Response to consultation on revised Good Medical Practice

July 2022

1. Introduction

1.1 The Professional Standards Authority for Health and Social Care ('the Authority') promotes the health, safety and wellbeing of patients, service users and the public by raising standards of regulation and registration of people working in health and social care. We are an independent body, accountable to the UK Parliament. More information about our work and the approach we take is available at www.professionalstandards.org.uk.

1.2 As part of our work we:

- Oversee the 10 health and care professional regulators and report annually to Parliament on their performance
- Accredit registers of healthcare practitioners working in occupations not regulated by law through the Accredited Registers programme
- Conduct research and advise the four UK governments on improvements in regulation
- Promote right-touch regulation and publish papers on regulatory policy and practice.

2. General comments

2.1 We welcome the opportunity to respond to this important review of standards for medical professionals. We are aware that it comes just ahead of significant changes for the General Medical Council (GMC), with the introduction of statutory regulation for Physician Associates and Anaesthesia Associates, and a new model of regulation underpinned by new legislation. It will be important to ensure that the new iteration of Good Medical Practice (GMP) supports both aspects of GMC reform.

2.2 It also comes at a time of changing social attitudes. We are pleased to see the GMC recognising that more can be done by registrants themselves to tackle all forms of 'unfair discrimination', inappropriate sexual behaviour between colleagues, and other behaviours that contribute to toxic workplace cultures. We found the Equality Impact Assessment helpful, and overall felt that there was a strong commitment to Equality Diversity and Inclusion (EDI) in this exercise.

2.3 We also welcome the renewed focus on partnership with patients and colleagues, and leadership skills that apply to all medical professionals. However, we thought that the guidance could be stronger on specific responsibilities for medical professionals in leadership roles to promote inclusive, open, learning cultures which has been a theme of many recent and past inquiries and reviews into major healthcare failings.

2.4 We felt the guidance could be stronger and clearer on the matter of social media use – an area that both professionals and panels can find difficult to navigate, particularly the distinction between use of social media in private as opposed to a professional capacity.

2.5 We also found that parts of the guidance relating to conflicts of interest could go further to respond to the findings of both the Cumberlege[1] and Paterson[2] reviews.

3. Specific comments

3.1 Numbers in comments reference the numbering in the draft guidance.

Domain 1: Working with colleagues

3.2 Behaviours and Domain 1 general: it might be helpful to define the term 'unfair discrimination' or 'unfairly discriminate', as it could otherwise be open to unhelpful interpretation and challenge as to its meaning. We also note that there is one instance of 'discriminate' that is not qualified by 'unfairly' at 6.

3.3 5 and 56: we suggest that these clauses could also cover what medical professionals say and the way they express themselves, including through social media and networking websites. This would help to clarify interpretation of these clauses and bolster the new expectation around social media and networking website use set out in 6 and 74.

3.4 6: we welcome the mention of social media and networking sites. As mentioned above, in our view, there are other standards where we would expect to see reference to use of these platforms. We would also welcome assurance that these terms would cover material shared on messaging apps, and with groups privately, see comments relating to paragraph 74 of the guidance. Overall, clearer definition of these terms would be helpful, as we know this is a complex area for professionals, and indeed regulators and FtP decision-makers, to navigate.

3.5 7: we welcome the reference to taking action to tackle other people's toxic behaviours. To bring about cultural change, it is important for healthcare professionals to see this as part of their role, and for it to be seen as everyone's responsibility. The Independent Neurology Inquiry in Northern Ireland found that medical professionals were: 'apprehensive in raising a concern about the practice of a colleague or querying discrepancies that arose, which did not directly touch upon the welfare of their own patient'[3]. Other Inquiries have identified similar issues with staff unwilling or unable to raise concerns about colleagues, therefore there are clearly still barriers in this area which need to be addressed. We welcome the references at both 17 and 19 to reporting adverse

[1] *Volume 1 - Independent Neurology Inquiry, Report June 2022*. Available at: https://www.webarchive.org.uk/wayback/archive/20200721101148mp_/https://www.immdsreview.org.uk/downloads/IMMDSReview_Web.pdf

[2] https://www.gov.uk/government/publications/paterson-inquiry-report

[3] https://www.neurologyinquiry.org.uk/sites/ini/files/INI%20Final%20Report%20-%20Volume%201%20-%20%28Revised%204th%20July%202022%29.PDF

events or near misses and wider risks to patient safety including concerns about a colleague's fitness to practice. However we note that the guidance references the GMC's separate guidance on confidentiality. Whilst it is of course important that medical professionals maintain appropriate confidentiality, it may be worth the GMC considering whether there is any potential for mixed messages or any further action that can be taken to encourage speaking up where there are patient safety concerns.

