1. I write with regard to the GMC consultation on the Review of Good Medical Practice 2012.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 44,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

1 Do you agree that Good Medical Practice should be restructured under the four domains rather than the seven headings?

Yes, as we argued in our response to the GMC consultation on the Review of Good Medical Practice in 2011, we do agree that the document will be more useful to doctors if organised under the same four domains as the Framework for Revalidation.
2 Do you think that the new style is more appropriate to *Good Medical Practice* than the explanatory style it replaces?
Yes, it is clearer and more appropriate. That said, the GMC might consider publishing an expanded version that incorporates the supplementary advice, for those who prefer to use it in this way.

3 Do you think there is anything else that could be moved from the consultation draft of *Good Medical Practice* into additional guidance?
No.

4 Do you have any additional comments on the style and structure of the draft guidance?
No.

5 Do you have any comments about the duties of a doctor statement?
No.

6 Do you have any comments on the revised introduction?
Yes. The introduction is clear and concise, a good reminder to doctors about core professionalism as a medical practitioner.

As discussed in our response to the consultation in 2011, it is our view that the introduction could make explicit reference to revalidation and the role of *Good Medical Practice* in relation to this.

The introduction should also refer readers to the specialty-specific guidelines which are based on *Good Medical Practice*, such as *Good Medical Practice for General Practitioners*.

7 Do you think that we should refer to key pieces of legislation at paragraph 8?
Not sure. It would be inappropriate to list these, as any list may rapidly become out of date. Perhaps the guidance could suggest key items in a footnote, or alternatively refer to supplementary guidance which may be updated more frequently.

8 Do you have any other comments about the guidance in this section?
Yes – it has been suggested that requiring doctors to ‘monitor and improve the quality of [their] work’ (paragraph 9) sets an impossible target, particularly for any
doctor who is already working at a very high standard. More reasonably, doctors should be expected to monitor and maintain the quality of their work, identify and address any shortcomings.

Also, and as argued in our 2011 response, the ‘regularly’ in paragraph 7 has little meaning unless defined.

9 Do you agree that this guidance is right in principle?
Not sure.

Para 14a – you should clarify whether this is intended to mean that doctors must always check repeat prescriptions that have been issued by other doctors.

Para 14f – we would suggest changing ‘must… wherever possible avoid’ to ‘should avoid’ – so that doctors living in relatively isolated areas, for whom it may be far more practical to self-manage minor conditions, do not feel in breach of Good Medical Practice. GPs encourage patients to self-manage many minor conditions, and it seems sensible that doctors should be able to do the same – what is needed is clear guidance on which non-over-the-counter products are permissible to self-prescribe, and which are inappropriate.

10 Do you have any other comments about the guidance in this section?
Yes – the advice on referral at paragraph 13c, requiring the doctor to refer to another practitioner ‘who is accountable to a regulatory body’, which is similar to the previous version, has been observed to have unintended consequences. While it is of course appropriate to deter referral to unregulated medical providers, this restriction may also deter referral to a range of other therapeutic services – such as exercise referral schemes supporting cardiac and pulmonary rehabilitation, and other ‘social prescribing’ projects such as art therapy for people recovering from substance misuse. The guidance should be modified to reassure GPs that such referrals are acceptable.

We might also suggest, in either paragraph 13 or 14, an additional point: ‘You should support your patients to follow healthy lifestyles by offering evidence-based advice in a sensitive way.’

11 Do you agree this is a helpful addition to the guidance?
Yes – it is of obvious importance to encourage professional standards of record keeping.

12 Do you have any other comments about the guidance in this section?
Yes – paragraph 18 should require that a brief description of the history is kept along with the clinical findings, since these alone are not sufficient to justify the working diagnosis.

Also, as argued in our response to the 2011 consultation, paragraph 16 could also include a stipulation that records be kept in a way that is easily understood by other healthcare professionals involved in that patient’s care – this may go beyond ‘clearly, accurately and legibly’.

