

The role of the GMC in supporting doctors in a pressurised environment

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Working with doctors Working for patients

GMC: Overview and corporate strategy

To prevent harm and drive improvement in patient care by setting, upholding and raising standards for medical education and practice across the UK

We will use our insights on medical education and practise to **re-focus medical regulation on supporting doctors to protect patients**

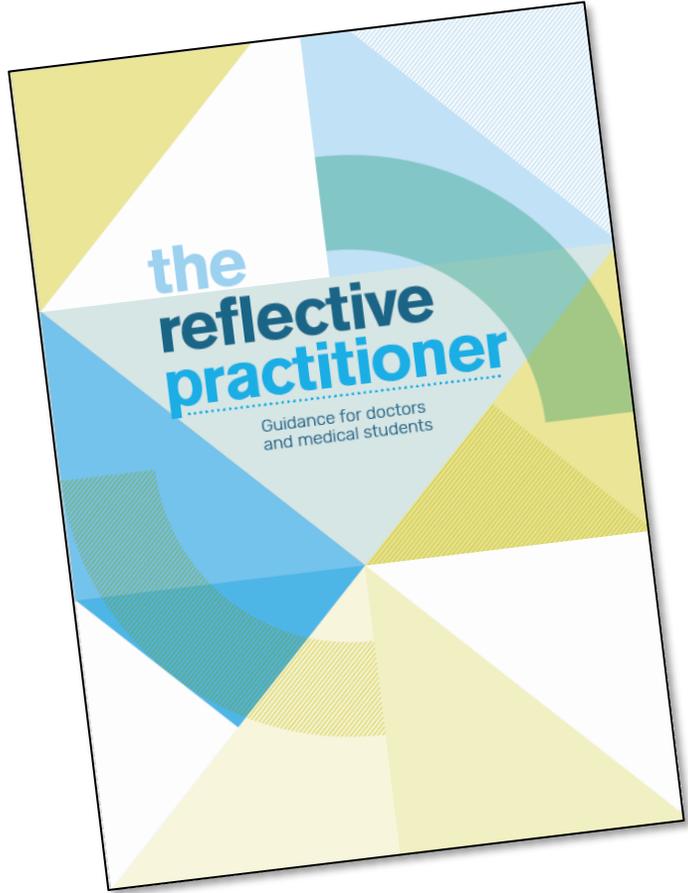
The screenshot shows the GMC website homepage. At the top, the title 'General Medical Council' is on the left, and search bars for 'Search the register' and 'GMC ONLINE' are on the right. A navigation bar below contains links for 'Registration and licensing', 'Ethical guidance', 'Education', 'Concerns', and 'About', along with a 'Search this site' bar. The main content area features a large image of a family (mother, father, and child) reading a book together. Below the image is the heading 'What we do' and a paragraph: 'We help protect patients and improve UK medical education and practice by supporting students, doctors, educators and healthcare providers.' A blue button labeled 'About the GMC' is positioned below the paragraph. At the bottom of the page, there are three columns of links: 'Check a doctor's registration status' with a 'Search the register' button; 'Working with doctors' with links for 'Becoming a doctor in the UK', 'Ethical guidance', and 'Revalidation'; and 'Working for patients' with links for 'Who we are and what we do', 'What you should expect from your doctor', and 'Raise a concern about your doctor'. An illustration of a hospital building and an ambulance is located at the bottom right of the page.

Supporting doctors in maintaining good practice

Strengthening collaboration with regulatory partners

Strengthening our relationship with the public and profession

Meeting the changing needs of UK health services

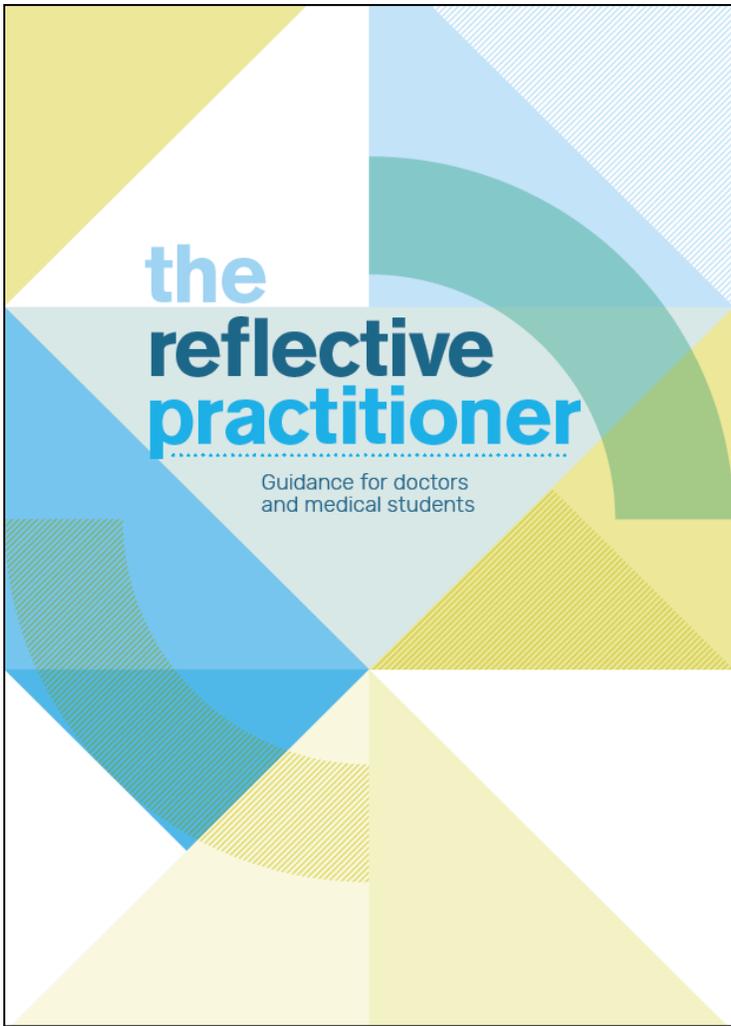


What does the GMC require?



