Association of Anaesthetists

Response to the GMC's consultation on the proposed changes to the Good Medical Practice guidance

July 2022

The Association of Anaesthetists is made up of over 10,000 anaesthetists in the UK, Republic of Ireland and internationally. We seek to promote patient care and safety. Along with colleagues in intensive care, anaesthesia is the largest specialty in the NHS.

Below is our response to the consultation on the proposed changes to the Good Medical Practice. We look forward to ongoing engagement with the GMC on ensuring the guidance is fit-for-purpose and upholds the highest standards of patient safety.

General comments

We agree with the need to continue having one set of core professional guidance for all those who are regulated by the GMC.

It should be noted, however, that medical professionals and others the GMC regulate have different roles and relationships with the patient throughout the care pathway. This is not just a stylistic and application concern, because depending on where a doctor is on that pathway, the relevance of some of the paragraphs within GMP will differ.

On a substantive point, we are concerned with the use of the term 'medical professionals' to include physician associates and anaesthesia associates along with those with on the medical register. This term is potentially confusing for the public, and will not provide them with a clear indication of what training those who are caring for them have undertaken, and what each person's roles and responsibilities are in the care pathway. We feel this could result in unintended consequences if patients are led to believe all those caring for them are doctors.

In the terminology used there must be a clear distinction between those with and without a medical qualification.

Tackling discrimination and promoting fairness and inclusion

Paragraph 6

We agree with the inclusion of the sentiment of this new duty around abuse, discrimination, bullying, exploitation, and harassment.

The Association has campaigned for many years on stopping bullying and promoting civility among colleagues through our #knockitout campaign. Not condoning such behaviour by others is key, and allowing tacit acceptance of poor behaviour by not calling it out is also critical. But we fear that without appropriate training for doctors to understand how to call out unacceptable behaviour, some may get unfairly penalised.

Similarly, whilst we agree that this duty should extend to digital interactions, it must be made clear that individuals can not be held responsible for comments made by others on their social media posts,

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nor be necessarily responsible for who is in, or what others post in, online groups which individuals also are a part of.

Paragraph 7

As mentioned above, taking action and supporting others who have faced bullying is imperative. We repeat our call for training to be provided to enable this duty to operate effectively.

There are scenarios which could result in medical professionals not feeling able to take action because, for example, they are also being bullied by the same person. Bullying is often multifaceted and is not a straightforward offender-victim-bystander relationship. Taking action could be many things, and others may have different expectations or desires to what action others should take. We call for clarification on these matters.

Paragraph 56

We agree that bias, unconscious or otherwise, should be minimised as far as possible with interactions with others. However, this necessitates comprehensive training on behavioural changes on inclusion and diversity, along with incorporating training on all of the protected characteristics in medical professional's medical training.

Paragraph 59

We agree with the addition of mentoring and professional support. The Association has been running a mentoring scheme for our members, which is run on a clinician-to-clinician basis. It has been a great success and has helped many members. We are happy to share learning and experience with the GMC to ensure this duty is impactful.

Paragraph 72

While a welcome addition to the guidance, the new duty (not to demonstrate uninvited or unwelcome behaviour that can be reasonably interpreted as sexual) is, we believe, currently worded in too vague a manner. It may inadvertently capture behaviour that all those involved would consider acceptable.

Theme two: working in partnership with patients

<u>Decision making and consent</u>

These conversations are difficult, and require sensitivity, openness and other personal skills. We believe that training is needed on how to carry out these specific conversations. It is also unclear in this new duty how clinicians are to say 'no' when a patient's requests cannot be met due to resources, medical limitations, or necessity. This exposes potential ethical issues, particularly around pain relief. This links to a later concern around the use of the term kindness, versus an understanding of respect.

Paragraph 34

Ensuring that patients understand the information they've been given is critical and we support this. However, as with a later concern around delegation of tasks – and in particular to our members, anaesthesia associates – this could be difficult to achieve in reality if an individual does not have contact with the patient. It's important that anaesthetists still have direct patient contact.

Paragraph 32

Being aware of legal requirements around mental health is a welcome duty, but training, once again, is required universally.

Patients' needs, rights and expectations

Paragraph 22

We have significant concerns with the term 'kindness'. We believe the term is too subjective. Clinicians often need to deliver difficult news, but it must always be clear. Being kind is generally an important quality, but not at the expense of patient care, and may get in the way of patients making informed choices.

We believe that the term 'respect' better covers this need to treat patients according to their needs and experiences. Any further words, in our view, are superfluous. We note that this term may have different cultural interpretations, but with the correct training in place, this could be mitigated.

Paragraph 27

Similar to the above, we believe the word 'openly' is too subjective, open to interpretation, and can be misunderstood. 'Honest', is sufficient to cover the need the duty.

Paragraph 29

We welcome the need to ensure communication needs are met with patients. We need more methods of communication readily available, such as easy reads, sign languages, Braille, and other language. We believe that this responsibility should sit with the Trust/Health Board, rather than an individual clinician.

Theme three: Working effectively with colleagues

Paragraph 5

Compassionate behaviour is important, but hard to define. We believe 'empathetic' is a better descriptor for this duty.

Paragraph 45

The need to check that a professional has the appropriate skills, qualifications and experience before a task can be delegated to them – while clearly important for patient safety and care – may mean that tasks are not delegated appropriately. It is important to allow delegation to take place and for each individual to be subsequently responsible for their own actions.

Theme four: Leadership

Paragraph 20

We support this new duty and believe it is important that colleagues feel able to raise concerns and that the concerns are acted on appropriately. The Association's Trainee Committee has produced infographics on challenging unprofessional behaviour and being an active bystander which support this duty.

Domain three: Professional capabilities

Paragraph 65

While we agree that medical professionals must provide the best service possible within the resources available, we feel it is important to note that resources – as well as decisions around procurement – are outside of the control of the individual medical professional and they should not be held accountable for failings of others including their employer.

Domain four: maintaining trust

Paragraph 74

While we agree with the principle behind the new duty about communicating as a professional, (as stated in our comment on paragraph 6), it must be made clear that individuals can not be held responsible for comments made by others on their social media posts. Similarly, we are concerned about the repercussions this will have on posts made by doctors before their medical career.

Clarification around what "publicly" communicating entails is required. For example, does this include closed online groups, or locked social media profiles?

Following practice from other public sector roles, for example teachers, there is a precedent that personal profiles (opposed to quasi-professional profiles such as those often found on Twitter) are hidden, with identifiable information about their roles within the public sector removed. The GMC may wish to consider if this is an appropriate standard for medical professionals.

Concluding remarks

The Association of Anaesthetists hopes that our response is useful to the GMC.

We repeat that we look forward to continuing engagement with the GMC on the above points to ensure the guidance is the best it can possibly be.

Contact

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