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Good Medical Practice for Doctors providing Primary Care Services in Prison

DH Department of Health

Department of Health

Good Medical Practice for Doctors providing Primary Care Services in Prison

HM PRISON SERVICE

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GPC
General Practitioners Committee

Royal College of General Practitioners

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For Recipient Use	

Dear Colleague

Re: Good Medical Practice for Doctors Providing Primary Care Services in Prison

Introduction
The General Medical Council has published *Good Medical Practice* as the basis on which all doctors should practise and be revalidated as fit to practise. For general practitioners the Royal College of General Practitioners and the General Practitioners Committee of the British Medical Association have written and published *Good Medical Practice for General Practitioners*. This provides more detail concerning the principles set out in *Good Medical Practice*, and the attributes of the Excellent GP and the Unacceptable GP. The text will be used as the basis for teaching new general practitioners, appraisal, continuing professional development, revalidation and the GMC's performance procedures.

Good Medical Practice for Doctors Providing Primary Care Services in Prison includes the text of *Good Medical Practice for General Practitioners*, which itself includes the text of Good Medical Practice. To differentiate between the three texts they have all been individually colour coded. **It is crucially important that when using *Good Medical Practice for Doctors Providing Primary Care Services in Prison* that all three texts are referred to as they complement each other.** This is important because a person deserves equivalent care regardless of the setting, and clinical generalists have skills and attributes that apply in any setting.

However, there are particular issues that confront doctors providing primary care services in prison and *Good Medical Practice for Doctors Providing Primary Care Services in Prison* contains added text enlarging on but not replacing the original text of *Good Medical Practice for General Practitioners*. The comments will be presented under the section heading to which they are most pertinent, but many apply in several sections. The added comments appear thus:

Additional observations relating to doctors working in prison: **[Text]**

These additional comments have been provided by a Working Group made up of doctors employed by the Prison Service, GPs who visit prisons to provide primary care services and GP educationalists. I would like to take this opportunity to thank them for their time and effort and also to thank all those people who commented on the document during its consultation phase.

Scope
The term "doctors providing primary care services in prison" covers clinical generalists in secure environments including doctors in the prison medical service, general practitioners visiting prisons, general practitioners with a special interest who work in prisons, etc.

Context

There are differences between the working lives of doctors in prison and in British general practice. The first difference relates to the independence and autonomy of the patients, and this is referred to in this document. This has importance for self-care, informed consent, confidentiality, privacy, access and doctor-patient trust.

The second difference relates to personal safety. All health workers are at risk of verbal abuse, threatening behaviour and physical challenge. While the same principles apply in all settings, the prevalence of a history of violence, severe behavioural disorder and psychosis is greater in prisons than in the community.

Thirdly, the managerial situation is different. Whereas in British general practice there has traditionally been a flat structure with high levels of doctor influence, prisons have a more hierarchical system. Doctors exercise less direct control over their physical environment and are dependent on their work with managers to achieve many objectives. While it is important that every doctor ensures that they have the appropriate equipment and that they know how to use it correctly, that the premises are appropriate, that access to their services is satisfactory and that medical records are routinely available during consultations, these aspirations require partnership working with management to be achieved.

From 1 April 2003 funding responsibility for prison health services will transfer from the Home Office to the Department of Health. This is the first step in a process which will see by 2008 prison health becoming part of the NHS with Primary Care Trusts (still in partnership with prisons) commissioning healthcare services to prisons.

The added text in *Good Medical Practice for Doctors Providing Primary Care Services in Prison* has been written in the light of the context of delivering clinical generalist services in the prison setting.

Conclusion

Both Good Medical Practice and Good Medical Practice for General Practitioners remain the fundamental guides for all doctors providing primary care services. However, this document offers more detailed, additional, advice for those doctors working in the context of prison health care.

This document is an evolutionary one. If you have any comments about the text please contact Chris Harris on 0113 2545335.

Yours sincerely

Professor Mike Pringle
Professor of General Practice, Nottingham

Contents

Members of the Working Group on Good Medical Practice for Doctors Providing Primary Care Services in Prison

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GOOD MEDICAL PRACTICE FOR GENERAL PRACTITIONERS

WITH ADDED TEXT RELEVANT TO DOCTORS WORKING IN PRISON

Synopsis

Periodic revalidation[1] of doctors aims to give the public confidence that their doctors provide a high standard of care. This document has been written to contribute to the process of revalidation by describing what is expected of a general practitioner (GP).

Starting from the General Medical Council's *Good Medical Practice* (2001 edition), the document describes why each particular aspect of care is important for GPs. These are described under the seven broad headings of:

Good clinical care
Maintaining good medical practice
Relationships with patients
Working with colleagues
Teaching and training, assessment and appraisal
Probity
Health and the performance of other doctors

These general descriptions are 'anchored' by summarising under each heading some points which describe an 'excellent GP' and some that describe an 'unacceptable GP'.

No GP can be expected to provide care described under all the headings of the 'excellent GP' all the time. We suggest that an excellent GP meets the 'excellent GP' criteria all or nearly all of the time; a good GP meets most of the 'excellent GP' criteria most of the time; and a poor GP consistently or frequently provides care described by the 'unacceptable GP' criteria.

Revalidation aims to ensure that all GPs are working to an acceptable minimum standard. Revalidation procedures therefore focus on the examples of unacceptable practice which are given in this document. It is recognised that all GPs will on occasion provide care that may appear to be unacceptable by these standards. Except under the most unusual circumstances, only those GPs whose care falls consistently or frequently below the standards expected will be at risk of failing revalidation.

1 A summary of the GMC's revalidation procedures is available at www.revalidationuk.info

Introduction

All patients are entitled to good standards of practice and care from their doctors. Essential elements of this are professional competence; good relationships with patients and colleagues; and observance of professional ethical obligations.

GMC Good Medical Practice, paragraph 1

General practice lies at the heart of medicine in the United Kingdom. Indeed, it is one of the great successes of the National Health Service (NHS). This is shown by the fact that countries all over the world are developing systems of medical care based on the UK model of general practice.

It is, and always has been, a professional responsibility to provide a high standard of care. However doctors in the United Kingdom are increasingly expected to be able to demonstrate their fitness to practise. In line with other professional groups and public services, there is an expectation of transparency and public accountability in the delivery of medical care.

The General Medical Council (GMC) has described the duties of a doctor as follows:

Patients must be able to trust doctors with their lives and well-being. To justify that trust, we as a profession have a duty to maintain a good standard of practice and care and to show respect for human life. In particular as a doctor you must:

- make the care of your patient your first concern;
- treat every patient politely and considerately;
- respect patients' dignity and privacy;
- listen to patients and respect their views;
- give patients information in a way they can understand;
- respect the rights of patients to be fully involved in decisions about their care;
- keep your professional knowledge and skills up to date;
- recognise the limits of your professional competence;
- be honest and trustworthy;
- respect and protect confidential information;
- make sure that your personal beliefs do not prejudice your patients' care;

- make the care of your patient your first concern;
- act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise;
- avoid abusing your position as a doctor; and
- work with colleagues in the ways that best serve patients' interests.

In all these matters you must never discriminate unfairly against your patients or colleagues. And you must always be prepared to justify your actions to them.

Why has *Good Medical Practice for General Practitioners* been written?

Periodic revalidation of doctors has been developed in order to demonstrate to the public that doctors provide a high standard of care. Revalidation is designed to promote high standards across the profession as a whole, and to provide better support for those doctors who need it. This document has been written to contribute to the process of revalidation by describing what is expected of a GP.

The GMC has described in general terms what is required of a doctor in *Good Medical Practice*. This sets out the standards which the GMC expects of doctors and the principles against that the GMC assesses doctors when their performance is questioned. As part of the development of revalidation, the GMC asked Royal Colleges and specialist societies to describe in greater detail what 'good medical practice' means for their discipline –hence the title Good Medical Practice for General Practitioners. The Royal College of General Practitioners (RCGP), working with members of the General Practitioners' Committee of the British Medical Association (GPC) and other organisations, undertook this work for general practice.

The document was written by a working party convened by the RCGP. A wide range of organisations were consulted. In November 1999, a draft was sent to all GPs in the United Kingdom for comment. Approximately two thousand replies were received. This document incorporates the feedback received during this consultation exercise. It has also been mapped to the 2001 edition of GMC's *Good Medical Practice.*

What standards are expected of a GP?

In seeking to define good medical practice for general practitioners, the GMC's *Good Medical Practice* was used as the starting point. Extracts from the 2001 edition of the GMC's document are reproduced in italics at the start of each section. In each section, we have described why that particular aspect of care is important for GPs. We have then anchored these general descriptions by summarising under each heading some points which describe an 'excellent GP' and some that describe an 'unacceptable GP'. While the issues we discuss are intended to cover all the aspects of care provided by GPs, the individual bullet points are not intended to be exhaustive.