- **22** You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:
 - **b** regularly reflecting on your standards of practice and the care you provide

The reflective practitioner guidance

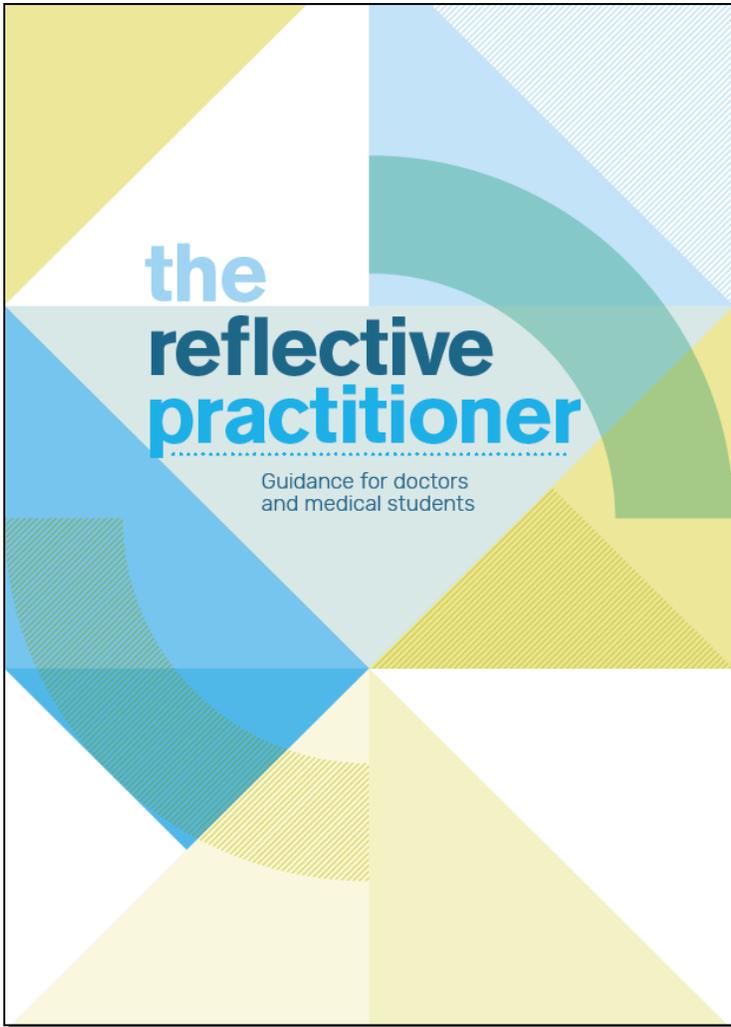


- Co-produced guidance by AoMRC, COPMeD, GMC and MSC
- Published 12 September 2018
- AoMRC/COPMeD toolkit – supports the guidance

www.aomrc.org.uk/reports-guidance/



Key messages



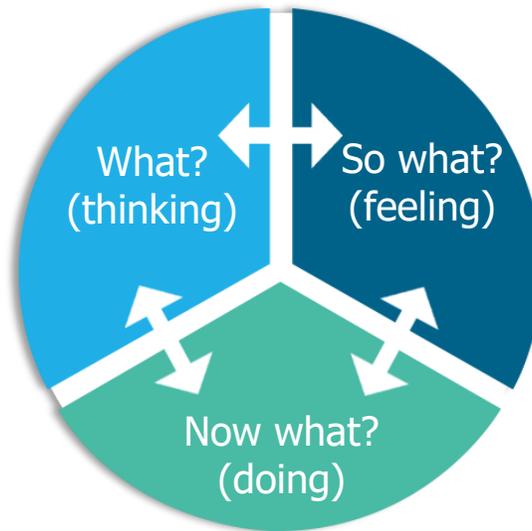
- Reflection is personal, there is no one way to reflect.
- Having time to reflect on both positive and negative experiences is important.
- Reflective notes should focus on learning or actions.
- Anonymise information as far as possible.
- Time and space should be given for individual and group reflection.

Disclosure – key points

- Reflective notes can currently be required by a court
- Don't record factual details in reflective discussions – should be recorded elsewhere
- Seek advice if in doubt about the content
- The GMC does not ask a doctor to provide their reflective notes in order to investigate a concern about them.

