one page, so it doesn't have any of the feeling of scrolling through a large document.” Medical Student, Male, England



“Examples are helpful – I was not aware there are fictional case studies until today.” Doctor, Female, GP, Primary, England

Dislikes

Although doctors and medical students were broadly positive about the guidance, they did have some criticisms, which generally fell into two categories:

- Open to interpretation
 - Many felt that the guidance was too general and lacking in specificity. They felt that there was a danger that doctors might interpret it incorrectly and get into trouble for not following it properly.
 - Some participants felt that while the guidance was very clear at the extreme ends, there were some ‘grey areas’ where there might be more than one ‘right’ answer.
 - Some wanted to have more ‘next steps’ type guidance i.e. not just say what the standard was, but provide instructions on what to do if the standard wasn’t being met.
- Unrealistic
 - A number of doctors felt that the guidance was idealistic and didn’t take into account the actual working conditions of most doctors. There were limits to how much doctors really could follow the guidance, given the pressures on time and other resources.

“The language used by the GMC allows it to take really any decision it likes as it is so open to interpretation. This allows the GMC to give two separate answers to two of the same dilemmas, but might leave one candidate open to worse outcomes because of unconscious bias. This is what systems of discretion create - room for privilege to be exercised.” Doctor, Male, Specialty Trainee, Secondary, Scotland

“Found it easy to read, but not always easy to interpret. Perception can colour any guidance and can make facts fit if argued from different perspectives.” Doctor, Female, SAS, Secondary, England

“I absolutely agree with the fundamentals laid down in the guidance. But how do you provide an alternative, non-objecting doctor for the patient to see in a timely manner if there is nobody else on site?” Doctor, Female, GP, Independent, England

“The tone at the moment, it’s really kind of... idealistic is the only word I could use, and I think the tone that I would like it to go would be informed realism.” Doctor, Male, Specialty Trainee, Secondary, England

Guidance format and accessibility

At first glance doctors and medical students felt that the guidance was easy to navigate; however on close inspection (particularly when completing the scenario



exercise in the forum), certain issues were raised. Doctors sometimes found it difficult to find answers to ethical questions unless they knew the exact terminology to use. This is why some doctors found it easier to use generic search engines rather than search on the GMC website itself.

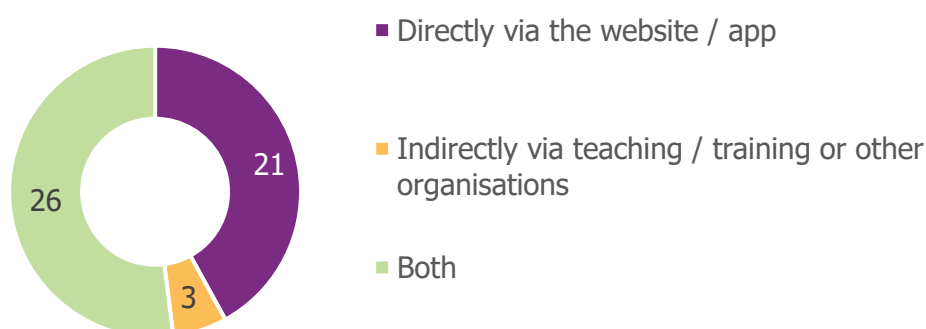
“I put “dealing with abusive patient” in the GMC search bar and nothing came up.” Doctor, Female, GP, Primary, England

“Looked at the "professionalism" and "raising concerns" categories, surprised not to find something relating to this issue in there. Tried search box next: "aggression" – only returned something about LD. Already rather frustrated, that seemed like a good keyword.” Doctor, Male, Specialty Trainee, Secondary, Wales

“In this scenario I looked up the GMC website and searched for 'patient will', 'beneficiary of patient will' and 'gift from patient'. There was nothing immediately relevant returned from these searches. The ethical guidance tab option was also very broad and I did not see a relevant section.” Doctor, Male, Consultant, Community, NI

In terms of preferred format, as shown in Figure 12, most doctors and medical students were happy to carry on receiving the guidance directly via the website or app and / or indirectly via teaching, training or other organisations.

Figure 12: For the information provided by the GMC, is your preference to access it directly yourself via the website/an app or indirectly through teaching / training or other organisations?



Base: All forum doctors/medical students (50)

In terms of functionality preferences, when prompted, there was an appetite amongst doctors and medical students for the ability to bookmark and to tailor information to specialty or level. However, a small minority did raise concerns about potential privacy issues.



