GMC consultation on Good Medical Practice explanatory guidance

1. I write with regard to the GMC consultation on Good Medical Practice explanatory guidance.

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.

3. The College welcomes the opportunity to respond to this consultation. We have responded in detail below to the individual sections, but first we have a couple of comments on the guidance as a whole.

4. Firstly, and most importantly, we are concerned that this ‘explanatory guidance’ does not go far enough in making the distinction between ‘guidance’ and ‘rules’. It is laudable that efforts have been made, as suggested by ourselves and other
respondents, to shorten the main text of Good Medical Practice. However, many sections of these explanatory guidance booklets/statements include sentences that begin ‘you must’ – not unreasonably, doctors will assume that these are therefore rules, with the same status as Good Medical Practice, and that it is necessary for them to familiarise themselves with and be able to recall the entire text. The net result is to increase rather than reduce the burden. We would argue that much greater clarity is needed over the status of guidance – a recent Law Commission consultation ¹ on professional regulation suggested regulators could issue ‘Tier 1’ and ‘Tier 2’ guidance, with clear definition of the status of each. The GMC should consider something along the lines of this approach, or at least be more cautious in its statements.

5. Also of concern to us is that this guidance, quite specific in some areas, is then silent, or shows a lack of contextual understanding in others. The outcome will be that doctors may be persuaded of the seriousness of the strictures around areas of their conduct, but then left without clear guidance on how to proceed in specific circumstances without endangering their registration. The section on conflicts of interest in commissioning was felt to be particularly inadequate in this respect, with a failure to recognise or respond to the realities of the present situation (for doctors in England at least). The section of social media was also felt to be less than comprehensive. We would argue that, if the guidance is unable to encompass all the complexities of these areas, at the ‘cutting edge’ of new developments, it may be better to stay silent and revert to the core requirements of Good Medical Practice.

6. Specific consultation questions are addressed below:

**Acting as a witness in legal proceedings**

1 Is the guidance clear?

Some of the language is not sufficiently clear. In paragraph 4, a definition of what it means to ‘act independently’ is required, as this is not clear otherwise.

In paragraph 14, the reference to an ‘objective, unbiased opinion’ is a contradiction in terms, since an opinion is by its nature subjective. The definition in paragraph 10 of an ‘opinion based on your professional experience and judgement’ is more realistic.

Paragraph 19 should make clear that a doctor may be asked to give evidence in a generalist area – the word ‘specialist’ should be avoided here.

**Delegation and referral**

2 Is the definition of delegation clear?

Yes

3 Is the definition of referral clear?

Yes

5 Is the guidance clear?

There are a number of problems with this section. Most notably, in our view it doesn’t recognise the greater complexity of referral in the modern NHS, and will leave some doctors uncertain or vulnerable. Doctors are being asked to refer patients to referral management services – patients are then held waiting while the service determines whether the referral is appropriate. The referral may then be passed to a third party whom the doctor has not nominated, or may be referred to a team rather than an individual. It is not clear (as we indicated in our response to the consultation on Good Medical Practice earlier this year) who is responsible for the patient at each stage in this process, and the present guidance offers no real help here.

Paragraph 5 is not specific enough – we would argue there may be a case for listing appropriate professions and/or regulatory bodies. For example, what would be the status of a referral (or delegation?) to a chiropractor? What would be the status of a referral to a non-medical organisation such as the Citizens Advice Bureau?

In our view paragraph 7 is overly prescriptive and unworkable for the referring doctor – if followed in its entirety in a standard GP consultation it would leave little time for actual patient care. 7d in particular could be quite onerous – the conscientious doctor will have to show referral forms to the patient and get consent forms signed every time. And, logically, why should the same standard not apply to all communications about the patient (e.g the reply to the referring doctor).
Also in relation to paragraph 7d, what should a doctor do if the patient refuses disclosure of information where the treatment is urgent? If the guidance is going to be this prescriptive, it needs to discuss this kind of complexity. We would suggest instead that a less prescriptive text is used, perhaps:-

"when making referrals or delegating care, you must pass on sufficient relevant information of the patient’s condition, past history, investigations, medications, allergies and where appropriate social history. Where possible the reasons for referral or delegation should be discussed and agreed with the patient together with the reasons for the referral or delegation. Where information of a sensitive nature is to be passed to a third party as part of the referral or delegation, patient consent should usually be sought."

**Ending your professional relationship with a patient**

2 Are there any other examples when it might become necessary to end a professional relationship with a patient?

There are probably many other examples possible. One suggestion is a circumstance where a patient has intruded into the personal/family life of the doctor (for example stalking them or a family member). We would also argue that there should be a distinction made between episodes where a relationship must end immediately (most obviously violent incidents) and those less serious incidents where a practice gives notice of intent to remove a patient from their list, or gives written warning that they will be removed if an incident happens again. Some guidance on these kinds of procedures, perhaps even going so far as suggesting appropriate wording for warning letters, might be useful.

