Law Society of Scotland

Consultation Response

General Medical Council: Updating our expectations of newly qualified doctors in the UK: reviewing the outcomes for graduates

January 2018

Introduction

The Law Society of Scotland (the Society) is the professional body for over 11,000 Scottish solicitors. With our overarching objective of leading legal excellence, we strive to excel and to be a world-class professional body, understanding and serving the needs of our members and the public. We set and uphold standards to ensure the provision of excellent legal services and ensure the public can have confidence in Scotland's legal profession.

We have a statutory duty to work in the public interest, a duty which we are strongly committed to achieving through our work to promote a strong, varied and effective legal profession working in the interests of the public and protecting and promoting the rule of law. We seek to influence the creation of a fairer and more just society through our active engagement with the Scottish and United Kingdom governments, parliaments, wider stakeholders and our membership.

Our Health and Medical Law sub-committee, welcomes the opportunity to consider and respond to the General Medical Council consultation: Updating our expectations of newly qualified doctors in the UK: reviewing the outcomes for graduates. The sub-committee has the following comments to put forward.

General comments

The outcomes listed are professional values and behaviours, professional skills and professional knowledge. The GMC publication *"Good Medical Practice"* 2013, has four outcomes, namely:

1. Knowledge, skills and performance,
2. Safety and quality, communication,
3. Partnership and teamwork, and
4. Maintaining trust.

It may be more appropriate for students and junior doctors to have their training reflect the guidance that will influence their medical practice on a daily basis.

It is submitted that training should reflect as closely as possible what will be expected of doctors as soon as they have graduated, since students and junior doctors will be required to follow the prescribed code of conduct in "*Good Medical Practice*".

As far as draft procedures are concerned, It would be more realistic if students could practice on real patients so that they would be able to learn in real situations. The focus should be on providing adequate resource for simulation training prior to students being allowed to work on patients. However, we recognise that it is not always possible or practical to facilitate this, but that it should be available whenever possible.

Since treatment is to be patient-centred, it is clear that students and junior doctors have to learn a number of essential skills but they have to be in the correct context and under the guidance and supervision of a medical team.

Legislation in Scotland requiring integration of health and social care came into effect in April 2016. This change reflects the changes happening to our population. It is recognised that the draft outcomes recognise the importance of integration and that the patient should be at the centre of treatment. The proposals set out in this consultation take this into account and as such would meet the expectations of the general public.

Students and junior doctors have to understand that medical treatment is not a "one size fits all". This draft guidance takes equality and diversity into account and the proposed outcomes will help students and junior doctors understand this. Integration is about putting patients, not services, at the centre of decisions. This draft guidance recognises this.

Account should be taken of the "*Good Medical Practice*" publication and the draft outcomes should reflect closely what is required of doctors in that document. Students and junior doctors, with the support of those training them, should be exposed to many different clinical settings, both in the hospital and also in the community. That way, newly qualified doctors learn what is expected of them in practice. Listing what is expected of junior doctors, or the types of patient being treated in the draft outcomes should not be exhaustive, since it is not possible to consider every situation. However, it is helpful to give guidance in a general way.

It is important that a newly qualified doctor should be able to apply what he or she has learned at medical school and understand how that translates into what has to be done in practice. Lists can be helpful as examples of the type of treatments, or the type of patient requiring treatment. However, a list might be considered exhaustive and junior doctors should also be aware that unique situations may arise in daily practice. An understanding that newly qualified doctors will need to be able to provide care in a range of settings, including in the community, in general practice and in hospitals is important and this will help with the integration issue of health and social care.

All medical schools should have the tools they need to promote excellence in their medical students and this should be universally put into practice.

The structure of the outcomes should match the nine domains of the generic professional capabilities framework. This will make it easier to apply and for students and their supervisors will know that everything is covered. If the same format is followed in each GMC publication, this will make it easier to follow.

Medical science does not move very quickly but a two yearly review does not seem unreasonable to update the guidance

The education of our future doctors is very important and this GMC review is welcomed.