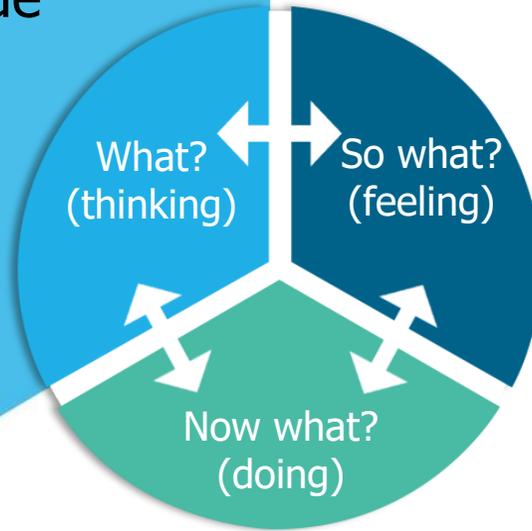


Framework for reflection

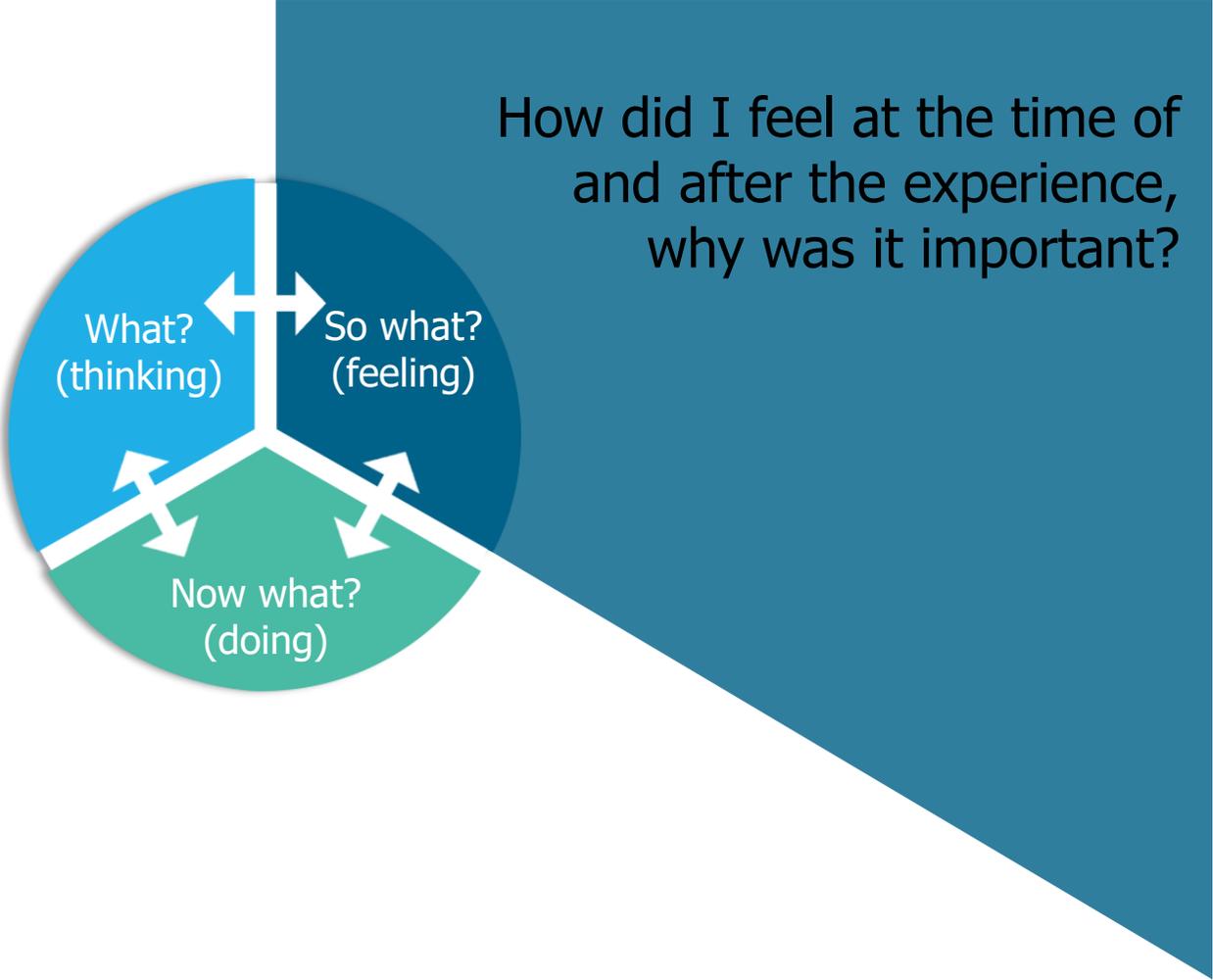


Thinking

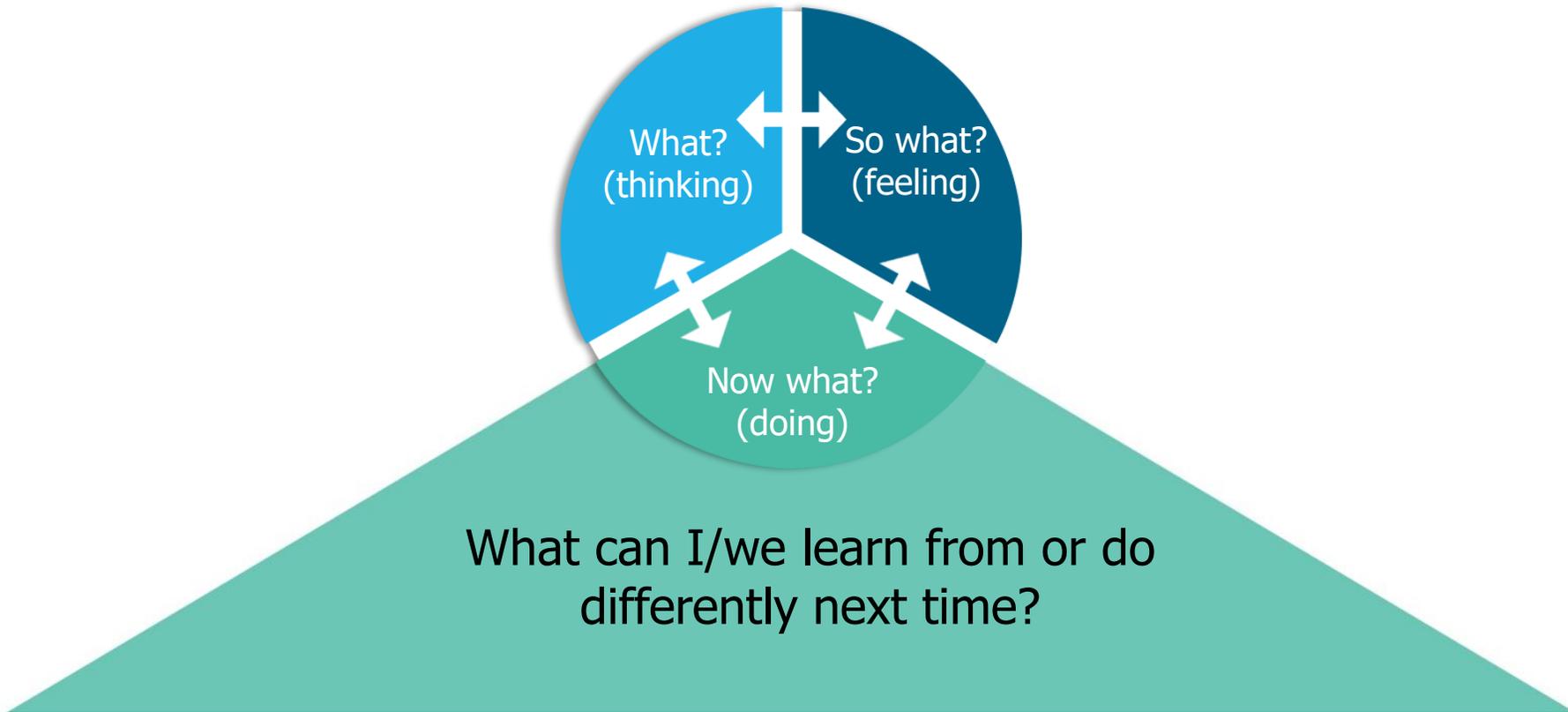
What was I thinking when I took the actions or made the decision that I did?