“Bookmarking pages would be useful to come back, particularly if you are reviewing a case for an extended period of time and want to share information with colleagues.” Doctor, Male, FY, Secondary, England

“I’d rather not have my activity monitored.” Doctor, Male, Specialty Trainee, Secondary, Scotland

Other spontaneous suggestions for alternative formats and / or to improve the overall accessibility of the information and support provided by the GMC included an app, webinars and podcasts. Doctors and medical students felt that providing content in a more interactive way might help to encourage engagement. Some also felt that it would be useful to get immediate responses to specific ethical queries, for example via a chatbot or a helpline.

Guidance content

By and large doctors and medical students felt that the guidance was comprehensive, although there were a few areas where it was suggested that updates may be necessary including:

- Social media
- Working with colleagues, particularly in relation to bullying or harassment
- Working within resource constraints
- Digital / remote consulting

Meeting specific needs

Most participants felt that there were few, if any, barriers to accessibility in relation to the format or content of the guidance when it came to users with specific impairments or protected characteristics. This view was shared by those doctors who were expressly recruited to take part in the research as users who might have specific needs; indeed, it was more the case that other doctors projected their own concerns about others with protected characteristics, than those people themselves flagged any issues.

Most felt that the written guidance was accessible for people with visual impairments or learning difficulties in terms of the language and layout. However, there were a couple of suggestions as to how it could be further improved:

“An option to view black text with yellow background would be good for sight impaired.” Doctor, Male, Specialty Trainee, Secondary, Scotland

“I would think from an accessibility point of view, I don’t know if it’s available in larger print or like a greyscale print, for example. The reason I turn to PDFs, again, is because it’s a bit easier for me to manipulate if I needed to make it a bit bigger or change it. And I think for speed, maybe some of the different chapters or contents could be colour coded as well.” Doctor, Female, Specialty Registrar, Primary, England



It was felt doubly important that the guidance be provided in a variety of different formats for these users.

“For people like myself who have dyslexia ... videos, short video clips are really helpful, and they can explore the use of podcasts as well... They are very important stuff that you have to have, those guidelines, because they are the law and it... gives you the kind of framework to practise, but if you want doctors with a range of disabilities to be cognisant of it, then maybe look at other ways to give details.” Doctor, Male, Specialty Trainee, Secondary, England

There were some concerns that doctors who had not studied in the UK might be more likely to find it difficult to interpret some of the guidance, or might not even know of its existence.

“I would tend to contact an MDO if I was worried. It seems to me they know the rules the GMC abide by but don't write - "what they're really looking for is..." It's puzzling that the GMC doesn't just say what it wants. I can see that this unspoken rule set might disadvantage doctors without the benefits of a British upbringing or a British trained ear, to pick up on inferences and cultural norms.” Doctor, Male, Specialty Trainee, Secondary, Scotland

“I wonder whether doctors coming from abroad to work in the UK understand just how much GMC guidance is available. I have had a need to look at the equivalent guidance for two or three other countries (all countries that provide a lot of PLAB candidates), and it was very didactic and superficial, so they may not even imagine there is anything worth looking at.” Doctor, Male, LED, Secondary, Wales

Stakeholders

Overall views

Stakeholders were similarly positive about GMC's guidance overall.

In the RO survey, most said that they were satisfied with both the content and accessibility of the guidance, as shown in Figure 13.



Figure 13: Overall, how satisfied are you with the following in relation to GMC guidance?



Base: RO survey respondents (36)

Stakeholders, although a number identified specific aspects where they felt the guidance could be improved, tended to feel that, overall, the GMC guidance was useful.

“I find *Good medical practice* very clear and helpful. I keep a paper copy on my desk as well as the electronic version saved to my desktop. I think the other guidance documents, when I find them, are well written and helpful.” RO

“Overall, it’s a paragon of succinctness and simplicity, in a good way.” Adviser

Tensions

Similarly to doctors, stakeholders note the tension in the GMC’s role as both regulator and provider of support – but many feel that it is right that the guidance comes from the GMC, for this very reason.

“I think, if it was separated into two different organisations... there might be a problem with interpretation. So if they’re both in the same organisation, there is an advantage to having that closeness in terms of an iterative process.” Adviser

Again, mirroring feedback from doctors, most stakeholders felt that the guidance struck the right balance in terms of the amount available.

