

# Good medical practice: public consultation on core guidance on professional standards

## RCGP Response, July 2022

### Context

This response was drafted by the RCGP professional standards team after consultation with a wide range of key internal committees, stakeholders, and Council members. The comments and suggestions below take into account the variety of scopes of work, career stages, and workplaces of our membership. We've provided a summary of our overall feedback on the proposed updates to Good medical practice, as well as comments on specific paragraphs and sections. Where we largely agree, or do not have specific comments on a particular paragraph, we have not included it below.

We have used bold when quoting from the proposed updated guidance and italics when suggesting alternative wording.

### Summary

Overall, we were pleased to see the GMC updating their core guidance on professional standards and the clarity that many of the updates provided on key areas of Good medical practice (GMP). We welcome the aim for the guidance to **'play a part in helping to create workplace cultures which are inclusive, fair, civil and compassionate for all'**. We were also grateful for the opportunity to comment on the proposed updates and look forward to continuing to work closely with the GMC to ensure professional standards are clear, relevant, and support medical professionals to maintain high standards of care.

While we welcome these stated aims, we feel strongly that clarity is needed about the purpose of the document as a whole. The consultation survey states that **'GMP is embedded in all our regulatory functions, informing...decision making throughout our fitness to practise procedures'** and there is a section in the guidance explaining how GMP is used when considering fitness to practise concerns. There are also 78 of the 88 paragraphs detailing standards which state what a medical professional **'must'** do.

However, GMP also states that it **'is not a set of rules'** and that the GMC expects **'medical professionals to use their judgement to apply the professional standards in practice'**. Considering the explanation that GMP informs decision making in fitness to practise procedures, the overall purpose of the document needs much greater clarity. If it is not a set of rules and medical professionals should use their judgement when applying the standards, then the inclusion of so many references to what they **'must'** do

is misleading. This is further confused by the survey document which repeatedly explains additions and amendments to what a medical professional **'should'** do which is then detailed as a **'must'** do in the proposed updated version.

The inclusion of the following in the section on how medical professionals are expected to use the standards is also likely to cause anxiety about how much weight GMP holds: **'If medical professionals apply the guidance, and act in good faith and in the interests of patients, they will be in a good position to explain and justify their decisions and actions if a concern is raised about their practice'**.

One of the questions the survey asks is **'what acts as a barrier or a positive influence on how our standards are put into practice'**. We feel this potential confusion about the purpose of the document and how much weight the standards carry in fitness to practise procedures is a significant barrier for medical professionals attempting to put the standards into practice. We would, therefore, welcome greater clarity on how these standards are used in fitness to practise procedures. If GMP is used in this intended way then keeping the standards **'high-level'** will not work for every paragraph as many become too generalised to be clearly applicable. We have also included comments in the sections below on specific paragraphs which state what you **'must'** do and would benefit from greater clarity in order for medical professionals to ensure they are following those standards, or which aren't achievable in a number of contexts.

A further **'barrier or positive influence on how our standards are put into practice'** is the increasing workload pressures facing general practitioners and other medical professionals. GMP cannot be read in isolation, ignoring the huge strain medical professionals are under which is out of their control. With so many of the paragraphs in this document detailing what medical professionals **'must'** do, we would recommend including an acknowledgement that they can only do so much within the current system and the resources available to them.

The survey also asks for **'views on what additional areas the explanatory guidance should cover'**. We recognise the need for medical professionals to **'consider the wider impact of healthcare activity on population health (e.g. antibiotic resistance) and on the environment (e.g. harm from single use plastics)**, and consider it logical to introduce the term **'global health'** to paragraph 18 (now 65). However, medical professionals may need support to understand what **'global health'** considerations mean in the context of their own practice. Additionally, actions to support sustainability are likely to be implemented at organisational or system level, where the individual medical professional may have limited control. Finally, it is important that consistency is achieved between Good medical practice and relevant medical curricula in relation to sustainability.