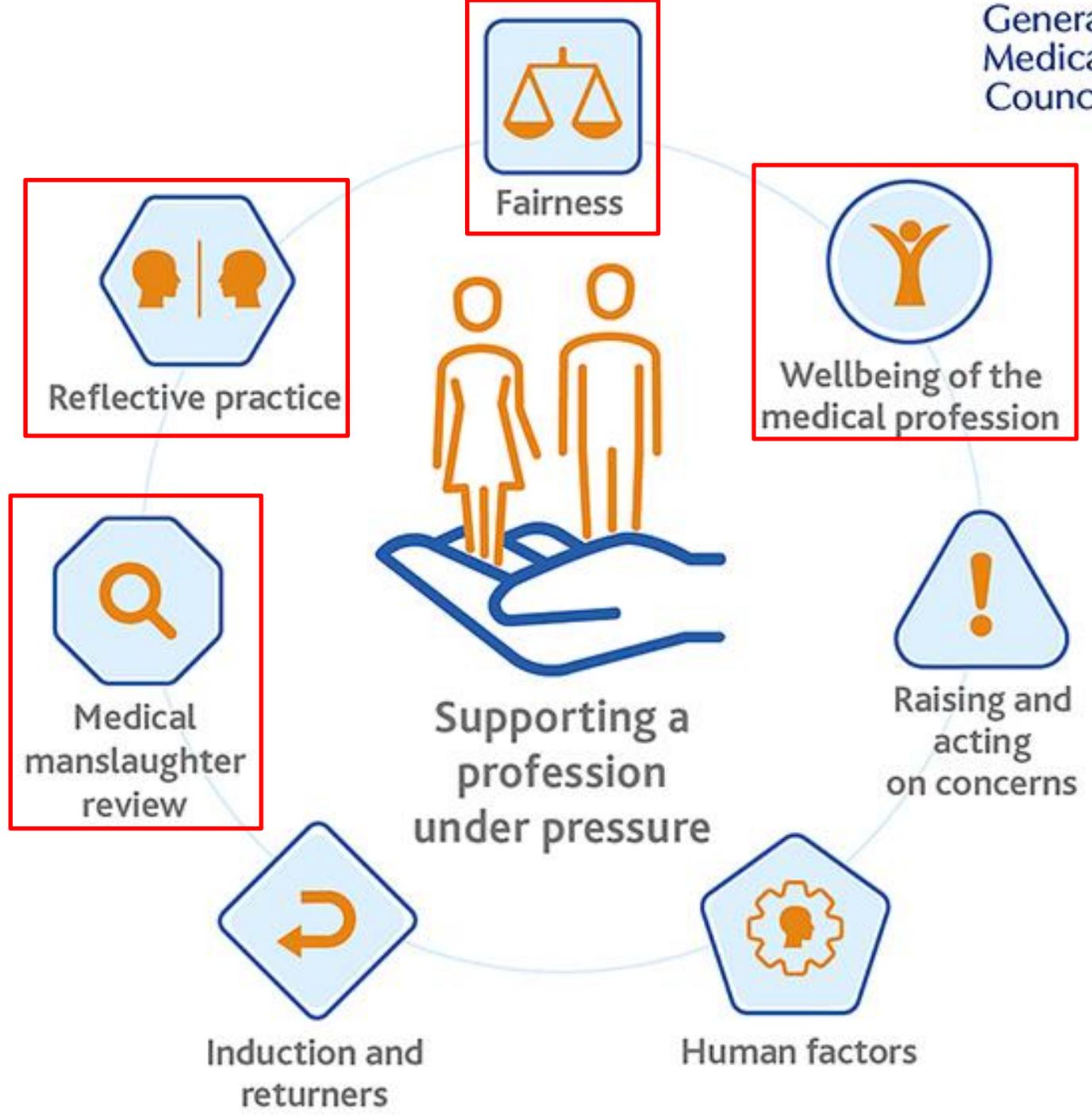
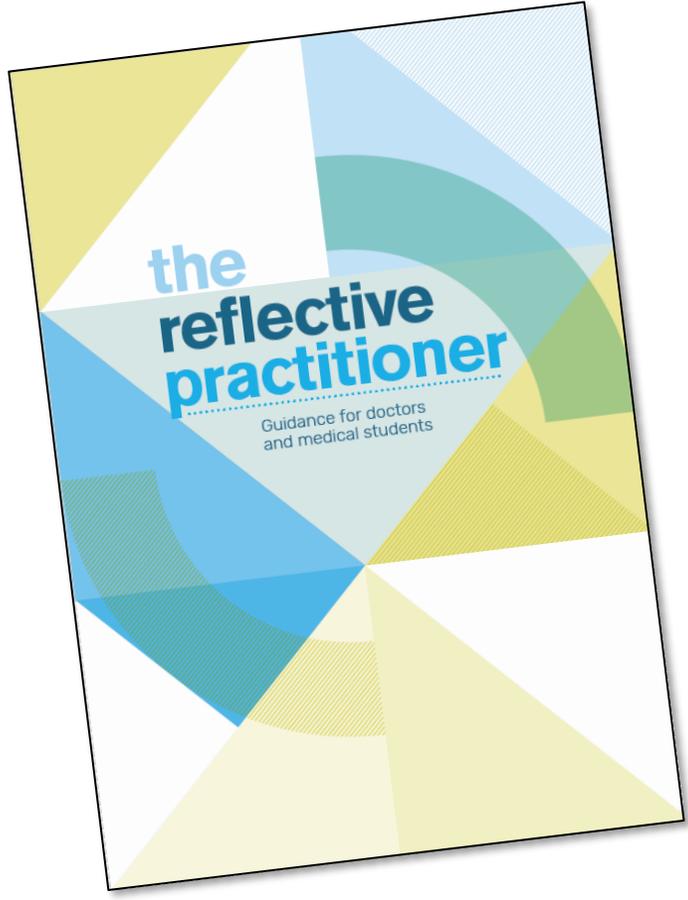


Feeling



Doing





2019: Three Independent Reviews



Independent review of gross negligence manslaughter and culpable homicide

June 2019
Working together for a just culture

FAIR TO REFER?



June 2019

Reducing disproportionality in fitness to practise concerns reported to the GMC

This independent research conducted by Dr. Doyin Atewologun & Roger Kline, with Margaret Ochieng, was commissioned by the General Medical Council to understand why some groups of doctors are referred to the GMC for fitness to practise concerns more, or less, than others by their employers or contractors and what can be done about it.

Caring for doctors Caring for patients

How to transform UK healthcare environments to support doctors and medical students to care for patients

Professor Michael West and Dame Denise Coia

Fair to Refer?

Why did we commission it?



BME Drs are nearly twice as likely to be referred by employers than white doctors

BME Drs referred by employers 10%
White Drs referred by employers 6%

International grads are two and a half times as likely to be referred by employers than UK grads

12% of IMGs c/w
5% of UK graduates

Fair to Refer?: What the research involved

- A rapid literature review and stakeholder engagement informed sample selection and identified themes to explore
- 12 trusts - representative by region and representative by Trust type across all 4 UK countries
- **Primary care-** interviews and focus groups were carried out with 41 doctors
- **Secondary care-** 15 case studies of organisations were undertaken; in each case study Drs of all levels of seniority & other relevant staff (e.g. HR directors) took part in interviews & focus groups
- Focus on identifying good practice to support the recommendations

Fair to Refer?

What did they find?



Factors identified which have led to a disparity in referrals:

a lack of consistent effective induction, feedback and support

working patterns that leave some doctors isolated and unable to access as many learning opportunities as others