“I think it is fine as it is; better to be succinct and concentrate on the underlying principles rather than seeking to expand it.” RO

“For me, it’s partly about brevity, they tend to get that balance right, they don’t write 799 pages any more about things because that’s not helpful. I think they’ve got that balance a lot better than they might have done in the past.” Adviser



Unlike doctors, where the general consensus was that the guidance was generally seen as too open to interpretation, there was more of a split of views amongst stakeholders as to whether the GMC guidance achieved the right balance. A number of stakeholders specifically praised the guidance for not being overly prescriptive.

"I would expect it to remind people of the things to take account of. I don't expect it to give you an answer, I hope it isn't a search function where you type in your problem and it tells you what to do." Employer

"The GMC seem to have moved away from that very prescriptive kind of position and being better at setting out principles and frameworks to which the doctor should then make the decision." Adviser

"I think people think the guidance seems maybe a bit too vague but I don't think it can be anything other than that. Because it can never envisage every single scenario that a doctor might face." Adviser

Some advisers, for example, from the defence unions or Royal Colleges, did see it as their role to interpret the guidance on behalf of their members – that they were there to take it one step further on their behalf.

"For the individual consultant, trainee or whoever who's using our guidance, yes, they don't have to go and make those connections, but we will make the connections for them." Adviser

However, others echoed frustrations voiced by some doctors that the guidance could be too general and therefore different people might have different readings of what certain parts of it mean. Some highlighted specific examples of wording or phrasing that could have different interpretations:

"The problem with *Good medical practice* is that it's often quite vague... sometimes it's really helpful, but often it talks in really general terms, not very specific so, that makes it very difficult because it's sort of open to interpretation then. When it's not terribly specific, it's a bit like telling a child they've got to be good. You know, you've got to be good, but what do you mean by that?...What the GMC doesn't really ever do is give examples. They don't back up their guidance with examples, which would help you benchmark our decision making." Employer

"It says that "you should only ever stop providing care to people where there's an absolute irretrievable breakdown of the doctor/patient relationship". So that, if a patient who really wanted me to carry on looking after them, moved out of my area and was 200 miles away and I felt that I was unable to continue to deliver their care and they were saying "oh, no, no, look at paragraph 62, you've got a responsibility to do it"." Adviser



"Sometimes even with the guidance it's not always entirely clear. The 'knife wounds in the emergency department' one in particular, I can remember trying to set an exam question on this and, having gone through the different bits of guidance, particularly if it's a juvenile, you end up that even looking in the GMC guidance you reach points where it's telling you to do different things in different places. Where, I suppose, the rules fall down, where they conflict or do not cover a situation and then, if you haven't actually taught people to think ethically as opposed to 'look what the GMC says, do that and you'll be okay', then you've failed them, I think, if you haven't taught them how to problem solve." Educator

Related to this, a couple of stakeholders specifically raised concerns that the guidance had been interpreted differently by the GMC than themselves when it came to certain cases.

"There sometimes seems a disconnect between an RO's view on the seriousness and the stance taken by the GMC." Employer

Likes

The aspects of the guidance that stakeholders were most likely to praise mirrored those mentioned by doctors:

- Clarity of language, tone and structure.
- Comprehensive content.

Dislikes

Criticisms of the guidance focussed around the following areas:

- Navigation of the site
 - While this was an issue that did come up for doctors (particularly after they had looked more closely at the guidance themselves), it was much more likely to be raised by stakeholders (who were more used to using the guidance). They were frustrated that unless you knew the exact search terms, it wasn't always possible to find the specific guidance you were looking for.

"I've not always found the search engine particularly useful or easy to use... you might put something in knowing the guidance is there, it doesn't come up and you think 'I know it's there, I just can't remember what particular paragraph it is', and it's perhaps that you haven't put a key word or phrase in or you have to trawl through it." Adviser

"More comprehensive indexing. For example, one cannot look up 'misleading' but has to look through to find it is covered by para 71. Prescribing for friends and family, one has to remember this is not even indexed as '(close) personal relationships'." RO



- Dissemination of the guidance
 - A number of stakeholders had little criticism of the guidance itself, in fact, they thought the guidance was very good, but the problem was that doctors themselves weren't taking advantage of it as a resource. This was seen to be partly due to the fact that doctors chose not to look at it because they were disinclined to use GMC materials generally (due to a lack of trust in the organisation), and partly simply down to lack of awareness, both of the extent of material available but also of its importance. Stakeholders felt that doctors would benefit from a better understanding of how the guidance could help them, both from a practical day-to-day point of view (i.e. supporting them with difficult ethical decisions) but also to help them maintain their own professional standards (i.e. ensure they were up-to-date in their knowledge of what was expected of them). There was a concern, particularly amongst employers, that this lack of awareness resulted in doctors finding themselves in trouble in situations that potentially could have been nipped in the bud earlier on. To overcome these barriers, stakeholders felt that the GMC needed both to position the guidance differently, and work at expanding the channels through which it is disseminated, for example providing the guidance in different and more accessible formats.