An excellent GP meets the 'excellent GP' criteria all or nearly all of the time.

A good GP meets most of the 'excellent GP' criteria most of the time.

A poor GP consistently or frequently provides care described by the 'unacceptable GP' criteria.

No GP can be expected to provide the care described under the headings of the 'excellent GP' all the time – though he or she will aspire to that. Likewise, we recognise that good GPs will, on occasion, provide care that appears to be 'unacceptable' by these standards. Where standards are not met, it may not always be the fault of the doctor. Sometimes this may be due to lack of resources, and GPs may find it difficult, or impossible, to meet patients' increasing expectations in the absence of an increase in resources.

In setting standards for performance, the GMC, or any other assessing body, is looking for consistent inability to meet acceptable standards of practice. Just as the RCGP looks for consistent patterns of high standard care for its awards, so the GMC looks for consistent patterns of poor performance before calling a doctor's fitness to practise into question. A single incident would only lead the GMC to question a doctor's fitness to practise under the most exceptional circumstances. Moreover, a doctor's practice cannot be called into question unless there is evidence of seriously deficient performance, serious professional misconduct, or serious physical or mental impairment.

To whom does this document apply?

The document applies to all GPs, whether or not they are principals, and whether or not they are working in the NHS. However, some points apply only to GPs who are NHS principals.

Good medical practice needs to be interpreted in the context of each individual doctor's practice. GPs practise in very different circumstances – the needs of patients vary greatly, resources are unevenly spread, and the support that individual practices have to call on varies greatly. While all GPs aspire to provide the best care to all their patients, what they can achieve may depend on the circumstances in which they find themselves. Revalidation will take into account the circumstances of each individual doctor applying for revalidation.

Some general practitioners have special interests and provide services either within a secondary care team, or as a service to other primary care colleagues. The tasks carried out by these general practitioners may sometimes be equivalent to parts of those carried out by a consultant. General practitioners providing such services must be properly trained, accredited and supported in the work that they do. Audits must demonstrate, for example, that they provide a service at least as good as that of traditional hospital based care. The work which these doctors do falls outside that normally done by a general practitioner, and this document does not therefore consider the issues relating to GPs with a special interest in detail. However, the statements from the GMC's *Good Medical Practice* apply to all doctors, and therefore need to be interpreted in the light of the work that each doctor is doing. More detailed guidance for GPs who are carrying out such special work will be made available in due course.

We hope that the document will be used to guide GPs, as well as those with responsibility for assessing their performance, those considering how revalidation of GPs might be approached, and those involved in the various quality-assessment schemes operated by the RCGP. It will also help patients to know what standards they can expect of their GP.

Good clinical care

1. Clinical care

Good clinical care must include:

- *An adequate assessment of the patient's conditions, based on the history and symptoms and, if necessary, an appropriate examination.*
- *Providing or arranging investigations or treatment where necessary.*
- *Taking suitable and prompt action when necessary.*
- *Referring the patient to another practitioner, when indicated.*

In providing care you must:

- *Recognise and work within the limits of your professional competence.*
- *Be willing to consult colleagues.*
- *Be competent when making diagnoses and when giving or arranging treatment.*
- *Provide the necessary care to alleviate pain and distress whether or not curative treatment is possible.*
- *Prescribe drugs or treatment, including repeat prescriptions, only where you have adequate knowledge of the patient's health and medical needs. You must not give or recommend to patients any investigation or treatment which you know is not in their best medical interests, nor withhold appropriate treatments or referral*
- *Report adverse drug reactions as required under the relevant reporting scheme, and co-operate with requests for information from organisations monitoring the public health.*[2]

If you have good reason to think that your ability to treat patients safely is seriously compromised by inadequate premises, equipment, or other resources, you should put the matter right, if that is possible. In all cases you should draw the matter to the attention of your Trust, or other employing or contracting body. You should record your concerns and the steps you have taken to try to resolve them.

GMC Good Medical Practice, paragraphs 2, 3a – 3c, 3f – 3h, 4

Providing competent assessment and treatment is at the heart of good medicine. As a GP, you need to be skilful in acquiring information that relates to your patient and his or her presenting problem. Where possible, you should allow enough time so that you can assess problems that may underlie the presenting problem.

You should have consulting skills which elicit sufficient clinical information for diagnosis and management, achieving coverage of important areas including difficult and sensitive ones. Your consulting style should be responsive to individual patients' needs, involving them in decisions about management.

2 *Confidentiality: protecting and providing information.* Available at www.gmc-uk.org

You should carry out appropriate physical examinations. This does not mean that every patient needs to be examined, or that patients need to be examined on every occasion. However, you do need to put yourself in a position in which you would be able to identify an important problem if one was there. You should be particularly careful when assessing problems and giving advice on the telephone, when serious problems are potentially more easily missed or misdiagnosed.

You should involve your patient in defining the aims of treatment, arrangements for follow up and long-term plans for care. You should advise your patient on the available treatments he or she needs, and where possible provide them. You should avoid giving treatments that are unnecessary. Sometimes this may involve time-consuming negotiation with the patient.

You need to practise in premises that contain basic medical equipment which will enable you to assess and manage problems appropriately. In addition to keeping such equipment, you need to maintain it in a condition which is safe (e.g. adequately sterilised) and know how to use it. You need to understand and be able to meet the requirements of current health and safety legislation.

You should undertake appropriate investigations and referral with attention to timing and pacing. Both under-investigation and over-investigation, and under-referral and over-referral, can expose patients to risk.

All medical treatments are associated with a risk of adverse reaction. It is important both for good patient care and for the safety of others that such incidents are appropriately reported. You should remain alert to the possibility of medical care having untoward effects and where appropriate report such events promptly.

The management of a problem includes giving patients up-to-date information on acute and chronic health problems, on prevention and lifestyle, and on self-care. You should be aware of and have access to a variety of ways in which patients can get this information. These might include patient leaflets, personalised information sheets, and addresses and telephone numbers of self-help groups and other health and social services organisations.

You must maintain adequate knowledge and skills as a GP. You also need to be aware of your level of competence, so that you can decide when a problem needs to be referred to another doctor.

The excellent GP

- maintains his or her knowledge and skills, and is aware of his or her limits of competence;
- takes time to listen to patients, and allows them to express their own concerns;
- considers relevant psychological and social factors as well as physical ones;
- uses clear language appropriate for the patient;
- is selective but systematic when examining patients;
- performs appropriate skilled examinations with consideration for the patient;
- has access to necessary equipment and is skilled in its use;

- uses investigations when they will help management of the condition;
- knows about the nature and reliability of investigations requested and understands the results;
- makes sound management decisions which are based on good practice and evidence;
- has a structured approach for managing long-term health problems and preventive care.

The unacceptable GP

- has limited competence, and is unaware of where his or her limits of competence lie;
- consistently ignores, interrupts, or contradicts his or her patients;
- fails to elicit important parts of the history;
- is unable to discuss sensitive and personal matters with patients;
- fails to use the medical records as a source of information about past events;
- fails to examine patients when needed;
- undertakes inappropriate, cursory, or inadequate examinations;
- does not explain clearly what he or she is going to do or why;
- does not possess or fails to use appropriate diagnostic and treatment equipment;
- consistently undertakes inappropriate investigations;
- shows little evidence of a coherent or rational approach to diagnosis;
- draws illogical conclusions from the information available;
- gives treatments that are inconsistent with best practice or evidence;
- has no way of organising care for long-term problems or for prevention.

Additional observations relating to doctors working in prison:

To ensure the safety of the doctor, the same imperatives apply as in any front line service, for example Accident and Emergency departments and general practice. However, given the higher prevalence of a history of violence, severe behavioural disorder and psychosis the doctor working in prison must give greater attention to the environment and working practices. The aim should be to manage risk and maintain security without compromising good clinical care.

Each doctor working in prison has a responsibility to ensure that the appropriate equipment and facilities are available to undertake their work and meet the expectations of *Good Medical Practice*. In prison, as in other settings such as hospitals, this requires partnership working, with prison service managers and also between prison service managers and their local NHS colleagues.

The lifestyle of some patients and their lack of previous interaction with health care services may mean that there is an opportunity whilst they are in prison for them to be advised about and possibly engage in health promotion activity. A doctor working in prison should be aware of the opportunities to influence their patients' life style. For more information on the Prison Service's strategy on health promotion reference should be made to "Health Promoting Prisons: a shared approach"[3]

There is also a need for extra emphasis, because of the high incidence of mental health and multiple presentation of illnesses, for a co-ordinated approach to be taken to the provision of clinical care packages.