Nevertheless, the GMC may want to give consideration to the inclusion of a fifth domain on sustainability, as long as it is clear to medical professionals how this new domain relates to their own practice. The UK Health Alliance on Climate Change has provided an example of a fifth domain on sustainability as part of their submitted response to the GMC, which could provide a starting point for further work in this area.

## Equality, Diversity and Inclusion

We welcome the stated aims of this review to **'identify ways in which the guidance, or its interpretation in practice, may have adverse impacts on people who share protected characteristics'** and to **'identify ways the guidance might help to advance equality, diversity and inclusion'**. While we agree with the proposed changes to emphasise the responsibility of medical professionals to consider how their personal beliefs may affect colleagues and patients, and to treat patients as individuals, we feel the guidance could go further. We have suggested the inclusion of a new paragraph under domain four which we feel moves GMP from outlining the responsibility of medical professionals to avoid discrimination in their own actions, to a more active role of reducing the incidents of discrimination in the profession as a whole, albeit with appropriate support and training from organisations and health services (see Domain 4 comments).

We have also included a suggested amendment to paragraph 56 to highlight the importance of medical professionals being conscious of the specific communities in which they work and the impact that may have on their work.

## Feedback on specific sections of the proposed updated GMP

### The purpose of good medical practice (pages 2-3)

As stated above, we feel that the purpose of GMP needs further clarification. The wording as it is currently proposed appears to contradict itself.

In particular, we propose reviewing the section on **'How we expect medical professionals to use the professional standards'** and removing the reference to GMP not being a **'set of rules'**. Instead, more information should be provided on how medical professionals are expected to exercise judgement and to what degree the standards in GMP are used in fitness to practise procedures.

### Behaviours of medical professionals registered with the GMC

We welcome the clarity of this section in providing a clear and comprehensive list of the behaviours expected of all medical professionals. However, these statements are not always achievable in every situation. For example, the expectation to **'act promptly if I think the safety, dignity or comfort of patients or colleagues are being compromised'**: handling a situation like this often requires skill, leadership, time and diplomacy and acting promptly may not always be the best course of action. This may also concern junior doctors or less senior medical professionals in a team who, for example, may fear the consequences of acting if a more senior colleague is deemed to have compromised the dignity of a patient. Similarly, a patient's comfort could be deemed to have been compromised by something out of a medical professional's control. For example, if there are no hospital beds available. In this situation there may be little a medical professional can do to **'act promptly'**.

Putting patients first is a defining feature of medical professionalism and it is something that GPs, and indeed other medical professionals, strive to do. However, there is also a potential conflict between the safety and comfort of a patient and that of a colleague. If prioritising the comfort of a patient, for example, requires a medical professional skipping their break or extending their shift then their own comfort and, subsequently, the care they are able to provide to their patients, may be compromised. We suggest this behaviour is separated to consider patients and colleagues separately. This potential conflict also applies to the first listed behaviour: **'make the care of patients my first concern'**. Medical professionals will always strive to care for their patients to the best of their abilities, but if that is to the detriment of their personal lives – for example, if a family member becomes seriously ill – as it is currently worded, this behaviour implies that a medical professional should prioritise their patients over their family. This potentially compromises the medical professional's ability to provide acceptable care to their patients. These concerns could be addressed with the addition of *'professional'* to read *'make the care of patients my first professional concern'*. This wouldn't stop medical professionals putting their patients first but would allow for the rare exception where they may risk compromising their ability to provide acceptable care, for example if personal circumstances proved too stressful.

The behaviour **'work within my competence and keep my knowledge and skills up to date'** could be clarified. In the current wording it is very broad. For example, a medical professional could spend a period of their career with a very narrow scope of practice where much of their existing knowledge and skills are not required. As medical professionals are expected to consider these standards when preparing for their medical appraisal for revalidation, we suggest including the word *'relevant'* in this behaviour to clarify what is expected.