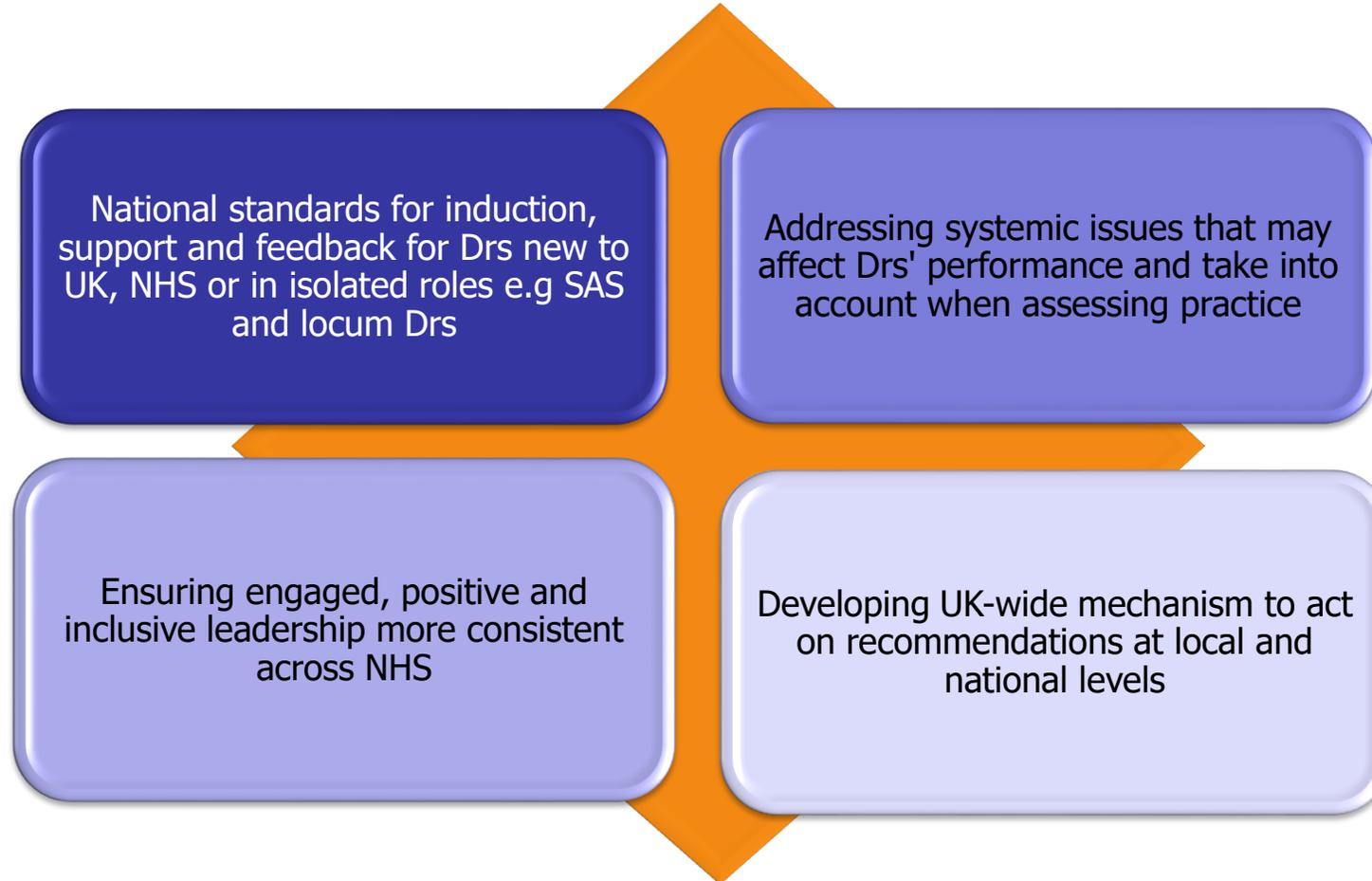
Divisive cultures - some doctors being treated as 'outsiders'

organisational cultures responding to things going wrong by trying to attribute blame rather than focusing on learning

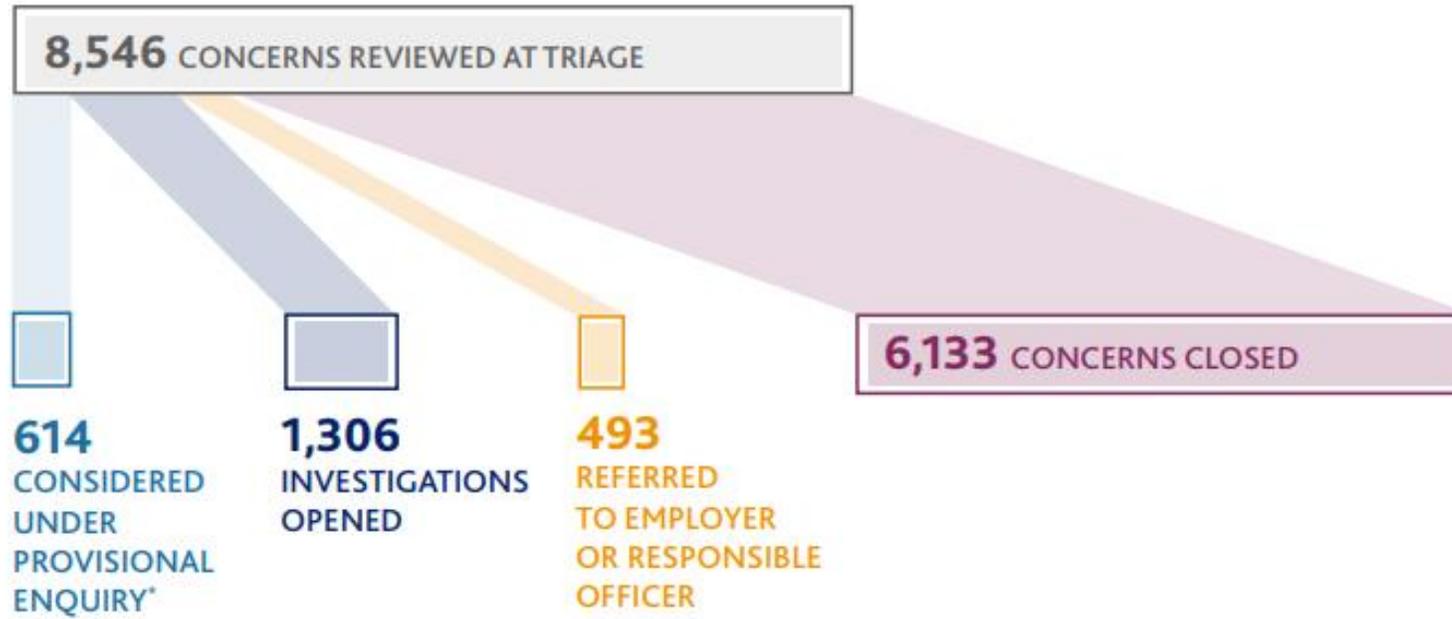
some leadership teams being remote and inaccessible

Fair to Refer?