3 Health Promoting Prisons: a shared approach A strategy for promoting health in prisons in England and Wales. Department of Health 2002

2. Keeping records, writing reports and keeping your colleagues informed

In providing care, you must

- *keep clear, accurate, and contemporaneous patient records which report the relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed;*
- *keep colleagues well informed when sharing the care of patients;*
- *You must be honest and trustworthy when writing reports, completing or signing forms, or providing evidence in litigation or other formal inquiries. This means that you must take reasonable steps to verify any statement before you sign a document. You must not write or sign documents which are false or misleading because they omit relevant information. If you have agreed to prepare a report, complete or sign a document or provide evidence, you must do so without unreasonable delay.*

GMC Good Medical Practice, paragraphs 3d, 3e, 51

Keeping good records of the clinical encounter enables you, other doctors and other clinical staff to understand the care that the patient has been given. Medical records provide the basis for future care and are the main way to share information with other members of the practice team who may be providing care for a patient. They are also documents which may be needed for legal purposes.

Medical records include both written ones and ones held on computer. Your paper records should be legible and entered sequentially, with hospital reports, laboratory reports and x-ray reports filed in date order. Records of consultations should include the presenting problems, results of relevant examinations or investigations undertaken, and an indication of the management plan. The records of patients on long-term therapy should include a clear summary of medication. Important information in records should be easily accessible, for example, as part of a summary.

Records should contain factual information and opinions which relate to diagnosis or treatment. You should remember that patients are entitled to read their records. They may also legitimately ask that you do not record some things that they tell you. When you agree to write a report based on the patient's notes, for example for a solicitor or an insurance company, you must complete it truthfully and factually.

Members of your practice team need information about patients in order to provide care for them. However, patients may sometimes assume that no-one else has access to the information they have given you. You should therefore be careful not to share information which you believe the patient might wish to be private. You may need to check with the patient about what can be shared with colleagues. You must always respect the patient's wishes about confidentiality except where this would put someone else at risk of serious harm. The GMC gives further guidance on confidentiality in its booklet: Confidentiality: Protecting and providing information.[4]

If you see a patient outside your practice setting (e.g. in a walk-in centre or an out-of-hours co-operative), you should inform the patient's GP about the care you give, unless the patient objects.

Communication with specialists to whom you refer is discussed in section 12.

The excellent GP

- records appropriate information for all contacts including telephone consultations;
- respects the patient's right to confidentiality and provides information to colleagues in a manner appropriate to their level of involvement in the patient's care;
- ensures that letters are legible and copies kept on file;
- files GP notes, hospital letters, and investigation reports in date order.

The unacceptable GP

- keeps records which are incomplete or illegible, and contain inaccurate details or gratuitously derogatory remarks;
- does not keep records confidential;
- does not take account of colleagues' legitimate need for information;
- keeps records that cannot readily be followed by another doctor;
- consistently consults without records;
- omits important information from a report which he or she has agreed to provide, or includes untruthful information in such a report.

Additional observations relating to doctors working in prison:

Doctors working in prison often perceive themselves to be under pressure to share confidential clinical information with non-clinical people within the prison. Prisoners have, however, the same rights to confidentiality as when they are in the community. This means that reports requested by the prison authorities – for adjudication purposes, after injury or self-harm, or in matters of discipline, for example – should normally only contain confidential identifiable information with the prisoner's consent. They should be invited to give informed consent to any sharing of information and should be reassured that health information is not disclosed to other prison staff without such consent.

To allow prisoners to make a valid judgement about their consent they should be explicitly reassured that their withholding of consent will not result in any change in their medical treatment. When seeking consent doctors should also be aware and sensitive to prisoners' perception of themselves being under pressure to give consent. This perception may result from the need, for security reasons, for a third party to be present during the consultation. There is a fine line of judgement to be made here between respecting patients' rights to a confidential consultation and safeguarding the health care team and the security of the prison. For consent to be meaningful it needs to be freely given by an individual who is informed and not subject to outside pressures. This is still a relatively new area and future reference to forthcoming guidance from the Department of Health "Confidentiality: A Code of Practice for the NHS" may be helpful.

4 *Confidentiality: protecting and providing information*. Available at www.gmc-uk.org

However, as set out in Guidance on the Protection and Use of Confidential Health Information in Prisons and Inter-Agency Information Sharing[5] there are exemptions to this principle:

"Exceptional circumstances which override an individual's wishes arise when the information is required by statute or court order, where disclosure is essential to protect the patient, or someone else, from risk of death or serious harm, or for the prevention, detection or prosecution of serious crime. The decision to release information in these circumstances should be made by the nominated senior professional and it may be necessary to take legal or other specialist advice".

The flow of information between the prisoner's general practitioner in the community and the prison doctor, and then back again, has traditionally been poor.

Doctors working in prisons have a responsibility to change this tradition. Care can only be delivered if information relating to patients immediate care needs is made available when requested. Doctors working in prison will be expected to play their part in facilitating information flow and educating their GP and other health care colleagues. If a prisoner's condition or management has changed significantly during time in prison, the doctor working in prison should ensure that a discharge summary or letter notifies those changes to the prisoner's general practitioner. If the prisoner is no longer registered with an NHS general practitioner, or is moving to a new area on release, a written summary with contact details for the doctor working in prison should be handed to the prisoner prior to a planned release.

5 Guidance on the protection and use of confidential health information in prisons and inter-agency information sharing. Information and Practice Note. Prison Health Policy Unit, April 2002

3. Access, availability and providing care out of hours.

You must be readily accessible to patients and colleagues when you are on duty.

You must be satisfied that, when you are off duty, suitable arrangements are made for your patients' medical care. These arrangements should include effective hand over procedures and clear communication between doctors.

If you arrange cover for your own practice, you must satisfy yourself that doctors who stand in for you have the qualifications, experience, knowledge and skills to perform the duties for which they will be responsible. Deputising doctors and locums are directly accountable to the GMC for the care of patients while on duty.

GMC Good Medical Practice, paragraphs 19e, 39, 40

Patients place a high priority on having good access to GPs. A number of issues relate to access and availability. These include being able to get through on the telephone, having an appointment system which meets the needs of your patients, providing appointments with particular doctors in order to provide continuity of care, having a system which identifies urgent problems, and providing access for disabled patients.

Patients appreciate being able to contact the surgery throughout the working day, though this is sometimes not possible to arrange in smaller practices. Your practice leaflet should say when the surgery is open and when the phones are answered. The phone system should be adequate to meet the needs of your patients and your practice.

Patients value being able to talk to a doctor or nurse on the phone, and this often avoids the need for a surgery consultation or visit. Your practice leaflet should make it clear whether you have arrangements for patients to talk to a doctor or nurse on the phone.

Difficulty getting appointments, and long waiting times at the surgery, are common sources of complaints and dissatisfaction. Your appointment system should recognise the needs of your population; for example, those whose first language is not English may have difficulty with a complicated appointment system, and patients in deprived areas may be more likely to attend without appointments. A flexible system with both booked appointments and open access may be best in some areas.

Being able to see a particular doctor is one of the most important features of general practice for patients – higher levels of continuity of care are consistently associated with higher levels of patient satisfaction. Sometimes commitments outside the practice, holidays, and so on make it difficult for a doctor to provide continuity of care; under these circumstances, you should ensure that adequate continuity is provided within the team.

You need to establish a system for distinguishing and managing requests for emergency, urgent, and routine appointments – this will normally be in the hands of a receptionist or a nurse. You need to ensure that your receptionists are trained to be able to operate the system correctly, and, if you are employing staff, you must accept final responsibility for the working of the appointment system.

As practice staff are often the first point of contact with a GP's surgery, they need to understand the importance of confidentiality in their dealings with patients.

When you are on call, you must ensure that you can be contacted easily. You need to ensure that equipment such as a mobile phone is working and, where appropriate, there should be a back-up system such as a pager. You also need to be accessible to colleagues, and other agencies such as the ambulance service or social services. In addition to being accessible when on duty, you must also ensure that your response to requests for help is appropriate; for example, responding rapidly in an emergency situation.

Twenty-four-hour cover for patients in general practice is increasingly provided by GP co-operatives and deputising services. It is your responsibility to ensure that a system is in place which will check that any doctor who stands in for you has the necessary qualifications, experience, knowledge, and skills to perform the duties for which they will be responsible. This is also important when you employ locums in your own practice. For out-of-hours care, you need to ensure that there is a system for transferring information concerning out-of hours consultations to the patient's usual doctor. You should assume full responsibility for any relevant information about your patients that is handed over by another health professional.