Medical professionals will always strive to uphold the highest standards of behaviours in all of their professional interactions. To avoid unrealistic expectations and potentially demoralising the profession, we suggest adding a caveat to this section to acknowledge that there will always be exceptions. For example, it could read: *'As a medical professional I will strive to'* before the bullet point list.

## **Domain 1: Working with colleagues**

We welcome the focus on interpersonal relationships outlined in paragraphs 1-7 and the recognition that personal relationships with colleagues are as important as professional relationships. The effective working of any healthcare system must rely on good communication between medical professionals. We would suggest including a further paragraph or statement about mediation and repairing relationships with colleagues when there has been conflict.

**4. When you are on duty you must be readily accessible to colleagues seeking information, advice, or support**

This may not always be possible or, if a medical professional is working on behalf of a patient at the time, the right thing to do. We suggest changing '**must**' to '*should*' for this paragraph.

**6. You must not abuse, discriminate against, bully, exploit, or harass anyone, or condone such behaviour by others. This applies to all interactions, including on social media and networking sites.**

And

**7. You should take action, or support others to take action, if you witness or are made aware of bullying, harassment, or unfair discrimination.**

Bullying in the workplace is never acceptable, and we welcome the inclusion of this important issue in GMP. It is, therefore, crucial that these two paragraphs are worded clearly and intended to support those being bullied or witnessing bullying to act. We feel the current wording of both paragraphs is too vague and open to interpretation.

We suggest greater clarity about the level of responsibility a medical professional may hold in reference to not condoning '**such behaviour by others**' and taking '**action...if you witness or are made aware of bullying...**'. As mentioned previously, these paragraphs could be of concern to more junior medical professionals who may fear repercussions if challenging bullying behaviour from a more senior colleague. We also suggest clarification about what may be included in '**networking sites**' and the level of responsibility a medical professional has to ensure they aren't seen to '**condone such behaviour by others**'. Many medical professionals are, for example, included in Whatsapp and Facebook groups with a large number of colleagues. To what degree may they be expected to call out potential discriminatory behaviour in that context? Similarly, would a medical professional be expected to call out bad behaviour from anyone on social media sites like Twitter, where there are millions of users and posts every day? The level of responsibility a medical professional has in these settings needs to be clarified.

**8. You must contribute to continuity and coordination of patient care. This is particularly important when patient care is shared between teams, or when patients are transferred between care providers. You must:**

- a. Share all relevant information with colleagues involved in patient care (within and outside teams), including when you go off duty, when you delegate care, or refer patients to other health or social care providers.

**b. check (where practical) that a named clinician or team has taken over responsibility when your role in a patient's care has ended. This may be particularly important for patients with impaired capacity or who are vulnerable for other reasons.**

We welcome the stated importance of sharing relevant information with colleagues when delegating or referring patients. This is especially important when the care or treatment of a patient is transferred between primary and secondary care. However, we would suggest that the wording of this paragraph reflects the fact that many medical professionals will have limited influence on the wider systems and structures within which they work. It may not always be possible to contribute to the coordination of patient care if a medical professional has no defined connection to other teams involved in caring for that patient.

**9. You must not assume that someone else will pass on the information needed for patient care.**

This is a welcome addition to GMP and is particularly important when transferring patient care between primary and secondary care teams.

**10. If you identify problems arising from poor communication or unclear responsibilities within or between teams, you must act promptly to deal with them.**

This is not always possible or appropriate. For example, if a locum GP reliant on work in a particular practice or area identifies a problem in the communication or responsibilities of a practice, they may feel reluctant or lacking all the relevant information to **'act promptly to deal with them'**. We suggest changing this paragraph from a **'must'** to a *'should'*.