3.6 9: we welcome this addition but suggest that it would be better phrased as a positive duty, to make it clearer and easier to comply with. Wording along the lines of 'you must ensure that someone else will pass on the information needed for patient care…' might be preferable.

3.7 15-17 and 20: we welcome the references in 15-17 to taking part in clinical governance activities and responding to risk and in 20 to supporting colleagues to raise concerns but in our view this could go further. It would be helpful for the guidance to emphasise more strongly the responsibility of those in leadership positions to promote inclusive, open, learning cultures. This was a theme which arose clearly from the recent Ockenden Review into failings at Shrewsbury and Telford Hospitals NHS Trust. Previous inquiries and reviews have also highlighted concerns about organisational culture and a tendency to defend past actions rather than learn from where things have gone wrong. We recognise that improving organisational culture is a much larger issue and cannot be addressed by professional regulation alone. However, the guidance should make clear the responsibility of healthcare professionals to positively engage in learning from harm as laid out in the Berwick Report.[4] It may be helpful to link this responsibility to the duty of candour.

Domain 2: Working with patients

3.8 24: the statements about conscientious objection and responsibility for finding alternative provision do not appear to put patients first. It should be for the professional to arrange for the patient to see another practitioner, and to assess the risks of doing so. In addition, the document should acknowledge that safe, timely alternative provision may not always be available – for example in rural settings – and that in those situations, the professional may have to provide treatment despite their objection. This would align with the responsibility on professionals to provide 'continuity of care' as outlined at paragraph 8.

3.9 28: we found the meaning and purpose of this requirement unclear, once removed from the context of the consent guidance.

3.10 38: we were pleased to see GMP being updated to reflect new ways in which care can be provided.

3.11 45: it might be helpful to signpost this statement as the 'duty of candour', for clarity and consistency with other professional regulators.

[4] *A promise to learn – a commitment to act - Improving the Safety of Patients in England National Advisory Group on the Safety of Patients in England.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

3.12 47: we suggest there might be other circumstances in which it could be appropriate for the medical professional to end a professional relationship with a patient, for the benefit of the patient – for example, if there is a risk of boundaries being crossed. The broader concept would be something along the lines of 'if it is no longer possible to maintain a trusting and professional relationship between professional and patient'. In our 2008 guidance *Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals* we stated that: "If a healthcare professional is sexually attracted to a patient and is concerned that it may affect their professional relationship with them, they should ask for help and advice from a colleague or appropriate professional body to decide on the most professional course of action to take. If, having sought advice, the healthcare professional does not believe they can remain objective and professional, they must:

- find alternative care for the patient
- ensure a proper handover to another healthcare professional takes place
- hand over care in a way that does not make the patient feel that they have done anything wrong."[5]

3.13 We also note that as is set out under 24, conscientious objection to providing care is given elsewhere as a valid reason for potentially ending a relationship with a patient.

Domain 4: Professional capabilities

3.14 We welcome the additions to Domain 4 that strengthen the commitment to dealing with conflicts of interest. Nonetheless, given the severity of the risks identified in both the Paterson and Cumberlege reviews, we felt that more could be included on this point. For example:

- standard 75 on advertising could also include a requirement to declare any conflicts when advertising services;
- standard 82 should envisage that a conflict may be so problematic as to require the professional to avoid it or remove it altogether
- It reads like an omission for standard 83 not to mention sales representatives alongside patients and colleagues.

Domain 4: Maintaining trust

3.15 74: The current wording of this part of the guidance refers to 'when communicating publicly as a medical professional you must…' and goes on to reference behaviours that medical professionals must demonstrate in all written, spoken, and digital communications. We would welcome clarity on whether this is deliberately drawing a distinction between behaviours in professional and private life. Given that misconduct in private life can fall under the jurisdiction of

[5] Council for Healthcare and Regulatory Excellence 2008, *Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals.* Available at: https://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/sexual-boundaries-responsibilities-of-healthcare-professionals-2008.pdf?sfvrsn=a8c77f20_8

fitness to practise, if this is the intention then we would query whether this may be misleading to suggest that only communications in a professional capacity should comply with the guidance.

3.16 We would also have liked to see in the draft a stronger expectation that medical professionals should take care not to spread disinformation that could expose patients to unnecessary risks as well as damaging public confidence, whether through social media or elsewhere.

4. Further information

4.1 Please get in touch if you would like to discuss any aspect of this response in further detail. You can contact us at:

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