The excellent GP

- has opening hours which meet the needs of the patient population and are clearly stated;
- monitors how the appointments system works;
- has a system for receiving or returning phone calls from patients;
- has an effective system to identify and respond to emergencies, and a system to deal with requests for same-day appointments;
- can always be contacted when on duty and arranges immediate action in an emergency situation;
- only uses out-of-hours cover arrangements where high standards of care are provided;
- checks the registration of locums with the GMC and only employs a locum who has provided a JCPTGP certificate (or a curriculum vitae if he or she entered practice before such certificates were issued) and two references from previous employers, and who has attained a high standard of practice (e.g. possession of the MRCGP);
- can demonstrate an effective system for transferring and acting on information from other doctors about patients.

The unacceptable GP

- has very restricted opening hours;
- does not have adequate arrangements for patients to contact the practice by phone;
- provides no opportunity for patients to talk to a doctor or a nurse on the phone;
- cannot be contacted when on duty, takes a long time to respond to calls, or does not take rapid action in an emergency situation;
- has no knowledge of the qualifications of locums employed in the practice or ignores doubts about their ability;
- has no system for transferring information about out-of-hours consultations to the patient's usual doctor;
- does not follow up relevant information about his or her patients that has been provided by another health professional.

Additional observations relating to doctors working in prison:

In general practice many requests for advice or assistance come from a third party, usually a close relative or neighbour who can usually be thought to be calling with the patient's consent. In prison the patient has no choice but to use an intermediary to gain urgent care; that intermediary may be a nurse or health care officer, but is often a prison officer. Consent cannot be assumed and special care should be exercised to avoid the disclosure of confidential information.

Because access to care may be particularly difficult for people in prison, any structural and organisational blocks to access should be identified by the doctor and efforts made to resolve any issues in partnership with Prison Service management. For example, difficulty in patients attending due to prison regimens, physical access problems for the disabled and lack of awareness of how to access medical services are all important potential constraints. The pressures on outpatient appointments due to transport problems, availability of security staff or prisoner relocation are also significant issues.

4. Treatment in emergencies

In an emergency, wherever it may arise, you must offer anyone at risk the assistance you could reasonably be expected to provide.

GMC Good Medical Practice, paragraph 9

Medical emergencies – such as cardiac chest pain, acute dyspnoea, and severe trauma – are uncommon in general practice. However, when they occur they require high levels of technical skill. It is your responsibility to ensure that both you and your team are confident and competent to provide medical care for the emergencies that are likely to arise in your area. This is particularly important if you do not have easy access to an accident and emergency department.

You need to be able to respond rapidly to a medical emergency if you are on call. You should have available, and be able to use, the necessary equipment and drugs to enable you to respond appropriately to medical emergencies. You should arrange appropriate short- and long-term follow up for patients who have required emergency care, including referral to other health professionals when necessary. You should consider the needs of the family and friends of patients who have required emergency care.

If you are present when a person needs emergency care – for example, if a person collapses or is injured in a public place – you should provide any treatment or assistance which is within your professional competence.

The excellent GP

- responds rapidly to emergencies;
- has policies that all team members are familiar with for the organisation and management of medical emergencies;
- arranges appropriate training for practice staff in managing emergencies;
- has up-to-date emergency equipment and drugs and ensures that they are available for any doctor, e.g. a locum, working in the practice;
- works effectively with the emergency services;
- gives consideration to the broader implications of a medical emergency for the patient's family and friends;
- reviews the care of emergency cases as part of clinical meetings, using techniques such as significant event auditing.

The unacceptable GP

- cannot be contacted in an emergency or does not respond quickly;
- provides ineffective or erratic care in emergencies;
- provides no support to practice staff in managing emergencies;
- has insufficient emergency drugs or equipment, or has drugs which are out of date;
- does not maintain his or her resuscitation skills;
- does not appropriately follow up patients who have experienced a medical emergency.

Additional observations relating to doctors working in prison:

Doctors working in prison must be aware of the systems in place for handling perceived or real emergencies and must be satisfied that delays are minimised.

These systems should also include significant event auditing and their findings should inform the regular process of review.

5. Making effective use of resources

In providing care you must:

- *Make efficient use of the resources available to you*

You should try to give priority to the investigation and treatment of patients on the basis of clinical need

GMC Good Medical Practice, paragraphs 3i, 7

There is a tension between the needs of a GP's individual patients and the needs of the population as a whole. No health care system can provide all possible treatments from which patients might benefit, and the needs of individual patients have to be balanced against those of society. Good GPs are aware of this tension and seek to balance the needs of their patients and of society.

Wasting resources means that there is less available for your patients and those of other doctors. So you should use resources in a cost-effective way. In both NHS and private care, you should avoid unnecessary or unnecessarily expensive treatments.

Some doctors have explicit responsibility for commissioning services for a wider population. When health care resources are limited, disadvantaged patients are particularly likely to suffer. Therefore, as far as possible, these doctors should ensure that resources are allocated and used to reduce inequalities in health.

However, your prime responsibility as a GP remains to your individual patient. Where adequate care is not given, as a result of poor professional performance, this should be identified and remedied. When adequate care cannot be given because of shortage of resources, this should be made explicit, both to the patient and to those who are in control of those resources.

The excellent GP

- only prescribes treatments which make an effective contribution to the patient's overall management;
- takes resources into account when choosing between treatments of similar effectiveness.

The unacceptable GP

- consistently prescribes unnecessary or ineffective treatments;
- takes no note of resources when choosing between similar treatments;
- refuses to register patients whose treatment may be costly.

No additional observations relating to doctors working in prison.

Maintaining good medical practice

6. Keeping up to date, and maintaining your performance

You must keep your knowledge and skills up to date throughout your working life. In particular, you should take part regularly in educational activities which maintain and further develop your competence and performance.

Some parts of medical practice are governed by law or are regulated by other statutory bodies. You must observe and keep up to date with the laws and statutory codes of practice which affect your work.

You must work with colleagues to monitor and maintain your awareness of the quality of the care you provide and maintain a high awareness of patient safety. In particular, you must:

- *take part in regular and systematic medical and clinical audit, recording data honestly. Where necessary you must respond to the results of audit to improve your practice, for example by undertaking further training.*
- *Respond constructively to the outcome of reviews, assessments or appraisals of your performance.*
- *Take part in confidential enquiries and adverse event recognition and reporting to help reduce risk to patients.*

GMC Good Medical Practice, paragraphs 10–12

New treatments are regularly introduced to general practice, and old ones are superseded. You need to keep yourself aware of the most significant of these changes across the full range of the problems that GPs see. As the gatekeeper to secondary care, you also need to be alert to changing specialist practice – detailed knowledge is not necessary, but you need to know enough to make appropriate referrals to specialists.

You need to plan your continuing education with care, trying to identify and fill gaps in your knowledge and performance. Honest self-evaluation and audit of your own performance is emerging as the basis of personal development plans in general practice.

Ways of doing this include a personal learning diary compiled during surgeries as well as proactively identifying, and regularly reviewing adverse events that suggest the possibility of poor quality practice. Once problems are identified, you need to ensure that you take appropriate and prompt action to change your own practice or that provided by your practice team. Among resources provided by a number of organisations, assessment instruments and a programme to support planned education for general practitioners, Assessment instruments and a programme to support planned education for general practitioners, Accredited Professional Development, are available from the RCGP (www.rcgp.org.uk).

For doctors working in the NHS, national and local priorities will increasingly influence this educational agenda. You will need to take account of these priorities in planning your own education and the development of your practice. You should respond constructively when problems in your care are identified through peer review or audit.

You need to be critical about the quality and effectiveness of the education on which you rely to maintain your skills. You should ensure that the educational methods that you use are of high quality and are appropriate. You should beware of being over-dependent on sources of information and educational events that may be commercially biased (e.g. meetings sponsored by companies whose contents are dictated by the company's products).

All health professionals should take part in regular and systematic clinical audit. You should join with members of your team to take part in audit and commit yourself to finding ways of improving your care where necessary.

The other ways in which you maintain high-quality clinical care need to reflect the breadth and nature of the discipline. In maintaining good care you should therefore be aware of a range of ways of monitoring and improving care (e.g. significant event analysis, risk management) and involve all your team members in maintaining and improving the quality of care which your practice provides. Clinical governance provides a framework which may help you do this.

Another part of keeping up to date is keeping up to date with the law. Many areas of general practice are influenced by statute. Important aspects of law influencing clinical practice include child welfare, mental health, controlled drug prescribing, provision of medical certificates for sickness benefits, fitness to drive and death certification. If these are relevant to your areas of clinical practice, you must ensure that your knowledge of the regulations remains current.

If you employ staff or provide public access to your premises, you have additional responsibilities to be aware of and respond to. These include employment law, health and safety law and related matters, and regulations governing access to premises (e.g. by disabled people, both patients and employees).