**11. When you delegate tasks or duties, you must be satisfied that the person you are delegating to has the appropriate qualifications, skills and experience to carry them out, and that they will be appropriately supervised and supported if necessary.**

This is not feasible in primary care as written. For example, a primary care medical professional is unlikely to know the specific person they are delegating to when referring a patient for care elsewhere. Instead, we suggest this paragraph is reworded to focus on the importance of ensuring the person or team you are delegating to has agreed to take on the care of that patient or task. We would also suggest that this paragraph is edited to make it explicit that a medical professional is responsible for acting on the results of any tasks or tests they instigate.

**15. You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:**

- a. contributing to discussions and decisions about improving the quality of services and outcomes
- b. taking part in regular reviews and audits of your work and that of your team, responding constructively to the outcomes, taking steps to address any problems, and carrying out further training where necessary
- c. regularly reflecting on your standards of practice and the care you provide
- d. reviewing patient feedback where it is available.

It would require, potentially, a lot of work for medical professionals to fully comply with this paragraph. We suggest rewording 'This includes' to 'This could include' so that the subsequent items are viewed as examples for how to 'take part in systems of quality assurance and quality improvement' rather than a prescriptive list.

**16. You must be familiar with, and use, the clinical governance and risk management structures and processes in any organisations that you work for or to which you are contracted.**

While we welcome this paragraph highlighting the importance of clinical governance and risk management processes, this may not be reasonably achievable for all medical professionals. For example, a peripatetic locum GP may find it difficult to fully familiarise themselves with all of these stated processes and systems at the start of a single shift with a practice. Instead, the responsibility for ensuring medical professionals are properly informed of all relevant governance and risk management processes should be with the organisation in which they are working. We suggest changing this paragraph from a 'must' to a 'should' and shifting the responsibility from the medical professional to the employer. For example: *'You should engage with all relevant induction processes in any organisation that you work for or to which you are contracted. This includes the clinical governance and risk management structures and processes.'*

**18. Patient safety may be affected if there is not enough cover. So you must take up any post or shift you have accepted, and work your contractual notice period before leaving a job, unless the employer has reasonable time to make other arrangements or your personal circumstances prevent this.**

We welcome the amendment to this paragraph to include shifts. This is especially important in general practice where practices often have to rely on locums to help manage increasing workload pressures. However, there are circumstances when it may not be possible for medical professionals to fulfil the requirement of this paragraph. To

prevent medical professionals feeling anxious about meeting this requirement, we suggest either changing **'must'** to *'should'* or expanding on the **'personal circumstances'** which may **'prevent this'**. For example, if there are clear medical, or family reasons that a medical professional may be unable to continue in a post.

Paragraphs 15 to 18 are all affected by the current shortage of medical professionals throughout primary and secondary care. Without addressing this (beyond **'Patient safety may be affected if there is not enough cover'**), the document is missing the most important factor in patient safety. The GMC cannot resolve this, but GMP could include a further paragraph suggesting medical professionals who become aware of a significant shortage of staff affecting patient safety report the shortage to a suitable colleague or team.

**19. You must act promptly if you think that patient safety, dignity, or comfort is, or may be, seriously compromised.**

**a. If a patient is not receiving basic care to meet their needs, you must act (where possible) or immediately tell someone who is in a position to act straight away.**

**b. Where the risk concerns inadequate premises, equipment or other resources, policies or systems you should, if possible, put the matter right. You must raise your concern in line with our guidance and your workplace policy. You should also make a record of the steps you have taken.**

**c. If you have concerns that a colleague may not be fit to practise and may be putting patients at risk, you must ask for advice from a colleague, your defence body, or us. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken.**

This paragraph is similarly prescriptive and not always possible for medical professionals to carry out. We have provided examples of this in our comments on the **'Behaviours'** section. Point b also includes a mixture of what a medical professional **'must'** and *'should'* do. We would suggest rewording this point to clarify what is required and what is suggested.

We would also suggest including a further point here about whistleblowing. There are some excellent resources produced by the GMC on whistleblowing and this could be an opportunity to alleviate some of the concerns medical professionals have about raising concerns about or with more senior colleagues.