Contrary to paragraph 6, it is already the case that patients are sometimes discharged as a result of resource implications – for example where a patient is co-paying for a treatment such as counselling and cannot afford to maintain the co-payments. We would agree with the principle of the statement, but would be concerned that it will set many doctors on a direct collision course with the healthcare providers who employ them. Failure to discuss these implications is not helpful to the doctors who face them.

It is right that a complaint in itself does not justify ending the relationship with a patient. However, it should be noted that complaints are a major source of doctor stress, ill health and sometimes even suicide. It is arguable that, where a complaint has had a significant
personal impact, and a doctor is concerned that they may no longer be able to deliver the required high standard of care, it may be preferable that he or she be permitted to terminate the relationship.

3 Is this new guidance helpful?

We agree with the principle of paragraph 11, but are concerned that the language is somewhat rooted in past models of care – nowadays the practice may be wherever the clinician is - in the supermarket or gym, for example. Some reflection of this modern reality would be useful.

5 Is the guidance clear?

Paragraph 5 – some clarity on how it is to be determined that ‘it is no longer in the patient’s interest to continue’ would be useful. What if the doctor feels it is not in the patient’s interest, but the patient disagrees? Perhaps the guidance should include recommendations around mediation for these circumstances.

6 Do you have any other comments on Ending your professional relationship with a patient?

Paragraph 6 – it should also be noted here that it is not appropriate to end a professional relationship with a patient for the purpose of initiating a personal or sexual relationship.

Financial and commercial arrangements and conflicts of interests

1 Is it helpful to have all these issues grouped together in the guidance?

Though there are obvious links between these issues, we would suggest the guidance might usefully separate them out further. Given current changes in the English NHS, commissioning warrants a more extensive sub-section. We would also note that conflicts of interest are not always financial – they may be and often are professional or personal. Examples of professional conflicts of interest include when a doctor cares for members of the same family, or where they care for another healthcare professional – in this instance they have a duty not only to the professional/patient in front of them, but also to that professional’s patients. The guidance needs to find a place for discussion of these other kinds of conflict of interest.

2 Is there anything else we could usefully say that would apply across the UK?
It is understood that, for doctors in England, commissioning now has different implications to elsewhere in the UK - but there’s no reason why more thorough discussion of the implications should not be covered in this guidance. Commissioning is so fraught with conflicts of interest that this is one area where doctors involved will appreciate absolutely clear guidance, and the current section is not adequate. We would suggest something like the following:-

- Membership, directorship, part or whole ownership of any organisation, including third sector, that might stand to gain from any commissioning decision now or in the future must be declared in every relevant verbal or electronic discussion that is pertinent to clinical commissioning.

- All partnerships, no matter how small must be declared by all GPs in all clinical commissioning discussion on the basis that they and their practices are members of a clinical commissioning group.

- All doctors involved in discussions, as well as formal procurement decision processes must declare any and all potential conflict of interest by them, their families, partners or associates.

- It will be for the CCG, with the agreement of commissioning partners, to determine if a potential conflict of interest might prejudice a procurement process in the full knowledge of the potential for legal challenge.

- The presumption is that all known commercial interests, no matter how small, must be made clear and unambiguous at all time during all discussions that impact on clinical commissioning or clinical behaviour.

Beyond this, we would argue for an overall statement that commissioning of services must do no harm – that is, commissioning decisions may be fair, transparent and comply with the law but still be inappropriate and contrary to the best interests of patients. This guidance, and the GMC in general, can do a useful service by reiterating that this is not acceptable.

5. Is the guidance clear?

In our view there should be direct discussion of the quality premium to be paid to GP commissioners in England – this is a direct incentive to GPs to save money for the commissioning group, and will undoubtedly affect how doctors behave. The GMC can have a major role in providing guidance on how to respond to this, to protect doctors and through them their patients.
It is also our view that paragraph 24 is naïve – it is likely to be entirely typical in the future that many organisations, not just insurance companies and solicitors, will offer financial incentives according to the number of customers/patients referred. Doctors need more guidance and protection for how to operate in these circumstances.

7 Do you have any other comments on Financial and commercial arrangements and conflicts of interest?

This section in particular doesn’t do enough to acknowledge the changed reality for doctors working in England, and the full extent of potential conflicts of interest in the reformed NHS. Doctors now have competing interests in:-

- The patient in front of them or in the waiting room.
- The wider population.
- The commissioning organisation (especially in the case of GPs) and;
- The employer (particularly foundation trusts operating as commercial organisations).

Doctors within private providers may have entirely different regulatory or contractual requirements – many providers do not permit whistle-blowing, which will put doctors in direct conflict with Good Medical Practice; or they may force doctors to follow particular care pathways, predominately because of financial arrangements – what does a doctor do if they disagree?

Paragraph 15 – should there not be discussion here of organisations such as Circle, where the clinicians are also shareholders and thus have a financial stake in all referral decisions? As elsewhere, the principles stated are correct, but insufficiently nuanced for the new circumstances of the NHS in England. Doctors, and their patients, need more protection.