The excellent GP

- is up to date with developments in clinical practice and regularly reviews his or her knowledge and performance;
- uses these reviews to develop personal and practice development plans;
- uses a range of methods to monitor different aspects of care and to meet his or her educational needs;
- has information available on laws relating to general practice;
- has a named person in the practice who is responsible for Health and Safety at work and employment matters, and ensures compliance with them.

The unacceptable GP

- has little knowledge of developments in clinical practice;
- has limited insight into the current state of his or her knowledge or performance;
- selects educational opportunities which do not reflect his or her learning needs;
- does not audit care in his or her practice, or does not feed the results back into practice;

- is hostile to external audit or advice;
- does not understand or respond to the law relating to general practice;
- where employing staff, neither understands nor meets his or her responsibilities as an employer;
- has unsafe premises, e.g. hazardous chemicals or sharp instruments are inadequately protected.

Additional observations relating to doctors working in prison:

Special laws and statutes apply to the care of some prisoners. The doctor working in prison must be aware of and keep up to date concerning these provisions.

Individual doctors remain responsible both for identifying their own educational needs and for finding the means to address them. However, employers also have a responsibility to facilitate this process locally.

Some of the recommendations from The Report on the Working Group on Doctors Working in Prison are relevant here. For example; for the Prison Health Task Force to establish links with Post Graduate Deaneries; for Deaneries to include prison doctors in their training activities; and for Prison Health Policy Unit to work with Workforce Development Confederations to ensure current and future training needs of prison healthcare staff are included in their plans. As these are implemented they will encourage doctors and Prison Service managers to work with the NHS to maximise the educational opportunities around continuing professional development.

Relationships with patients

7. Providing information about your services

If you publish information about the services you provide, the information must be factual and verifiable. It must be published in a way that conforms with the law and with the guidance issued by the Advertising Standards Authority.

The information you publish must not make unjustifiable claims about the quality of your services. It must not, in any way, offer guarantees of cures, nor exploit patients' vulnerability or lack of medical knowledge.

Information you publish about your services must not put pressure on people to use a service, for example by arousing ill-founded fear for their future health. Similarly, you must not advertise your services by visiting or telephoning prospective patients, either in person or through a deputy.

GMC Good Medical Practice, paragraphs 48–50

Providing information to patients is an important and positive part of practice. Patients want to know what services are provided in the practice, which ones can only be used on your recommendation, and which ones they can access directly. They need to know about your arrangements for out-of-hours care. This applies both to written information (e.g. your practice leaflet) and to recorded telephone information. Where you leave a message on your answer phone, it should be clear to callers when they can next speak to practice staff.

The information in your practice literature needs to be accurate and factual, and avoid making unfavourable comparisons with others. Your responsibilities are to provide information for your own patients and to those thinking about registering with your practice. You should not go out and canvass or entice patients to join your practice. Further guidance on the acceptable limits of advertising is available from the GMC[6].

The excellent GP

- has a clear, accurate and up-to-date practice leaflet, containing information about services provided;
- leaves clear messages if an answer phone is used.

The unacceptable GP

- does not have a practice leaflet, or has one which is untrue or self-promoting;
- uses vague or incomplete messages on the answer phone;
- visits or phones prospective patients to encourage them to join the practice.

6 Providing information about your services. Available at www.gmc-uk.org

Additional observations relating to doctors working in prison:

Information on how to access medical care should be available, in appropriate languages and media, for all prisoners. This should be displayed in areas accessible to all prisoners, for example wing notice boards. These displays should also make the most of the opportunity to share information on healthcare with prisoners with particular regard to health promotion literature. Such information should also be included in the Prison Induction Programme.

8. Relationships with patients – maintaining trust

Successful relationships between doctors and patients depend on trust. To establish and maintain that trust you must:

- *Be polite and considerate and truthful.*
- *Respect patients' privacy and dignity.*
- *Respect the right of patients to decline to take part in teaching or research and ensure that their refusal does not adversely affect your relationship with them.*
- *Respect the right of patients to a second opinion.*

You must not allow your personal relationships to undermine the trust which patients place in you. In particular, you must not use your professional position to establish or pursue a sexual or improper emotional relationship with a patient or someone close to them.

Good communication between patients and doctors is essential to effective care and relationships of trust. Good communication involves:

- *Listening to patients and respecting their views.*
- *Giving patients the information they ask for or need about their condition, its treatment and prognosis, in a way they can understand, including, for any drug you prescribe, information about any serious side effects and, where appropriate, dosage*
- *Sharing information with patients' partners, close relatives and carers, having first obtained patients' consent. When patients cannot give consent, you should share the information which those close to the patient need or want to know, except where you have reason to believe that the patient would object if able to do so.*

Obtaining consent

You must respect the right of patients to be fully involved in decisions about their care. Wherever possible, you must be satisfied, before you provide treatment or investigate a patient's condition, that the patient has understood what is proposed and why, any significant risks or side effects associated with it, and has given consent. You must follow the guidance in our booklet Seeking Patients' Consent: The Ethical Considerations[7]*.*

Respecting confidentiality

You must treat information about patients as confidential. If in exceptional circumstances there are good reasons why you should pass on information without a patient's consent, or against a patient's wishes, you must follow our guidance on Confidentiality: Protecting and Providing Information[8] *and be prepared to justify your decision to the patient, if appropriate, and to the GMC and the courts, if called on to do so.*

GMC Good Medical Practice, paragraphs 19a–19d, 20, 21,17, 18

The length of the sections in *Good Medical Practice* which relate to trust reflects how fundamental trust is to the practice of medicine. A great diversity of individual patients come to consult their GP, and you have a responsibility to strive to gain and retain the trust of each one. Trust can only be built if you are committed to identifying and empathising with your patients' predicament and needs, and respecting their integrity and values. There is no place for personal bias or discrimination within a trusting relationship.

Trust is not a separate part of being a good doctor. Trust is earned by practising to the standards implied by other sections of this booklet – by maintaining your clinical competence, by taking patients seriously, by listening to them carefully, by examining them sensitively, by guarding confidential

7 *Seeking Patients' Consent: The Ethical Considerations.* Available at www.gmc-uk.org

8 *Confidentiality: protecting and providing information.* Available at www.gmc-uk.org

information and so on. Nevertheless, the GMC believes that trust is so fundamental to the successful practice of medicine that some of these aspects are repeated under this heading. Poor practice organisation also undermines trust – for example, loss of records, failing to write letters.

As a GP, you are uniquely placed to influence your patients through a clinical relationship that may extend over long periods, and of intimate knowledge of the dynamics of your patient's family and personal relationships. This position of trust must never cross the boundary between friendship and intimacy, especially when you see patients or their close relatives in vulnerable situations such as marital breakdown, bereavement, and, most especially, clinical consultation. When you see danger in a relationship with a patient you should immediately seek advice from colleagues, or advise the patient to change doctors. You should always arrange for a chaperone to be present if intimate clinical examinations are carried out in situations which are open to misinterpretation.

You will often acquire information about patients' personal or family finances. Your position of trust must never be abused to your personal advantage and you must never accept any financial reward outside the normal framework of professional fees, put pressure on a patient to provide a personal loan, or seek any bequest in a patient's will.

The context of your work within a defined community means that confidentiality is of exceptional importance. An understanding of the importance of confidentiality must extend to other members of the primary care team that you lead. If your practice gains a reputation of being careless with patients' confidences, this will destroy clinical relationships and damage trust in all doctors. Confidentiality is therefore an individual and practice responsibility.

If you are a NHS principal you will derive a significant proportion of your income from item of service payments. You must never undertake a clinical procedure or investigation involving personal reward unless it is clearly in the patient's best interest. Similarly, as a gatekeeper to secondary health care, you are trusted to recommend only appropriate investigations or treatments regardless of any potential personal inducement; for example, from the pharmaceutical industry or the private secondary sector.

For children under 16, you may need to judge the child's ability to understand about their care; where a child is capable of understanding the relevant issues, then he or she is entitled to confidentiality. This means that there will be circumstances where you should not disclose information about a child to his or her parents.

Trust is necessary if patients are to follow your advice. Mistakes are more likely to result in a formal complaint when they occur in a relationship where the patient has already lost trust in his or her doctor. We expand on what to do when things go wrong in Section 10.

The excellent GP

- treats patients politely and with consideration;
- takes care for the patient's privacy and dignity, especially during physical examinations;
- obtains informed consent to treatment;
- respects the right of patients to refuse treatments or tests;
- gives patients the information they need about their problem, in a way they can understand;
- involves patients in decisions about their care;
- keeps patients' information confidential – including consulting in private to make sure that confidential information is not overheard;
- is aware of the possibility of personal advantage accruing from a close clinical relationship, and avoids situations where personal and professional interests might be in conflict;
- does not seek or accept financial rewards from patients outside the normal framework of professional fees.