"I am not sure that doctors on the whole are aware of how important the guidance is and whether there should be more effort to raise awareness of it: ...this is the code of behaviour and gold standard that doctors should meet. It occurs to me that it can be only at the point of someone being referred to the GMC with concerns about their professional practice that there is a sudden understanding of the importance of GMP." RO

"How do we reach people... how can we make people more aware of particularly *Good medical practice*, before they've got a problem? Prescribing comes up... it's one that we've had a few run-ins with different people in. And it's so well written and so clear you kind of think it would just save people a lot of heartache if they ...knew it, and listened to it and believed it." Employer

"Uses of variety of media, just giving out a little booklet is no longer going to cut it. So, supported by little podcasts or video diaries... people like to access stuff in different ways don't they, and learners learn in different ways. If we could say to the students, alright at the end of the session why don't you go and look on this YouTube channel that the GMC have done, looking at these particular scenarios about confidentiality, or go on the website or listen to this podcast which is really helpful, or whatever it is, it would strike a chord with more people, than simply sending them to a website where they're going to look at a 20-page document which, let's face it, they're not going to do." Educator



- Ensuring all types of doctors are represented
 - A handful of stakeholders felt that the guidance was overly targeted at 'typical' doctors i.e. those in traditional hospital settings working for large Trusts, and didn't take into account those doctors working in different settings, for example, GPs, or non-practising doctors.

"I think most of the language is more geared to those who are delivering patient care and then I think the way *Good medical practice* is sort of interpreted through appraisal and revalidation is much more geared to a clinical setting." Adviser

"You need it to be applicable in NHS and private settings. It needs to be applicable in hospital and primary care. I don't know when it was written, I don't know which doctors it had in mind, because usually you do have one in mind as you're writing it. And I do wonder if when it was being looked at, it needs to be looked through all the different lenses. Work in general practice you work on your own in a room with a patient that is very, very different to working in a team in a hospital ward setting where you're not on your own, and so how it gets interpreted, you need to interpret it in that context." Employer

"Understandably there is often a slant towards NHS and treatment services. That can bias the guidance sometimes for those dealing e.g. with pension assessments, and has led to difficulty." RO

Guidance content

Most stakeholders felt that the guidance was comprehensive and covered off all the required areas, although there were some specific areas where a few stakeholders would welcome further updates or new content:

- Social media - although some doctors acknowledged that technology moved so fast that the GMC couldn't be expected to incorporate such changes into the core guidance.

"If I give you a concrete example of when I'd be referring to *Good medical practice*, for example, we recently have had a little run of cases of junior doctors, so these are doctors in training, inappropriately using social media. So, posting things on social media that they shouldn't have... When I'm managing those individual doctors one of the things I would always do is look to see what does the GMC say about this? And I looked up the GMC Social Media Guidance...[it] was published in 2013, when Instagram, which was one of the platforms which we were concerned about [had only just] been invented... the GMC Guidance is sometimes out of date." Employer



"I think it would be really difficult for the GMC to respond to every new development on social media and say, 'this is how we would interpret our guidance in relation to this particular situation', and I think the way for them to do that, if they're going to do it, would probably be in the resources. So providing a worked case example." Adviser

- Working with others, particularly healthcare professionals from different disciplines or in management positions. It was felt that with the increased use of multidisciplinary teams, it was more important than ever that this aspect of professionalism was emphasised in the guidance.