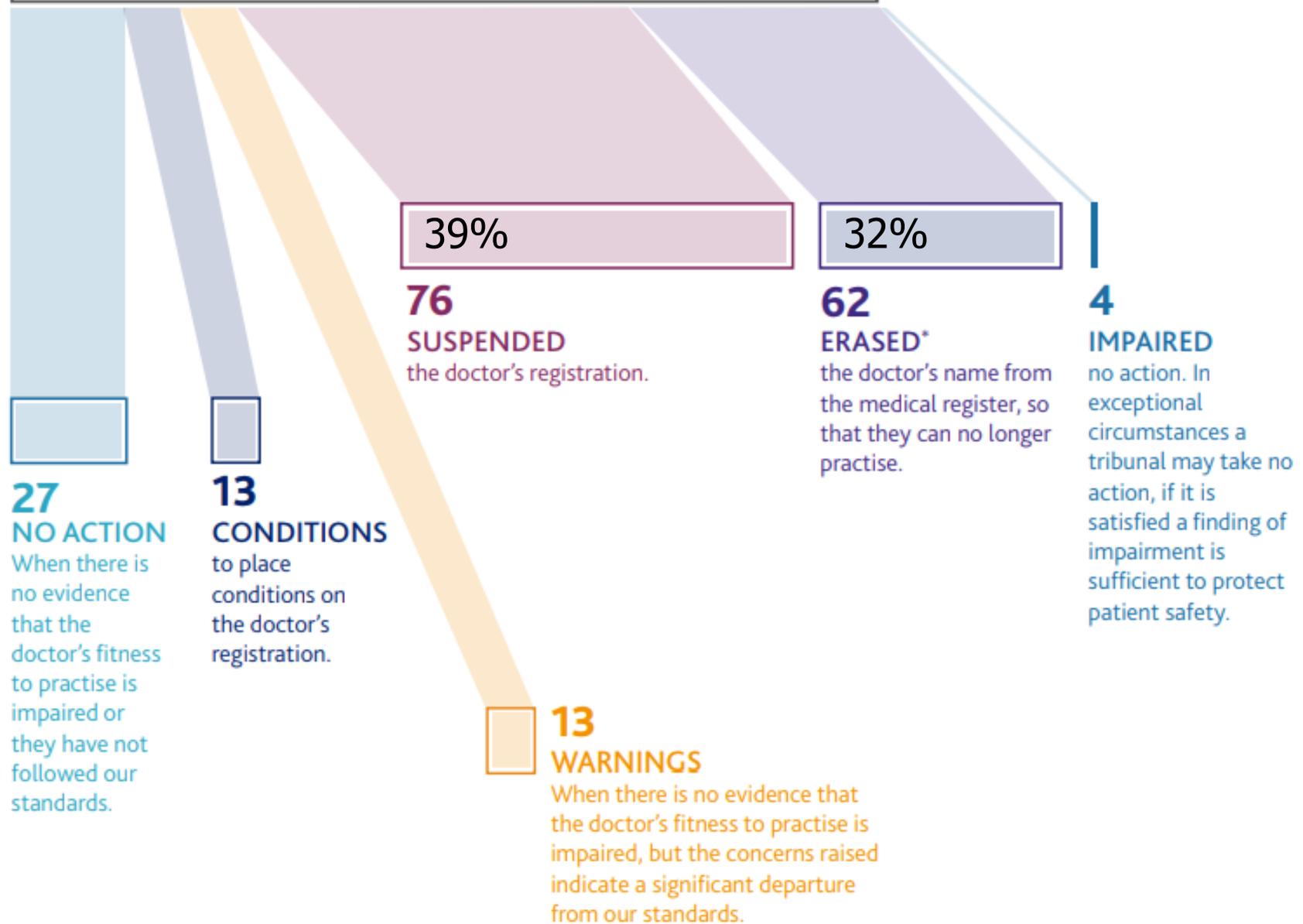
- Recommendations



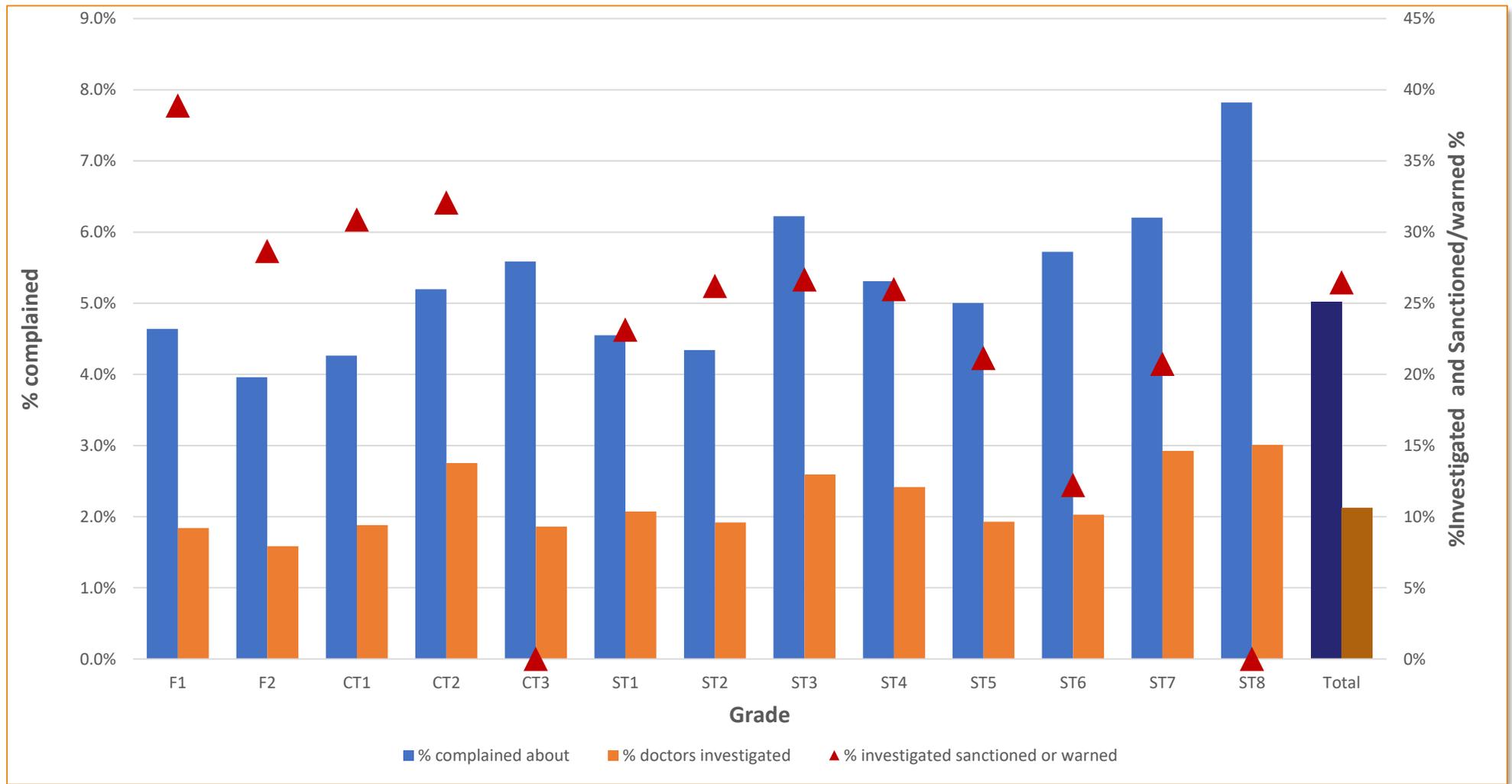
2017 Outcomes of triage



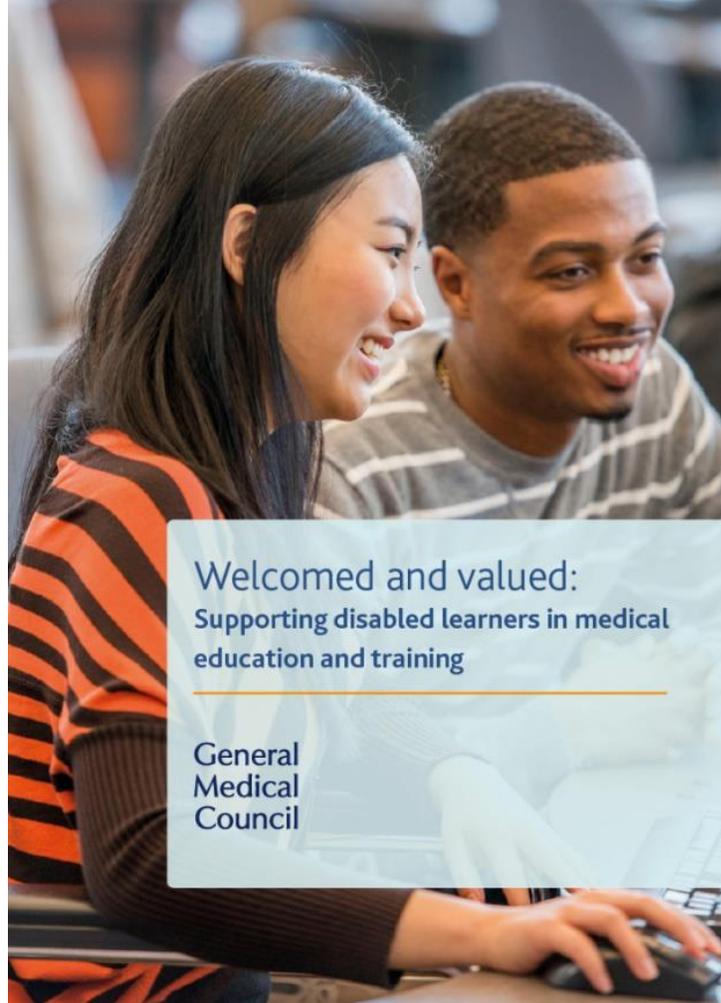
195 OUTCOMES



Trainees and FtP



Welcomed and valued: Advisory guidance for supporting disabled learners in medical education and training – May 2019



www.gmc-uk.org/ablemedics

Disabled doctors in training must be supported to participate in clinical practice and educational activities

As the professional regulator, we firmly believe disabled people should be welcomed to the profession and valued for their contribution to patient care

Welcomed and valued: Supporting resources

www.gmc-uk.org/ablemedics

Shared experiences	>
Able medics podcast	>
Welcomed and valued appendix	>
Gateways to the professions resources	>
Examples of reasonable adjustments	>
List of contacts	>
Related links	>

- Personal stories of disabled medics
- Podcast series with experiences of doctors and educators