The unacceptable GP

- exploits relationships with patients to his or her own advantage;
- ignores the patient's best interests when deciding about treatment or referral;
- consistently ignores, interrupts, or contradicts his or her patients;
- is careless of the patient's dignity, and assumes his or her willingness to submit to examination without seeking permission;
- makes little effort to ensure that the patient has understood his or her condition, its treatment, and prognosis;
- is careless with confidential information;
- fails to obtain patients' consent to treatment;
- has inappropriate financial or personal relationships with patients;

Additional observations relating to doctors working in prison:

There can be a real tension between the requirement to respect patients' privacy and dignity, and the need for security. All prisoners have an entitlement to a confidential consultation within the limits identified by a risk assessment. As already described under "Keeping records, writing reports and keeping your colleagues informed", a prisoner's right to confidentiality is, except under exceptional circumstances, the same as in any other context.

There is also an additional tension to the doctor/patient relationship resulting from the patient being a prisoner with consequently reduced autonomy. This can take the form of the patient becoming institutionalised in their approach to life and viewing the doctor working in prison as a figure of authority more so than would be the case outside the prison setting. In developing good doctor/patient relationships this needs to be considered.

Given the nature and potential complexity of a doctors caseload in prison it would be good practice for doctors to look to provide each other with peer support when required.

9. Avoiding discrimination and prejudice against patients

The investigations or treatment you provide or arrange must be based on your clinical judgement of the patient's needs and the likely effectiveness of the treatment. You must not allow your views about a patient's lifestyle, culture, beliefs, race, colour, gender, sexuality, disability, age, or social or economic status, to prejudice the treatment you provide or arrange. You must not refuse or delay treatment because you believe that patients' actions have contributed to their condition.

If you feel that your beliefs might affect the advice or treatment you provide, you must explain this to patients, and tell them of their right to see another doctor.

You must try to give priority to the investigation and treatment of patients on the basis of clinical need.

You must not refuse to treat a patient because you may be putting yourself at risk. But if patients pose a risk to your health or safety you should take reasonable steps to protect yourself before investigating their condition or providing treatment.

GMC Good Medical Practice, paragraphs 5, 6, 7, 8

Our society provides health care through the NHS for all its citizens. Every one of those citizens is entitled to equal access to effective health care according to his or her needs. You have a responsibility to assist patients to get appropriate access.

Your own personal beliefs must not colour your treatment of patients, for example, by discriminating on grounds of age, sex, religion, culture, or ethnic group. You should try to arrange interpreting services for patients who are not fluent in English, so that you do not have to use relatives to translate – the latter pays insufficient regard to the patient's dignity and his or her right to confidentiality.

At the same time, some patients are difficult to look after, and some may pose a threat to you and your staff. In general, you share with colleagues an overall responsibility to ensure that all patients have access to medical care if you are working in the NHS. Where you are providing care for a patient who might be dangerous, you must plan their care in order to minimise risk to you and other members of your practice. Although NHS regulations specify that violent patients must not be excluded from receiving general medical services, they also recognise that the behaviour of some patients compromises their right to access general medical services in normal locations.

If you have a conscientious objection to a particular form of treatment, you should explain this in a non-judgemental manner to the patient, and refer the patient to an appropriate colleague without delay.

The excellent GP

- treats all patients equally and ensures that some groups are not favoured at the expense of others;
- discusses racism and promotes equal opportunities within the practice team;
- is aware of how his or her personal beliefs could affect the care offered to the patient, and takes care not to impose his or her own beliefs and values;
- takes measures to protect the practice team from patients who might pose a threat.

The unacceptable GP

- provides better care to some patients than others as a result of his or her own prejudices;
- pressurises patients to act in line with his or her own beliefs and values;
- refuses to register certain categories of patients, such as the homeless, the severely mentally ill, or those with problems of substance or alcohol misuse;
- refuses to make appropriate arrangements to see patients who pose a threat, or carelessly puts at risk members of the practice who are seeing such patients.

Additional observations relating to doctors working in prison:

The prison service has The RESPOND Programme[9] that details its policy concerning discrimination and prejudice.

The Prison Service is very aware of the cultural diversity of its resident population and is currently developing appropriate diversity awareness training for all health care staff.

9 The RESPOND Programme is an ongoing Prison Service programme launched in 1999 on race equality for both staff and prisoners.

10. If things go wrong

If a patient under your care has suffered harm, through misadventure or for any other reason, you should act immediately to put matters right, if that is possible. You must explain fully and promptly to the patient what has happened and the likely long- and short-term effects. When appropriate you should offer an apology. If the patient is an adult who lacks capacity, the explanation should be given to a person with responsibility for the patient[10], or the patient's partner, close relative or a friend who has been involved in the care of the patient, unless you have reason to believe the patient would have objected to the disclosure. In the case of children the situation should be explained honestly to those with parental responsibility and to the child, if the child has the maturity to understand the issues.

If a child has died you must explain, to the best of your knowledge, the reasons for, and the circumstances of, the death to those with parental responsibility. Similarly, if an adult patient has died, you should provide this information to the patient's partner, close relative or a friend who has been involved in the care of the patient, unless you have reason to believe that the patient would have objected.

Rarely, there may be circumstances, for example where a patient has been violent to you or a colleague, has stolen from the premises, or has persistently acted inconsiderately or unreasonably, in which the trust between you and the patient has been broken and you find it necessary to end a professional relationship with a patient. In such circumstances, you must be satisfied your decision is fair and does not contravene the guidance in paragraph 6 of Good Medical Practice (section 10 of Good Medical Practice for GPs); you must be prepared to justify your decision if called on to do so. You should not end relationships with patients solely because they have made a complaint about you or your team, or because of the financial impact of their care or treatment on your practice.

You should inform the patient, orally or in writing, why you have decided to end the professional relationship. You must also take steps to ensure that arrangements are made quickly for the continuing care of the patient, and hand over records to the patient's new doctors as soon as possible.

Patients who complain about the care or treatment they have received have a right to expect a prompt, open, constructive and honest response. You must not allow a patient's complaint to prejudice the care or treatment you provide or arrange for that patient.

You must co-operate fully with any formal inquiry into the treatment of a patient and with any complaints procedure which applies to your work. You must give, to those who are entitled to ask for it, any relevant information in connection with an investigation into your own, or another health care professional's, conduct, performance or health[11].

If you are suspended from a post or have restrictions put on your practice because of concerns about your performance or conduct, you must inform any other organisations for whom you undertake work of a similar nature. You must also inform any patients you see independently of such organisations, if the treatment you provide is within the area of concern relating to the suspension or restriction.

Similarly, you must assist the coroner or procurator fiscal, by responding to inquiries, and by offering all relevant information to an inquest or inquiry into a patient's death. Only where your evidence may lead to criminal proceedings being taken against you are you entitled to remain silent.

In you own interest, and those of your patients, you must obtain adequate insurance or professional indemnity cover for any part of your practice not covered by an employer's indemnity scheme.

GMC Good Medical Practice, paragraphs 22–25, 29–33

10 In Scotland a person appointed under the Adults with Mental Incapacity Scotland Act, 2000

11 Section 35 of the Medical Act 1983 (as amended) places a legal duty on doctors to supply, on request from the GMC, any document or information which appears relevant to the discharge of the GMC's professional conduct, professional performance or fitness to practise functions. In addition, where a decision has been taken to investigate a doctor's conduct, performance or health through our formal procedures, the Act requires the GMC to obtain from that doctor the names of his or her employers or bodies for whom he or she contracts to provide services.

Not everything goes as planned in general practice. GPs must take great care to avoid doing anything that might damage their patients' health. However, sometimes GPs make mistakes despite trying to do their very best. When this happens, your patients have a right to expect a prompt, appropriate, honest and constructive response to their complaints. You must not allow the patient's complaint to prejudice your care of them. NHS GPs are required to have a practice-based complaints procedure to help when things go wrong. You should make sure that it operates effectively.

Mistakes can occur in the diagnosis, treatment, or management of the patient or in the way the service is provided. When a mistake has arisen, even before a complaint is made, you should act immediately to put matters right, if you can. You should apologise if you or your practice team are at fault, and explain fully what has gone wrong.

If a patient has died you should explain matters to the family to the best of your ability, unless you know that the deceased would have objected to this. If a patient is under 16, then the circumstances of the death should be explained to the parents or legal guardians.

Doctors do not always handle mistakes well. Patients find that doctors and their staff are often extremely defensive when things go wrong. Matters may proceed to a formal complaint simply because a doctor will not admit that something went wrong. Patients expect you to do your best to avoid mistakes; however they do not like cover ups when things have gone wrong.