## **Domain 2: Working with patients**

**22. You must treat patients with kindness, courtesy and respect.**



We agree with the principle of this paragraph but, as this is a **'must'**, we would like to see clarification of the definition of **'kindness'** in a medical context. This could mean different things to different medical professionals and may not always be appropriate, for example if a patient is demonstrating dangerous or abusive behaviour to a medical professional or colleague. We suggest this paragraph is either changed from a **'must'** to a **'should'** or includes *'where appropriate'* to acknowledge that it may not always be possible or best practice.

**24. If you have a conscientious objection to a particular procedure, you must tell the patient about their right to see another healthcare professional and make sure they have enough information to exercise that right.**

**In providing this information you must not imply or express disapproval of the patients' way of life, choices, or beliefs. If it is not practical for the patient to arrange to see another practitioner, you must make sure that arrangements are made for another suitably qualified colleague to take over your role.**

We welcome the removal of the requirement for medical professionals to explain to a patient if they have a conscientious objection to a particular treatment. However, we would suggest rewording the second part of this paragraph or removing the word **'imply'**. As it is currently worded, the use of the word **'imply'** is too vague and allows for the possibility of this paragraph enabling patients or colleagues with malicious intentions to use this against a medical professional because of their beliefs or way of life.

**28. You must try to find out what matters to patients so that you can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action.**

We welcome this addition, in particular the reference to finding out **'what matters to patients'** when exploring potential options. However, we suggest changing this paragraph from a **'must'** to a **'should'**. Time pressures and workload issues may compromise the ability of a medical professional, particularly in primary care, to spend the time needed with every patient to **'find out what matters'** to every patient. This is an ideal, but not always achievable.

**29. You must take all reasonable steps to meet patients' language and communication needs.**

While this is certainly the ideal, it is not always possible in primary care to access appropriate translation services when needed. There is also a need for greater access to appropriate technology to support those patients with communication needs. For example, those in the deaf community who may require access to alternative services in

primary care where telephone triage is often the first service used. We would suggest changing this paragraph from a **'must'** to a *'should'*.

**30. You must be considerate to those close to the patient and be sensitive and responsive in giving them information and support.**

There is a potential conflict between this paragraph and paragraph 25: **'You must treat information about patients as confidential, including after a patient has died'**. We suggest expanding on this paragraph to finish: *'within the limits of patient confidentiality and consent'*.

**32. You must start from the presumption that all patients have capacity to make decisions about their treatment and care. You must be aware of your duties under relevant legislation and have regard to relevant codes of practice. You should follow our guidance Decision making and consent, wherever you practise in the UK.**

We welcome this amended paragraph and it's move towards working in partnership with patients.

**33. All patients have the right to be involved in decisions about their treatment and care. You must work in partnership with them, and share with them the information they will need to make decisions about their care, including:**

- a. their condition, its likely progression and the options for treatment
- b. clear, accurate and up-to-date information, based on the best available evidence, about the potential benefits and risks of harm of available options, including the option to take no action
- c. the progress of their care, and your role and responsibilities in the team
- d. who is responsible for each aspect of patient care, and how information is shared within teams and among those who will be providing their care
- e. any other information patients need if they are asked to be involved in teaching or research
- f. any potential or actual conflicts of interest that may influence the treatment and care options you share with patients.

As with paragraph 32, this amended paragraph is a welcome move towards working in partnership with patients. However, it is too prescriptive in its current form. There are a number of examples, in primary and secondary care, where it may not be possible to

follow each of the points listed. If a patient is unconscious, for example, or if the time available to treat and care for a patient is limited. We therefore suggest this paragraph is either changed from a **'must'** to a **'should'** or is edited to read *'You must, where appropriate, work in partnership with them and share with them the information they will need to make decision about their care...'*.