- Additional advice, tools & frameworks to *Welcomed and valued* in appendix
- Examples of reasonable adjustments
- List of disability contacts for medical schools and HEE local teams / deaneries
- Links to disability-related organisations

Differential attainment




RESEARCH

Ethnicity and academic performance in UK trained doctors and medical students: systematic review and meta-analysis

Katherine Woolf, lecturer in medical education,¹ Henry W W Potts, senior lecturer in health informatics,² I C McManus, professor of psychology and medical education¹

¹Academic Centre for Medical Education, UCL Division of Medical Education, London N19 5LW, UK

²Centre for Health Informatics and Multiprofessional Education, UCL Division of Population Health, London N19 5LW

ABSTRACT

Objective To determine whether the ethnicity of UK trained doctors and medical students is related to their academic performance.

Design Systematic review and meta-analysis.

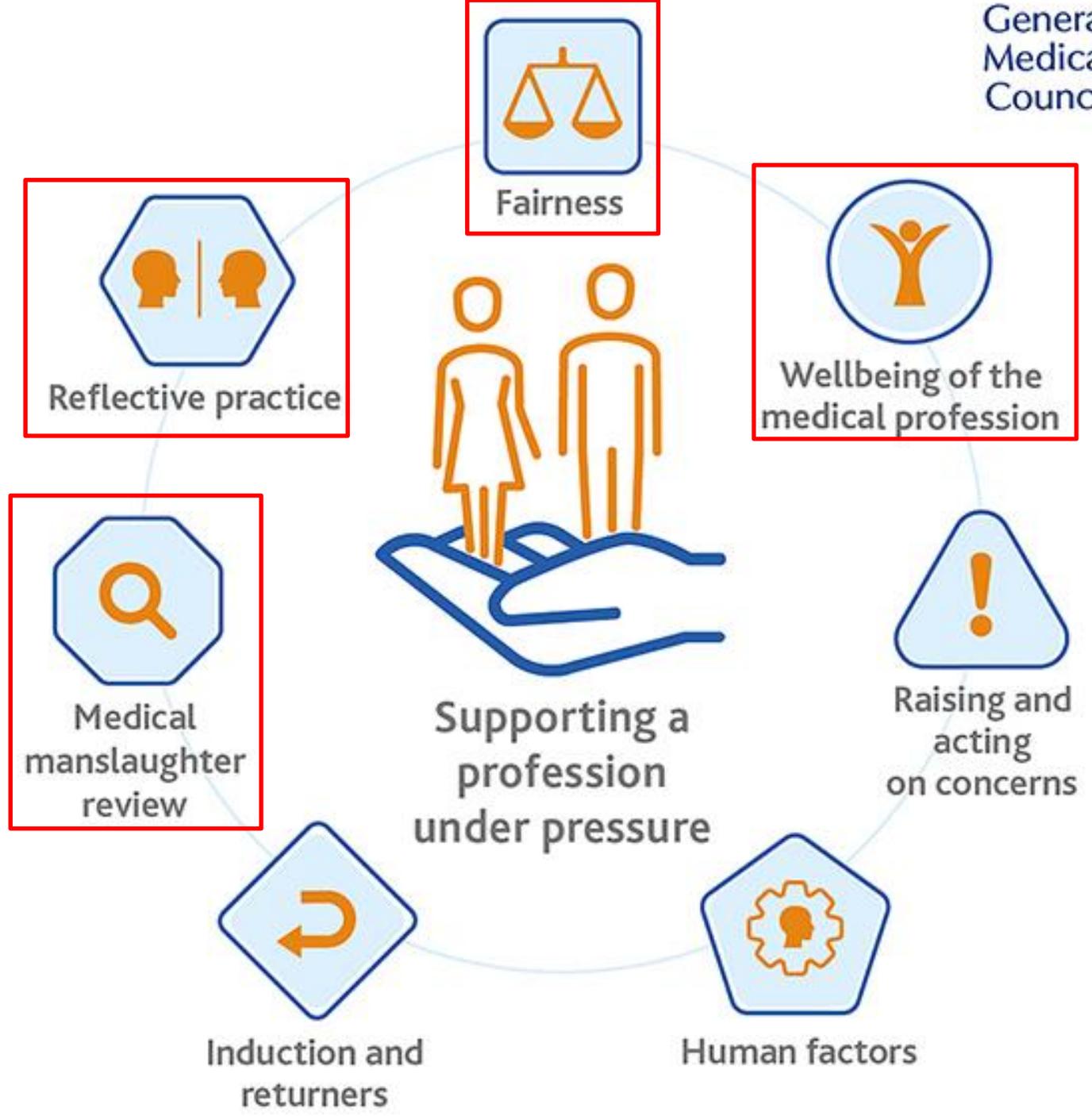
Setting Online databases PubMed, Cochrane and