When things have gone wrong, you must try to establish and to maintain a relationship of trust with your patient. Rarely, this relationship will break down to the point that you should cease to be the patient's GP, in both your and his or her interests. When this has happened, you should explain to the patient why you feel he or she should seek help elsewhere. You should be able to justify your decision if asked to do so. You should look after him or her until another GP is ready to take over care and then you should hand over the complete and up to date records promptly.

When you are deciding how to handle a mistake, you should think about how serious it was, whether it could have been avoided, whether it could be put right for this patient, how it could be prevented in future, and whether you or the practice need to change to prevent it happening again. Discussing mistakes frankly within the practice team is always helpful. You should support colleagues who have made mistakes; this includes acknowledging that a mistake has occurred and helping the person to find the best way forward both for the patient and your colleague.

The excellent GP

- contacts the patient soon after it is apparent that a mistake has occurred;
- apologises for himself or herself or for the practice staff;
- tells the patient what has happened and how it can be put right;
- co-operates with any investigation arising from a complaint;
- tries to maintain a relationship with the patient or family when a mistake has occurred.

The unacceptable GP

- does not acknowledge or attempt to rectify any mistakes that occur;
- does not make appropriate apologies;
- has no procedure for dealing with complaints;
- hinders or obstructs a complaint or investigation;
- allows a complaint to influence his or her care of the patient adversely;
- removes a patient from the practice list solely because a complaint has been made or is likely.

Additional observations relating to doctors working in prison:

In the event of something going wrong the Prison Service has its own procedures but it would be good practice for doctors to undertake their own significant event audits with the aim of learning from the experience and sharing good practice with colleagues.

Working with colleagues

11. Working with colleagues and working in teams

Healthcare is increasingly provided by multi-disciplinary teams. Working in a team does not change your personal accountability for your professional conduct and the care you provide.

When working in a team, you must:

- *Respect the skills and contributions of your colleagues.*
- *Maintain professional relationships with patients.*
- *Communicate effectively with colleagues within and outside the team.*
- *Make sure that your patients and colleagues understand your professional status and speciality, your role and responsibilities in the team and who is responsible for each aspect of patients' care.*
- *Participate in regular reviews and audit of the standards and performance of the team, taking steps to remedy any deficiencies.*
- *Be willing to deal openly and supportively with problems in the performance, conduct or health of team members.*

If you lead a team, you must ensure that:

- *Medical team members meet the standards of conduct and care set in this guidance.*
- *Any problems that might prevent colleagues from other professions from following guidance from their own regulatory bodies are brought to your attention and addressed.*
- *All team members understand their personal and collective responsibility for the safety of patients, and for openly and honestly recording and discussing problems.*
- *Each patient's care is properly co-ordinated and managed and that patients know who to contact if they have questions or concerns.*
- *Arrangements are in place to provide cover at all times.*
- *Regular reviews and audit of the standards and performance of the team are undertaken and any deficiencies are addressed.*
- *Systems are in place for dealing supportively with problems in the performance, conduct or health of team members.*

Delegation involves asking a nurse, doctor, medical student or other health care worker to provide treatment or care on your behalf. When you delegate care or treatment you must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved. You must always pass on enough information about the patient and the treatment needed. You will still be responsible for the overall management of the patient.

You should ensure that patients are informed about how information is shared within teams and between those who will be providing their care. If a patient objects to such disclosures you should explain the benefits to their own care of information being shared, but you must not disclose information if a patient maintains such objections. For further advice see the GMC guidance Confidentiality: Protecting and Providing Information[12].

12 Confidentiality: protecting and providing information. GMC. 2000. Available at www.gmc-uk.org

You must always treat your colleagues fairly. In accordance with the law, you must not discriminate against colleagues, including those applying for posts, on grounds of their sex, race or disability. And you must not allow your views of colleagues' lifestyle, culture, beliefs, colour, gender, sexuality, or age to prejudice your professional relationship with them.

You must not undermine patients' trust in the care or treatment they receive, or in the judgement of those treating them, by making malicious or unfounded criticisms of colleagues.

Further advice on working in teams is provided in The GMC's booklets Maintaining Good Medical Practice and Management in Health Care – the Role of doctors[13].

GMC Good Medical Practice, paragraphs 36, 37, 46, 43, 34, 35, 38

All GPs work in teams. These exist within the practice (the practice team), and there is also the wider primary care team which includes attached staff. Within your own practice, you will often be the employer and will have a leadership role. As primary care teams expand, you will increasingly need to have ways of working effectively with colleagues who come from other teams.

Patient care is enhanced when there is good team working, so you should monitor and, where necessary, try to improve the way in which your practice team functions. When relationships within the team break down, patient care usually suffers. Therefore ensuring good communication within your team is an important part of being a good GP. Primary care teams contain a wide diversity of individuals, each of whom contributes to the work and achievements of the team. Each has the right to be valued and treated fairly. There can be no place for any form of discrimination within the working of the team. You have a responsibility to treat your colleagues fairly, and not to harass or bully them.

Good team-working includes respecting colleagues both personally and professionally. It cannot take place unless you know about the abilities of the staff with whom you work, and have established channels of communication. You should ensure that these channels exist among your own staff, and try to establish satisfactory channels of communication with staff outside the practice. Your role in giving support, guidance, inspiration, and confidence to colleagues is a key part of developing a successful practice team.

Most GPs are employers or have responsibilities to manage staff. This gives you legal as well as leadership responsibilities. You must ensure that people you employ or manage are competent and trained for their jobs. Your responsibility for training means having some way of finding out what their training needs are, and arranging to meet those needs, provided adequate resources are available. A stand-in or locum GP also needs to be aware of the identity and role of other team members; it is the responsibility of principals to ensure good communication with locum doctors they employ and that relevant information is available to that locum in an easily accessible format.

As primary care teams become larger, care is increasingly delegated to other health professionals. It is your responsibility to ensure that the person to whom you are delegating has the ability to provide the care required. Patients have a right to expect a high standard of care, whichever member of the team they see. Increasingly, patients may go directly to other team members. For example, practice nurses may provide ongoing care for patients with asthma with only occasional discussions with the GP. In cases where a member of your staff is the first point of contact for patients, it is particularly important to ensure he or she has the training to provide the necessary care, and knows the limits of his or her competence.

13 Available at www.gmc-uk.org For Management in healthcare, see under 'More about standards of practice' and Teamwork in Medicine on the same website.

Sometimes the boundary between delegation and referral is blurred. Where delegation or referral is to a health professional with his or her own statutory regulatory authority or line management (e.g. clinical psychologist or community psychiatric nurse), then you are not responsible for care provided by that professional. However, even in these circumstances you retain overall responsibility for the patient's care if, for example, a patient's problem becomes more urgent while they are waiting for treatment.

Practice teams have an increasing responsibility to work collaboratively with other agencies; for example, social services and voluntary agencies. Good working relationships with other agencies will enhance the care you can give to your patients. Sometimes, primary care teams outside your practice are dysfunctional because of lack of resources or a stable workforce. You cannot be held responsible for this, but you can still make sure that you maintain the best contact possible between yourself, your practice team and those members of the wider primary care team with whom you need to have a working professional relationship.

Patients may need to know who is responsible for what, and whom they should talk to if there is a problem. This can be made clear in the practice leaflet.

The excellent GP

- has effective systems for communication within the practice;
- holds regular meetings with members of the practice team;
- knows how to contact individual primary care team members outside meetings;
- understands the health needs of the local population, and tries to ensure that the primary care team has the skills to meet those needs;
- aims to develop an organisation which offers personal and professional development opportunities to its staff.

The unacceptable GP

- does not attempt to meet members of the primary care team (e.g. district nurses or health visitors), or even know who they are;
- does not know how to contact primary care team members;
- does not know what skills team members have;
- delegates tasks to other members of the team for which they do not have appropriate skills;
- does not encourage staff to develop new skills and responsibilities;
- bullies or harasses his or her colleagues.

Additional observations relating to doctors working in prison:

All doctors work in teams. In the prison service, the doctor must be aware of the roles and responsibilities of colleagues and must strive to protect confidentiality.

Doctors working in prison should be aware of the important role they have to play as part of the wider health care teams that reach across the NHS/Prison Service boundary. The development of good working relationships between members of this wider health care team can lead to better patient care.

12. Referring patients

It is in patients' best interests for one doctor, usually a general practitioner, to be fully informed about, and responsible for maintaining continuity of, a patient's medical care.

When you refer a patient, you should provide all relevant information about the patient's history and current condition.