13 Do you agree that it is reasonable to ask this of all doctors?
Not sure – this risks imposing a heavy and impractical burden on the individual doctor, particularly for GPs who provide care over a period of time. We agree that it is important that patients know who is leading on their care, and doctors hold responsibility for their overall patient care. However, we are not at all clear what this recommendation means in practice and have doubts about how it could be enforced.

As the text stands, many doctors could technically be in breach – questions were asked by our respondents about whether this would mean that a doctor could be held responsible for someone else’s error occurring when they were not available, especially if they were not their employer. Also, many sessional doctors or salaried doctors might be a lead doctor, and their patients would see them as the lead for ongoing care, but they are not technically named as that patient’s doctor.

There is also insufficient clarity over who retains responsibility when a patient is attending an outpatient clinic regularly. A more general statement about continuity in both primary and secondary care is required while this difficult issue is clarified if possible. The emphasis (for general practice) should be on ensuring the development of practice policies that encourage continuity through handovers and named teams or named GPs for individual patients. At present the whole implication and intent of 20b is unclear and risks confusion.
Para 20c – this is also impractical, since a doctor will not have the social care information. Moreover, given both present standards of information transfer, and the requirements of confidentiality, this requirement is effectively meaningless.

14 Is it clear what we mean by saying the care doctors provide must be ‘compatible’ with all other aspects the patient’s care?
   No, this needs further explanation.

15 Do you agree that all doctors have a duty to act when they see a failure in the provision of basic care?
   Yes – however, supplementary guidance is needed to define how far that action should go if those primarily responsible for care do not change their approach.

16 Do you think it is reasonable to expect all doctors to support research in this way?
   Not sure – we would argue that this ought to be ‘should’ rather than ‘must’ – otherwise failure to participate in research might be seen as a significant performance issue, which we assume is not the intention.

17 Do you have any other comments about the guidance in this section?
   No.

18 Do you agree that the guidance on responding to risks to safety is clear?
   Yes.

19 Do you agree that this is a reasonable expectation on all doctors?
   Not sure – we are uncomfortable with a compulsory ‘Good Samaritan’ clause being part of Good Medical Practice, and would prefer ‘should’ to ‘must’ except in the case of patients to whom the practitioner already owes a duty of care.

20 Do you have any other comments about the guidance in this section?
   Yes. One of our commentators poses the question of whether the requirements of paragraph 21 would also apply to national policies or systems – what would be expected, for example, if a doctor’s professional judgement led him or her to judge that NICE guidance was wrong or out-of-date and compromised patient safety?

21 Do you have any comments about the guidance in this section?
Yes – paragraph 28 is a slight discrepancy from paragraph 14f, as mentioned at Q9 above. In both cases, ‘should’ rather than ‘must’ is appropriate.

22 Do you agree that, without the additional guidance, it is clear what is required of doctors?
Yes. We note, however, our comment in response to the 2011 consultation wherein we suggested that guidance should include a responsibility to persuade the patient of the benefits of sharing information to aid continuity of care, if they initially decline for their information to be shared.

23 Do you have any other comments about the guidance in this section?
No.

24 Do you agree that this is a helpful addition to the guidance?
Yes.

25 Do you agree that it is important for doctors to seek out mentors at these times of transition?
No. We do not feel it is appropriate for Good Medical Practice to stipulate that a doctor should seek out a mentor at points of career change. This may be desirable to some doctors but not to others; it should be needs-based, and its purpose clarified. Furthermore, it is hard to see how this stipulation could be enforced, and, without widespread support from the profession and from NHS organisations, how it could be resourced – since true mentorship does require time and resources. The GMC would need to provide evidence that mentoring improves performance or at least prevents deterioration – until then, this should not be included.

A more appropriate paragraph might read: ‘You should ensure that you seek skilled support (e.g. mentoring, advice or career counselling) if you are faced with difficulties in your role as a doctor or have a difficult professional decision to make.’