"I would appreciate inclusion of more regarding relationships with colleagues. There is plenty about how you should behave towards patients but little about colleagues." RO

"The wording currently is terribly bland and high level and it says little more than 'you should work collaboratively with your colleagues for the benefit of patients'. For example, there's nothing around respecting the knowledge and leadership capability of other professions, there's nothing about non-clinical professions and people and leaders and colleagues who actually have an equally important role to play in making sure that services are safe, effective, caring, responsive, well led.. unless some of the guidance is really helping doctors remember that they're part of a multi professional team, they will keep on behaving like they often behave." Employer

- Climate change and use of resources

"There's an area where it just says 'and you have a responsibility for ... I can't remember the exact wording but it's about wise and sensible use of available resources. I think that has always been interpreted as spend money wisely and I think that now, as a system and as a society... thinking about things like climate change... With what wider society is saying, what is being said by the Climate Change Committee at the moment, what the NHS is saying about the net zero plan, I think there's a professional responsibility to contribute to that wider potential success of the threat that society faces." Adviser

Meeting specific needs

Stakeholders did not raise any issues in relation to the guidance in terms of its accessibility for users with specific impairments. However, a number of ROs did discuss whether the guidance is suitable for doctors who trained outside of the UK. They did not feel that there were issues with the language per se (if doctors had proficiency to practise medicine, then they should be able to read the ethical guidance), rather they were concerned that they might not interpret the guidance in the same way as UK-trained doctors – or even be aware of its existence.



"I can see how, if you work in a completely different country with a completely different culture practising medicine, that would be quite hard, or... it may be difficult to make sense of it. And so, my worry is, whether it's being used in a way, whether it is explicitly or whether it's implicit to use, we are quite narrow in our understanding of what it means. And I don't think it's very culturally sensitive." Employer

3.6 Suggested improvements

Summary

Users in both phases of the research identified similar ways in which the guidance could be improved to make it more useful including: more examples to help bring it to life; more alternative formats, better dissemination and improved navigability.

Doctors, medical students and stakeholders

Participants were asked how the GMC could make the guidance as useful as possible for its users. The main suggestions to come through (common across both phases of the research) were:

- (More) examples
 - The most common suggestion from doctors and medical students was for more examples, scenarios and case studies to help illustrate some of the principles (it should be noted that many seemed unaware of the extent of the existing provision in the supplementary resources). Some thought it would be particularly helpful to be given examples of where the guidance had not been followed and what the repercussions had been of this. Although less pressing a request amongst stakeholders, it was felt that more content relating to the likely outcomes of particular situations would be beneficial to users of the guidance.
- (More) alternative formats
 - Doctors and stakeholders alike praised the videos and interactive tools that were available on the website, and welcomed the idea of having more of these sorts of resources. They thought it would be helpful if the guidance was made available in a variety of formats, including videos, webinars and podcasts.
- Better dissemination



- Many doctors and medical students were pleasantly surprised at the breadth of guidance and resources available and felt that this needed to be better communicated to doctors. They thought that it could be delivered via workshops or other channels such as medical journals and social media. While not surprised themselves at the extent of the guidance, stakeholders agreed that most doctors would be unaware of what was available and also wanted to see better dissemination and awareness raising. Doctors and stakeholders alike felt that doctors at later stages in their careers might be less aware of the extent of the provision – and potentially more likely to benefit from reviewing it.
- Tailoring
 - There was a call from some, for sections to be tailored to specific groups of doctors (or medical students) that would be particularly relevant to people at that career grade or in a certain specialty. Stakeholders would also welcome this, for example, a separate section aimed at ROs only.
- Improved navigability
 - Many stakeholders and some doctors felt that the search function could be improved and wanted to see better cross referencing / indexing both within the ethical guidance and other GMC guidance. They were frustrated that in some cases that one could only find specific guidance if one knew exactly what to look for. They also wanted to see more and improved links between the different types of guidance.

“More anonymised "casebook" type publications discussing cases that have been through the disciplinary panel or were dismissed before getting to the formal investigation stage.” Doctor, Male, Consultant, Secondary, Wales

“Sometimes a lack of specifics – the case studies help but many scenarios or elements aren't available. I think there is a great gap in terms of precise and applicable guidance on many aspect of professionalism and expectations of doctors in the world and healthcare systems we exist in nowadays, and it is overlooked how much of an impact bullying, harassment and discrimination there is... It would be helpful to have examples that are relevant to different career grades as we experience different scenarios and different challenges based on this.” Doctor, Female, Specialty Trainee, Primary, Wales

“If I want to be using it as an educational tool, I could potentially just play a video and go “right, I want to talk about this today, here’s what the GMC says about consent, here’s a five minute video for you to look at and then we’ll have a conversation about it”. That’s something that could be really useful for people who are doing it as an educational tool.” Adviser

“It might be useful to have a tab for favourites so you can save previous searches, with an option to connect your search to a reflection tool. This can



then be used to reflect on whatever issue you were dealing with and added to your appraisal or ARCP depending on your grade.” Doctor, Female, SAS, Secondary, England