**36. You must provide a good standard of practice and care. If you assess, diagnose, or treat patients, you must work in partnership with patients to:**

- a. assess their condition(s) adequately, taking account of their history including:**
  - i. symptoms**
  - ii. psychological, spiritual, social, economic and cultural factors**
  - iii. their views, needs and values**
- b. where necessary, examine the patient**
- c. provide (or arrange) prompt and suitable advice, investigations or treatment where appropriate**
- d. refer a patient to another suitably qualified practitioner when this serves the patients' needs.**

This paragraph, in particular point (c), is not always possible under the current pressures facing the NHS. We would also welcome greater clarity of how **'economic'** factors should be considered. For example, does this refer to whether a patient could afford to pay for aspects of their healthcare outside of the NHS, whether they may be able to afford prescriptions (in England) or whether, in primary care, a home visit may be more appropriate for a patient not able to pay for their travel to see a medical professional?

**37. In providing clinical care you must:**

- a. propose, provide or prescribe drugs or treatment (including repeat prescriptions) only when you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patient's needs**
- b. propose, provide or prescribe effective treatments based on the best available evidence**
- c. take all possible steps to alleviate pain and distress whether or not a cure may be possible**
- d. seek advice from a supervising clinician, or consult colleagues, where appropriate**
- e. respect the patient's right to seek a second opinion**

**f. check that the care or treatment you propose, provide or prescribe for each patient is compatible with any other treatments the patient is receiving, including (where possible) self-prescribed over-the-counter medications**

**g. consider the overall burden of the patient's drugs and treatments and whether the benefits outweigh any risks of harm**

**h. wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship.**

We welcome the addition of point (g). It allows doctors to move away from overtreatment and excess medication.

It is also important to note that a patient may put themselves at risk by delaying or choosing not to receive treatment, and the medical professional may not have knowledge of the situation.

We would also suggest that point (a) may not always be possible, particularly in primary care. For example, the current pressures facing general practice mean that patients are less likely to see their named GP at every visit and may have repeat prescriptions signed by other GPs who do not know the full history of the patient.

**38. Whether you provide clinical care in a face-to-face setting, or through remote consultations via telephone, video-link, or online services, you must provide safe and effective care. Where possible, you should agree with the patient which mode of consultation is most suitable to their individual needs and circumstances. If you can't provide safe care through the mode of consultation you are using, you should offer an alternative if possible or signpost to other services.**

This is a welcome addition and even more important for primary care in the current landscape. However, it is often not practical to agree with patients which mode of consultation is most suitable. Medical professionals may be limited in what they can offer to patients and the alternatives they are able to signpost to. Medical professionals also need to consider the wider practice or setting and patient population in which they work when deciding on the best mode of consultation. For example, in primary care it may be more efficient to carry out all initial consultations either over the phone or via video-link and escalate to a face-to-face appointment after that if needed. This paragraph may, therefore, give patients unrealistic expectations about the options currently available to them.

**40. You must support patients in caring for themselves and empower them to improve and maintain their health. This may include:**

**a. helping them to access information and support to manage their health successfully**

**b. supporting them to make decisions that improve their health and wellbeing.**

This reworded paragraph is a valuable step towards enabling doctors to hand responsibility back to patients for their own care, educating, and working in partnership with patients.

**44. You must not unreasonably deny a patient access to treatment or care that meets their needs. If a patient poses a risk to your own health and safety, or that of other patients or staff, you should take all available steps to minimise the risk before providing treatment or making alternative arrangements for treatment.**

This is a welcome amendment and removes the inappropriate onus on doctors to treat all patients, irrespective of the risk they may pose.

**45. You must be open and honest with patients if things go wrong. If a patient under your care has suffered harm or distress, you should:**

**a. put matters right (if possible)**

**b. offer an apology (apologising does not mean that you are admitting legal liability for what has happened)**

**c. explain fully and promptly what has happened and the likely short-term and long-term effects.**

We welcome the addition of point (b). It further encourages the medical professional and patient to work in partnership and empowers doctors to acknowledge errors without fear of liability.