26 Do you agree that it is reasonable for doctors to be willing to act as mentors to less experienced colleagues?
Not sure – whilst this might in some sense be good practice, it needs to be tied to some definition of what constitutes ‘acting as a mentor’.

27 Do you agree that this is a reasonable duty to expect of all doctors?
28 Do you have any other comments about the guidance in this section?
No.

29 Do you agree that the guidance on conscientious objections represents a fair balance between the patient’s and doctor’s rights?
Yes.

30 Do you agree this is a reasonable expectation of doctors?
Yes – though we’re not sure how it would be monitored/enforced.

31 Do you have any other comments about the guidance in this section?
Yes – as mentioned in our 2011 response, the section on conscientious objection (paragraph 52) ought to stress that a doctor must not hesitate to provide emergency treatment, even if this may risk contravening an individual’s beliefs.

32 Do you have any comments about the guidance in this section?
Yes – as mentioned in our 2011 response, paragraph 56 – ‘You must give your registered name and GMC reference number to anyone who asks for them’ – should explain that disclosure is a duty that should apply in matters relevant to the doctor’s practice – unless the GMC really intends that such information can be asked for in any context.

33 Do you agree that the new guidance makes clear the obligations of doctors towards people with disabilities?
Yes.

34 Do you have any other comments about the guidance in this section?
No.

35 Do you agree that the guidance achieves a fair balance in terms of the GMC’s role and remit?
Not sure – paragraph 68 leaves much open to interpretation. What would be the position in a situation where there had been an investigation of a doctor’s personal conduct, but no prosecution, and for example the local community made their own
judgement and were reluctant to be seen by the doctor? Would this doctor then be in breach of good medical practice?

36 Do you have any other comments about the guidance in this section?
   No.

37 Do you agree that we should give advice to doctors that covers all situations where they are communicating publicly, even if it is not directly connected to their medical practice?
   Not sure – the rules of professional behaviour apply whatever method of communication is used, and it may be useful to provide advice to doctors on using social media, but Good Medical Practice is probably not the appropriate place to do so. With regards to paragraph 71c, we’re not sure what value there is in a ‘duty to remember’.

   Also with regards to this section, and as discussed in our response to the 2011 consultation, we would argue that, given present changes to the management and delivery of healthcare (in England particularly), it would be useful to include a responsibility not to make unfounded claims about another healthcare provider.

38 Is this a useful addition to the guidance?
   Not sure – clearly there are occasions when many doctors feel it is appropriate not to tell the whole truth unless directly requested, though we would agree that doctors should never deliberately lie or mislead. With this in mind, paragraph 73c should be changed to ‘you must not deliberately give false or misleading information – since it is quite possible for any doctor to give misleading information through genuine lack of information or error.

39 Do you have any other comments about the guidance in this section?
   No

40 Do you agree that it is reasonable to include less detail in the core guidance?
   Yes.

41 Do you think it would be helpful to have examples in this section? If yes, please suggest examples that would be helpful in illustrating the principle.
No. Clearly, without examples, these paragraphs risk being a ‘catch all’ putting most doctors in breach of good medical practice – particularly the requirement to declare ‘any interest that you have’. However, we will be content for these examples to be included in the proposed supplementary guidance. This will be an important document, given the present changes in the English NHS and likely future emphasis on financial probity.

42 Do you have any other comments about the guidance in this section?
   No.

43 Is there enough focus in the guidance on the following (please tick all that apply)?
   Patient centred care – yes
   Patient safety - yes
   Issues relevant to doctors in training - yes
   Human rights – not sure
   Respect for patients’ dignity - yes

44 Do you have any other comments on the focus and scope of Good Medical Practice – a draft for consultation?
   Yes – we note that there is no reference to the increasing divergence between the healthcare systems of the four countries of the UK. Any discussion of duties of supervision and accountability needs to consider these changes and this divergence.

3. We gratefully acknowledge the contributions of members of the College’s Council in formulating this response

Yours sincerely

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Honorary Secretary of Council