4. Conclusions

- It was rare for practising doctors or medical students to seek out formal ethical guidance, primarily because most felt confident in their ability to address ethical issues based on their own experience, or they relied on their colleagues for advice. The pressure of their working environment also meant that doctors had limited time to refer to external guidance.
- When doctors and medical students did actively seek out written ethical guidance, the GMC was rarely their first port of call, except in more official situations where it was important that they got the 'rules' right. Doctors often relied on other sources of advice, such as defence organisations and Royal Colleges, many of whom were interpreting GMC guidance themselves. By contrast stakeholders often relied on GMC guidance as their main source, supplemented by guidance from other organisations.
- Upon reflection, many doctors felt that while they may not often refer directly to the guidance, given that professional standards were embedded within medical curricula, education and training, they would naturally be drawing upon them throughout their practice. This is encouraging for those at early stages in their careers; however more senior doctors may be unaware of how the guidance has changed since they first encountered it, particularly when considering how reliant more junior doctors are on the advice of their more experienced colleagues.
- While most doctors and medical students felt confident in their knowledge of the principles in *Good medical practice* (and often felt they applied them instinctively), awareness of the explanatory guidance was relatively low, and very few knew about the learning resources available. The hierarchy and difference between the pieces of guidance was generally not well understood by doctors or medical students. Stakeholders reinforced that there was often a lack of awareness amongst doctors as to both the extent of the guidance available and its importance (and the associated implications of falling foul of it).
- Overall, users were positive about the guidance, seeing it as clearly structured, well written and comprehensive.
- There was a perception amongst some that the guidance was difficult to interpret, in terms of applying it to real life situations, with doctors and medical students in particular calling for more case studies and examples to help with this. There were also some concerns that doctors who had not studied in the UK might be more likely to find the guidance difficult to interpret or be unaware of it, which could put them at a disadvantage. However, other users did praise the guidance for not being overly prescriptive and felt that the right balance had been achieved. It is possible that some doctors were unaware of the extent of materials already provided as learning resources which may have helped with interpretation.



- The other area where users wanted to see improvement was around the navigability of the website; doctors and stakeholders alike found it more difficult to find specific pieces of guidance than they would have expected.
- There was a sense amongst many that better dissemination of the guidance should be the priority. Given that many doctors and medical students were pleasantly surprised at the nature and breath currently available, it was felt important that this was better communicated, whether directly by the GMC or in partnership with the stakeholders that doctors more naturally turn to for advice. Providing the guidance in a range of alternative formats could also go some way towards raising awareness of the content.



5. Appendices

5.1 Overview of research approach



5.2 Sample

Forum sample

Criteria	No of participants
TOTAL	50
Type/career level	
Consultants	10
SAS	6
LED/Trust doctors	2
FY1/FY2	4
GPs (including some GP Partners and some more recently qualified)	10
SPRs - including senior house officer/core training/early specialty training grades	8
Final Year Medical students	10
Gender	



Male	26
Female	24
Country	
England	26
Scotland	10
Wales	9
Northern Ireland	5
Type of setting	
Primary care	11
Acute care (comprising a mix of specialties)	26
Independent sector	4
Other setting (including community care, mental health trust, public health)	8
Current role	
Locum	5
Non-clinical role	3
Where qualified	
Qualified inside EU (not UK)	4
Qualified outside EU (not UK)	10
Setting	
Urban	31
Suburban	10
Rural	9
Other variables	
Minority ethnic group	20

Depth interview sample

Criteria	No of participants
TOTAL	18
Type/career level	
Consultants	4
SAS	2
LED/Trust doctors	0
FY1/FY2	0
GPs (including some GP Partners and some more recently qualified)	2
SPRs - including senior house officer/core training/early specialty training grades	9
Final Year Medical students	1
Gender	
Male	11
Female	7
Country	



England	15
Scotland	2
Wales	0
Northern Ireland	1
Type of setting	
Primary care	6
Acute care (comprising a mix of specialties)	11
Independent sector	0
Other setting (including community care, mental health trust, public health)	1
Other variables	
Minority ethnic group	10

5.3 Discussion materials

Forum agenda

A full transcript of the online forum tasks and activities can be found by clicking the pin icon below.



Discussion guides

The discussion guides for the depth interviews can be found by clicking on the pin icons below:

'In the moment' interviews



'Seldom heard' interviews



Phase Two interviews (stakeholders)