**47. You should only end a professional relationship with a patient when the breakdown of trust between you both means you cannot provide good clinical care to the patient.**

We suggest this paragraph is amended to include acknowledgement that a medical professional may be able to continue to provide good clinical care but that, in doing so, they are compromising their own mental or physical health. For example, if a patient is threatening or bullying a medical professional, it may not impact on the care they receive but could negatively affect the medical professional. There may also be other legitimate reasons to end a professional relationship with a patient. For example, if a medical professional in primary care is treating their patient via remote consultations and that patient moves abroad, it may be appropriate to end the professional relationship. When

a patient has a long-term professional relationship with a medical professional, as is common in primary care, conflicts of interest may arise which were not previously a factor. The GP contract lists clear situations where it is appropriate to remove a patient from the practice list and this is wider than just a **'breakdown of trust'**.

This paragraph should, therefore, be expanded to acknowledge the wider range of legitimate reasons a medical professional should end a professional relationship with a patient.

### **Domain 3: Professional capabilities**

**48. You must be competent in all aspects of your work, including, where applicable, formal leadership roles, management, research, and teaching.**

We welcome the addition of **'formal leadership roles'**. However, we suggest a slight amendment to the wording to clarify the intent of the paragraph: *'You must be competent in all aspects of your work which require a licence to practise. This includes, for example, leadership, management, research, and teaching roles'*.

**56. You must reflect regularly on your standards of practice and the care you provide. You should consider how your attitudes, values, beliefs, perceptions, and personal biases (which may be unconscious) may influence your interactions with others, which could in turn affect outcomes for patients and colleagues.**

As this is a new paragraph, it would be helpful to illustrate how a medical professional may consider these **'attitudes, values, beliefs, perceptions, and personal biases'** and the potential impact they may have in their work. This could be done either by expanding on the wording as it is or producing supplementary explanatory guidance. This should also be reflected in the GMC's Supporting information for appraisal and revalidation document to ensure it reaches all medical professionals.

We would also suggest expanding this paragraph to include consideration of the communities that medical professionals work with. This is particularly important in primary care where the community in which a medical professional works may have a significant impact on their work. For example, some communities near military bases may have a higher proportion of veterans, and inner-city practices may work with a large homeless population. To acknowledge the importance of considering these factors, we would suggest altering the end of this paragraph to read: *"...which could in turn affect outcomes for patients, colleagues, and the communities in which you work"*.

**57. You must seek feedback and respond constructively to it, using it to improve your practice and performance.**

This paragraph needs greater clarity as it is listed as a 'must'. We suggest expanding on how often medical professionals must seek feedback, and how to measure and record a response to it. If this is in reference to the feedback required for medical appraisal for revalidation, then we recommend including reference to that.

**59. You should be prepared to contribute to mentoring, teaching, training and professional support of students and other colleagues. This is especially important for individuals new to practice in the UK, returning from a period away from practice, or who do not have easy access to sources of support.**

We welcome the addition of examples of groups who may otherwise lack fair access to development opportunities. However, there is a need to recognise that this requires time and that medical professionals should be allocated time to devote to professional support.

**62. You share the responsibility for shaping the culture of your working and learning environment whether or not you have a formal leadership role. You should develop leadership skills appropriate to your role, and work with others to make healthcare environments more supportive, inclusive and fair.**

This is a welcome addition, recognising that all medical professionals undertake leadership roles in various forms throughout their careers. However, this is aspirational and high-level, making it potentially difficult to meet, particularly for part-time or locum medical professionals.

**65. You must provide the best service possible within the resources available, taking account of your responsibilities to patients, the wider population and global health.**

As described earlier, we welcome the increased emphasis on sustainability in Good medical practice, albeit with recognition that some actions can only be implemented at organisational or system level. As previously suggested, although it would seem logical to introduce the term '**global health**' to this paragraph, medical professionals may need support to understand what '**global health**' considerations mean in the context of their own practice.