Specific comments

We note that the consultation is focused on three specific outcomes:

1. Professional values and behaviours
2. Professional skills
3. Professional knowledge

There are key elements from the three outcomes as described within the consultation that understandably overlap, as the provision of good care can only be achieved through an assimilation of these attributes.

It is increasingly evident from various studies that patient outcomes are related to human factors and non-technical skills including effective team working. We believe this has to be emphasised and appropriately reflected in this document. Some of these relevant points seem to be embedded into other points creating a degree of confusion on the subject matter.

A concise document summarising the key publications (including Promoting excellence: standards for medical education and training, Outcomes for graduates, Good Medical Practice) and how they relate to clinical practice is required and will be welcomed by an already busy and overstretched workforce.

Professional and ethical responsibilities

We note that paragraph 2 of the revised draft outcomes provides that '*Newly qualified doctors must be able to behave according to ethical and professional' principles. They must be able to: (at 2k) 'Demonstrate an understanding of how to promote, monitor and maintain health and safety in the clinical setting and how errors can happen in practice.'* We suggest that understanding '*how errors can happen'* needs to be in a separate sentence.

Paragraph 2k provides that they must be able to '*Demonstrate an understanding of the importance of raising and escalating concerns about patient safety and quality of care appropriately, through informal communication with colleagues and through formal clinical governance and monitoring systems including*

through the use of 'whistleblowing'' where necessary. The term 'whistleblowing' should be defined and reflect the GMC's position. What is the GMC,s expectation for this?

Patient safety and quality improvement

Newly qualified doctors must demonstrate that they can practice safely. They must participate in, and promote, activity to improve the quality and safety of patient care and clinical outcomes. They must be able to:

1. place patients' needs and safety at the centre of the care process,

2. 'promote and maintain health and safety in the clinical setting, including when providing treatment and advice remotely, and demonstrate an understanding of how errors can happen in practice.' As above, we suggest that again this should be a separate key point. It may currently be read more as an afterthought or adjunct to promoting and maintain health and safety.

3. 'demonstrate and apply basic human factors principles and practice at individual, team, organisational and system levels'. We suggest the deletion of the word 'basic' .

4. '…understand and have experience of the principles and methods of improvement. This includes adverse incident reporting and other quality improvement processes such as participating in national surveys and other quality control, quality management and quality assurance processes as required by the regulator, medical school or local education provider'.

We suggest that, in addition to the above, there should be mention of Mortality & Morbidity Meetings. 88% of consultants in Scotland [1] stated they participate in M&M or similar peer review meetings. The number of trainee doctors is likely to be larger. M&M processes describe a systematic approach that provides members of a healthcare team with the opportunity for timely peer review of complaints, adverse events, complications or mortality to reflect, learn and improve patient care. The importance of a structured M&M process is being emphasised in NHS Scotland.

Applying biomedical scientific principles

We note that paragraph 25 of the revised draft outcomes provides that ' *Newly qualified doctors must be able to apply biomedical scientific principles and knowledge to medical practice and integrate these into*

[1] The Scottish Mortality and Morbidity National Survey & Mortality and Morbidity Reviews Practice Guide – Working Version(May 2017) Available from: http://ihub.scot/media/1844/20170508-mortality-and-morbidity-reviews_final.pdf. [Accessed 9 Jan 2018.]

patient care. They must be able to: (25e) 'demonstrate knowledge of drug actions: therapeutics and pharmacokinetics; drug side effects and interactions, including for multiple treatments, long term conditions and non-prescribed drugs; and also including effects on the population, such as the spread of antibiotic resistance'.

Is the expectation here that every individual student should be able to memorise the thousands of prescriptive and non- prescriptive drugs? If so, this may be commendable, but we suggest that it may not be practicable. We believe that the emphasis should be on ensuring students recognise their limitations and understand the need to refer to national or local formularies when prescribing drugs (or doses) they are not familiar with. Perhaps this could also make a reference to and highlight the importance of team working and where to find available support.

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