INTRODUCTION

In 1995, a *BMJ* news article reported that all the students who failed clinical finals at the University of Manchester the previous year had been men with Asian names.¹ A systematic review of the predictors

Caring for doctors
Caring for patients

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Caring for doctors. Caring for patients

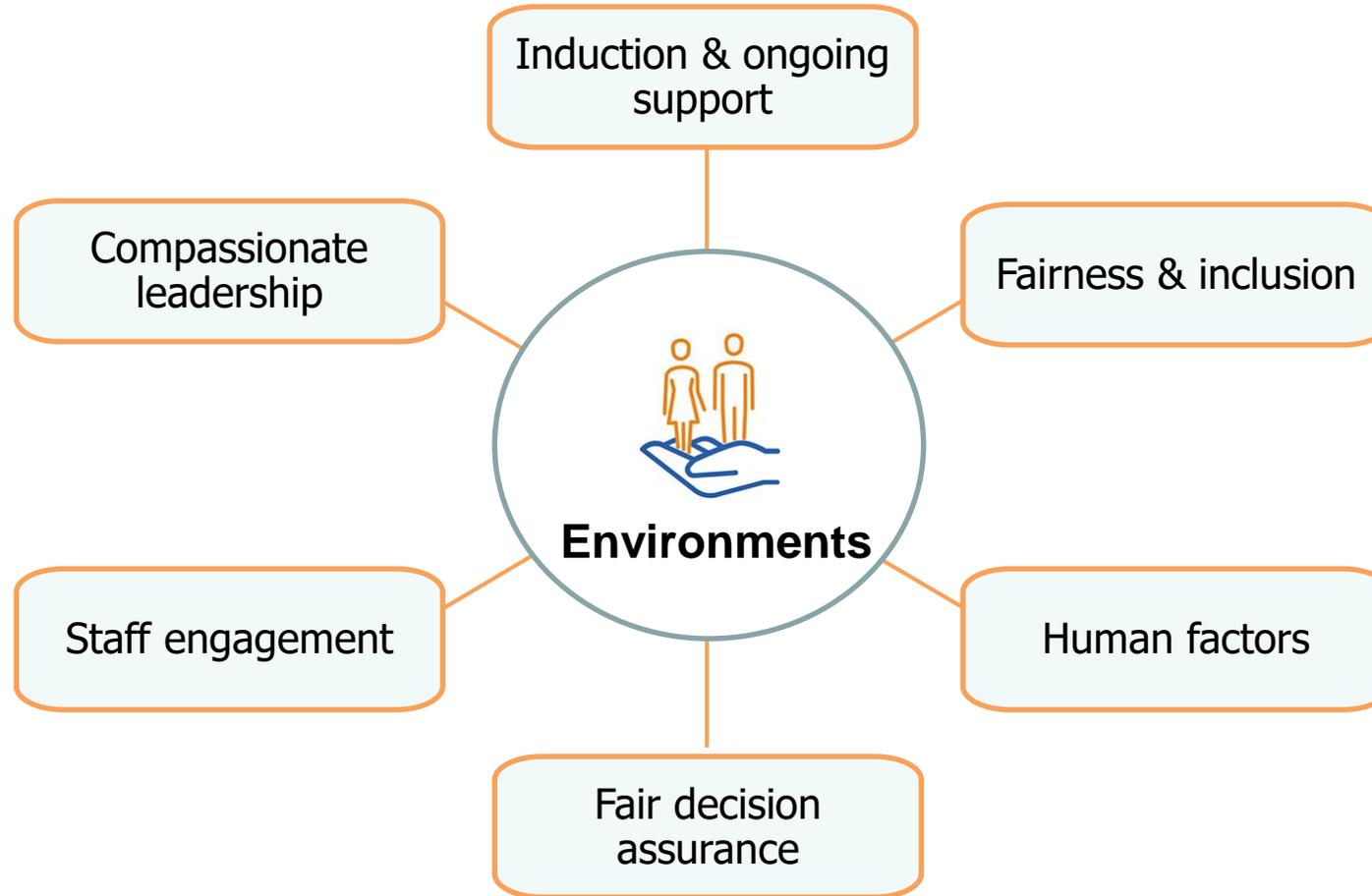


- **AUTONOMY/CONTROL** - the need to have control over our work lives, and to act consistently with our work and life values.
- **BELONGING** – the need to be connected to, cared for, and caring of others around us in the workplace and to feel valued, respected and supported.
- **COMPETENCE** - the need to experience effectiveness and deliver valued outcomes, such as high-quality care.

Our response: working with others

- Tailored four country approach
- Collaborative and active approach, building a coalition of the willing with a shared commitment to addressing the issues raised in the reviews
- Working together to design the implementation mechanisms to best address those issues – this will shape the substantive and most impactful response
- Working to align with four country NHS Plans
- Discussions with healthcare leads – February 2020

Common themes & challenges



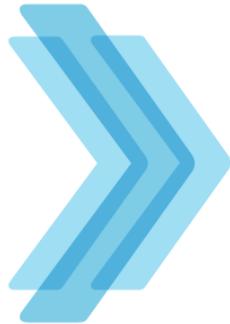
Caring to change

TheKingsFund>

BRIEFING

Caring to change

How compassionate leadership can stimulate innovation in health care



Authors
Michael West
Regina Eckert
Ben Collins
Rachna Chowla

May 2017

- Compassion – a core cultural value:
 - paying attention to the other and noticing their suffering – **attending**
 - understanding what is causing the other’s distress, by making an appraisal of the cause – **understanding**
 - having an empathic response, a felt relation with the other’s distress – **empathising**
 - taking intelligent (thoughtful and appropriate) action to help relieve the other’s suffering – **helping**

Culture

- From Latin (colere)
 - To tend the earth, to cultivate or nurture
- Cambridge English dictionary
 - the way of life especially the customs and beliefs of a particular group of people at a particular time
- Livescience.com
 - shared patterns of behaviors (sic) and interactions, cognitive constructs and understanding that are learned by socialization

Culture is determined by the shared values and behaviours of a group of people, an organisation or a society.

Time to act

“What has become clearer and clearer to me is that there is no cavalry coming: if we want the world to be a better place, we are the ones who need to stop talking about it and take action”

*Jeremy Darroch,
Group CEO & President Sky, Chairman BiTC*

Thank you

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