We recommend the GMC, produces guidance, or references acceptable guidance produced by other relevant organisations, on sustainability in healthcare, outlining how individual medical professionals, as well as organisations and the wider healthcare systems can work towards reducing their carbon footprint and practise in an environmentally, socially, and financially sustainable way.

As explained previously, the GMC may want to consider the suggestion of a fifth domain on sustainability. An example has been provided by the UK Health Alliance on Climate Change, which could provide a starting point for further work in this area.

**69. You should be registered with a general practitioner outside your family and your workplace.**

We welcome the addition of ‘**and your workplace**’ to this paragraph. However, this is not always possible or practical: for example, if a medical professional practises in primary care in a remote part of the UK.

**Domain 4: Maintaining trust**

Within this domain we would include a further paragraph about the responsibility of medical professionals to act as active bystanders – identifying when a colleague or patient is behaving in an inappropriate way and acting on it. This would send a strong message about the importance of EDI in the medical profession and demonstrate the GMC’s commitment to fairness and equality.

It is not always appropriate for medical professionals to immediately act when they are witness to discrimination, and indeed some, particularly more junior members of a team, may not feel able to take action themselves. However, including a paragraph on the importance of being an active bystander would empower medical professionals and help them understand their role in this area.

We would, therefore, suggest inclusion of the following: *“If you witness, or are informed of, behaviour from a patient or another medical professional which is discriminatory, you should act as an active bystander and either report the incident or take direct action to support the patient or colleague being discriminated against. Organisations and health services should support their staff with training and resources to empower them to act as active bystanders when required”*.

**72. You must not demonstrate uninvited or unwelcome behaviour that can be reasonably interpreted as sexual and that offends, embarrasses, humiliates, intimidates, or otherwise harms an individual or group.**



We welcome the acknowledgement that sexual harassment is never acceptable. However, as it is currently worded, this paragraph is too vague and allows for the possibility of malicious complaints and litigation, particularly the inclusion of 'embarrasses'. It also only references 'behaviours' as being potentially sexual, which appears to miss a lot of potentially offensive or sexual actions. We suggest simplifying this paragraph to say: *'You must not demonstrate uninvited or unwelcome behaviour or actions that can be reasonably interpreted as sexual'*.

**74. When communicating publicly as a medical professional you must:**

- a. be honest and trustworthy
- b. make clear the limits of your knowledge
- c. make reasonable checks to make sure any information you give is not misleading
- d. declare any conflicts of interest
- e. maintain patient confidentiality

**This applies to all forms of written, spoken and digital communication.**

Point (c) may benefit from clarification here. For example, in primary care, a practice may benefit financially from encouraging patients to attend the practice for their cervical screening or vaccinations. Under the current wording, medical professionals may feel confused about whether they would need to declare a conflict of interest if promoting these services.

We would also suggest expanding on what is meant by '**communicating publicly as a medical professional**'. For example, if a medical professional is working with a non-medical organisation where their role is acknowledged but they are not undertaking work that would require a licence to practise, would this still apply?

**78. You must make clear the limits of your competence and knowledge when giving evidence or acting as a witness.**

This paragraph could be expanded to include reference to writing fitness letters for patients. For example, fit for marathons, or fit for work.

**84. When designing, organising or carrying out research, you must put the interests of participants first. You must act with honesty and integrity and follow national research governance guidelines and our guidance.**

We suggest strengthening this paragraph to address the increasing pressures to include patients in any trial that may be relevant to them without them having a clear understanding of the real implications. The paragraph could include: *'When inviting a patient to be included in a trial, you must be clear that there is no certainty that it will benefit the patient, or that other treatments or no treatment could be as appropriate.'*

This paragraph could also be strengthened by including reference to the importance of high-quality research to reduce uncertainties in medicine.