Maintaining boundaries

Intimate examinations and chaperones

3 Is the guidance clear?
Paragraph 9 should be expanded to note that consent should be obtained significantly prior to the anaesthetic – possibly at the outpatient appointment – since patients awaiting operations should be considered vulnerable.

The guidance here is both too prescriptive and not specific enough. For example, having detailed the circumstance at paragraph 15 where a doctor prefers to have a chaperone present but the patient refuses, it doesn’t cover what the doctor should do if the examination is urgent and another clinician is not available for referral. The risk, as elsewhere, is that conscientious doctors may easily find themselves falling foul of Good Medical Practice.

Similarly, at paragraph 16, the requirement to note in the patient records every time a chaperone has been offered is one that many doctors are likely to fall foul of. As in the section on delegation and referral above, this guidance risks increasing the amount of information recording that doctors are required to undertake, at the likely expense of actual patient care.

5 **Do you have any other comments on Intimate examinations and chaperones?**

The guidance might usefully highlight the need for a doctor to be aware of cultural norms for specific patients, and to act within those norms wherever possible.

**Maintaining a professional boundary between you and your patient**

9 **Is the guidance clear?**

Yes, though additional points in the section on current patients (p23) might include that doctors should avoid:-

- Becoming emotionally dependent on patients;
- Using patients to gratify their own needs;
- Spending inordinate amounts of time with specific patients.

More generally, the emphasis on 'sexual or improper emotional' relationships with patients obscures what must be far more common – friendship relationships, which also create boundary issues for doctors. Some discussion of this might be helpful.

**Personal beliefs and medical practice**
6 Do you have any other comments on Personal beliefs and medical practice?

(GMP)Paragraph 52: Perhaps this would be better to say, ‘you must be willing to explain to patients if you have a conscientious objection if asked’.

(GMP)Paragraph 54 – it is arguable that expressing personal beliefs can easily and often exploit vulnerability, and should be avoided in most circumstances. The critical issue here is that a doctor’s views should not impact adversely on the patient’s care.

Paragraph 7: Arguably this does not address the real complexity of these kinds of issues. For example, a doctor may have a conscientious objection to termination of pregnancy under certain circumstances, but not others – the objection only becoming clear through conversation with the patient and understanding of a specific situation. This can’t be dealt with in a leaflet.

Paragraph 12: Arguably this underplays the importance that discussing a patient’s beliefs may have in the consultation. The art of medicine is in negotiating this complexity in a way that at the end of the consultation true communication has taken place and the patient has been enabled to make an informed decision. Occasionally this will go wrong and the doctor will miscalculate the situation, and a complaint may ensue. It would be sad to see the GMC instructing clinicians to steer clear of this important area of health care, which can improve concordance and health outcomes.

Paragraph 13: Arguably this is inconsistent with paragraph 52 in the main Good Medical Practice document, which requires doctors to be up-front about their personal beliefs.

Doctors’ use of social media

5 Do you have any other comments on Doctors’ use of social media?

We are not convinced that the GMC has or demonstrates sufficient understanding of the full implications of the use of social media, and in these circumstances it is very dangerous to be laying ground rules. It may be better, at this stage, when these implications are still being worked out, to leave the guidance as the same as for any other form of communication – with injunctions around not breaching confidentiality etc,
as per paragraphs 71 & 73 of Good Medical Practice. The RCGP is developing guidance on social media, and will be willing to discuss this further with the GMC.

Paragraph 12 – it is implausible to suggest that doctors operate different private and professional personae, and can switch between them on social media. It is of course right that doctors must not give specific and direct advice in a public setting – but in communicating through a medium such as Twitter it is impossible for the doctor to know who is picking up every message; patient confidentiality must not be breached, but beyond this there ought to be some acceptance of the more blurred boundaries of social media.

Paragraph 17 – It is hard to envisage the circumstance in which it would be appropriate for a doctor, writing in a professional capacity, to communicate anonymously. ‘Usually’ should be replaced by ‘always’ here.

Paragraph 19 – again, in our view this shows a lack of understanding of social media, and the lack of clarity in this section is likely to result in legal disputes. When exactly is a doctor supposed to become aware that a colleague’s online conduct is inappropriate? What of the instance where a doctor ‘re-tweets’ another person’s comments – where does the liability lie? It is not appropriate to make it a professional obligation on doctors to police their colleagues on social media sites.

**Taking up and ending appointments**

1 Is the guidance at paragraph 4 clear?

We would argue that this is not clear, since it only refers the reader to BMA guidance for junior doctors – when clearly the rules need to apply to doctors at all stages of their careers.

2 Is there anything else we should include in this piece of guidance?

It might be useful to include here the responsibilities of doctors as employers, particularly towards locums – in keeping with GMP paragraph 47.
7. We gratefully acknowledge the contributions of members of the College Council, members of our Patient Partnership Group and experts on medical ethics and commissioning in formulating this response.

Yours sincerely

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Honorary Secretary of Council