If you provide treatment or advice for a patient, but are not the patient's general practitioner, you should tell the general practitioner the results of the investigations, the treatment provided and any other information necessary for the continuing care of the patient, unless the patient objects. If the patient has not been referred to you by a general practitioner, you should inform the general practitioner before starting treatment, except in emergencies or when it is impracticable to do so. If you do not tell the patient's general practitioner, before or after providing treatment, you will be responsible for providing or arranging all necessary after care until another doctor agrees to take over.

Referral involves transferring some or all of the responsibility for the patient's care, usually temporarily and for a particular purpose, such as additional investigation, care or treatment, which falls outside your competence. Usually you will refer patients to another registered medical practitioner. If this is not the case, you must be satisfied that any health care professional to whom you refer a patient is accountable to a statutory regulatory body, and that a registered medical practitioner, usually a general practitioner, retains overall responsibility for the management of the patient.

GMC Good Medical Practice, paragraphs 42, 44, 45, 47

One of the strengths of general practice in the UK is the ability of GPs to provide the majority of care for patients, and to be responsible for their ongoing care when care is being shared with specialists. You need to know your strengths and limitations; these vary quite widely between individual GPs. So this subsection is partly about knowing the limits of your own competence.

Patients need to trust that you will refer them for a specialist opinion when it is necessary. In general, you should respect a patient's request for referral for a second opinion, although there may be circumstances in which you judge it not to be in the patient's best interests to be referred.

Communication is a key part of referral to a specialist or to another health professional, and can be poor (in both directions). If you supply inadequate information, then the other health professional may provide inappropriate treatment to the patient or, at the very least, waste valuable time. It is important to make clear in a referral what you hope a hospital specialist will do. GPs have sometimes felt it inappropriate to state this in the past, but hospital specialists are very clear that they want to know what you expect from a referral, including what continuing role you expect the specialist to take in the ongoing care of your patient. Likewise, it may be appropriate for you tactfully to feed back to a specialist if you feel that the outcome of a referral has not been the best for your patient.

Specialists and GPs with special interests should only accept patients with a referral from the general practitioner or another appropriate health care worker. Exceptions to this include accident and emergency, genito-urinary medicine, and contraception and abortion services. Similarly, occupational health physicians and police surgeons may see patients without a referral. In general, if you are referring on a patient whom you know is registered with another GP, for example, if you are a private doctor, you should inform the patient's GP unless the patient objects. There may, however, be some circumstances (e.g. police surgeons referring for urgent hospital care) where this is impracticable.

Sometimes, the patient may not wish information to be given to his or her general practitioner. You also need to be aware of sensitive information that the patient may not wish to be sent to other health care professionals. If in doubt, you should seek the patient's consent before giving sensitive information to another health professional.

The excellent GP

- provides, within his or her team, the types of care usually provided by GPs;
- makes appropriate judgements about patients who need referral;l
- chooses specialists to meet the needs of individual patients;
- accompanies referrals with the information needed by the specialist to make an appropriate and efficient evaluation of the patient's problem;
- where appropriate, feeds back to specialists views on the quality of their care.

The unacceptable GP

- does not refer patients when specialist care is necessary;
- consistently dismisses patients' requests for a second opinion;
- consistently refers patients for care which would normally be regarded as part of general practice;
- does not provide information in a referral that enables the specialist to give appropriate care.

Additional observations relating to doctors working in prison:

Good Medical Practice **says that: "it is in patients' best interests for one doctor, usually a general practitioner, to be fully informed about, and responsible for maintaining continuity of, a patient's medical care". The situation in prison is complex. For a very short-term prisoner their normal general practitioner can continue in this role. For long-term prisoners, the doctor working in prison will take on this role. Movement of prisoners from prison to prison complicates the picture. However, within the constraints of prison life, the doctor working as a clinical generalist should ensure that continuity and advocacy are maintained as far as is possible.**

In considering what treatment is required a doctor working in prison should be fully aware of the opportunities for referral to services that are available within the prison, such as drug education programmes and Counselling, Assessment, Referral, Advice and Treatment Services (CARATS).

As already mentioned, prisoners often experience special difficulties in attending out-patient appointments. The doctor working in a prison should facilitate, monitor and be an advocate for appropriate access to continuing secondary care for prisoners.

13. Accepting posts

You must take up any post, including a locum post, you have formally accepted unless the employer has adequate time to make other arrangements.

GMC Good Medical Practice, paragraph 41

General practitioners understand more than most doctors the importance of continuity of care and of access to primary care services for all patients. Once you have accepted a post, you must not compromise services to patients by withdrawing until alternative arrangements can be made. Likewise, if you engage someone's services, you should not subsequently unilaterally cancel the arrangement without appropriate notice.

The excellent GP

- provides the care that he or she has agreed to provide.

The unacceptable GP

- holds no personal responsibility for care that he or she has agreed to provide.

No additional observations relating to doctors working in prison.

Teaching and training, assessment and appraisal

14. Teaching and training, assessment and appraisal

You should be willing to contribute to the education of students or colleagues.

If you have responsibilities for teaching you must develop the skills, attitudes and practices of a competent teacher. You must also make sure that students and junior colleagues are properly supervised.

You must be honest and objective when appraising or assessing the performance of any doctor including those you have supervised or trained. Patients may be put at risk if you describe as competent someone who has not reached or maintained a satisfactory standard of practice.

GMC Good Medical Practice, paragraphs 13, 15, 16

Teaching students and young doctors is an important professional activity. The GMC encourages doctors to be involved in teaching, either by organising and carrying it out or by supporting teaching by others in your practice. However, if you have responsibilities for teaching, you need to ensure that you have appropriate teaching skills and that you continue to develop them.

As a teacher, you are in a position to inspire your students through personal example. The attributes of a good teacher include delivering high-quality care. Developing an environment where your practice team is involved in teaching will create an environment where excellence in clinical care can flourish.

However, if you have special responsibility for teaching you must also ensure that patient care is protected. The degree of supervision you exercise over a learner will depend on his or her experience and skills. Students or doctors in training must not be expected to see patients alone until you are satisfied that they have the appropriate skills, as well as access to advice, support, and supervision.

When teaching, you need to ensure that the appropriate facilities are available. Where the teaching commitment involves significant attendance in the practice (e.g. in vocational training), these facilities will include access to sources of information; for example, a well-equipped library and electronic access to other sources of information, and video and/or audio recording equipment. Directors of Postgraduate General Practice Education and university departments will let you know what they expect of their postgraduate and undergraduate teachers. This will include protected time for teaching.

You should tell patients if there is an observer (student or doctor in training) in their consultation, and give them an open opportunity to refuse consent before and during the consultation. Patients consulting with a GP registrar or other registered doctor in training should be informed of the doctor's training status (e.g. through practice leaflets or relevant notices), and have the opportunity to see a fully trained practitioner at an appropriate time if they ask.

Formative assessment of students and doctors in training is an important part of a teacher's role. You should share serious problems identified through formative assessment with the educational organiser and the learner. You should also assist where requested in formative and summative assessment of students and doctors in training. Such assessments must be conducted fairly and accurately. They must honestly reflect that person's performance as you see it.

The GMC gives further guidance on teaching in its booklet 'The Doctor as a Teacher'.[14]

The excellent GP

- has a personal commitment to teaching and learning;
- shows a willingness to develop both him or herself and other doctors or students, through education, audit, and peer review;
- ensures that patients are not put at risk when seeing students or doctors in training;
- understands the principles and theory of education, and uses teaching methods appropriate to the educational objectives;
- uses formative assessment and constructs educational plans;
- assists in making honest assessments of learners.

The unacceptable GP

- puts patients at risk by allowing the learner to practise beyond the limits of his or her competence;
- does not take teaching responsibilities seriously;
- offers no personal and educational support to the learner, and does not have appropriate teaching skills;
- uses inappropriate teaching methods and does not use formative assessment to identify learning needs;
- makes biased or prejudiced judgements when assessing learners;
- fails to take appropriate action when the performance of a learner is inadequate.

Additional observations relating to doctors working in prison:

In the prison setting special care should be taken to ensure the safety of students and learners. As in other settings, teachers should have and should maintain appropriate teaching skills, including how to maintain safe teaching environments.

The rights of patients to choose whether to be seen by a student or learner extend to prisoners. Their informed consent should be sought.

Many doctors working in prisons currently experience managerial appraisal. This managerial appraisal will continue, but should not be confused with formative, educational, professional appraisal that should be undertaken by another medical practitioner. Doctors should support and actively participate in such clinical appraisal.

14 *The Doctor as a Teacher* available at www.gmc-uk.org

Probity

15. Research

If you participate in research you must put the care and safety of patients first. You must ensure that approval has been obtained for research from an independent research ethics committee and that patients have given consent. You must conduct all research with honesty and integrity.

More detailed advice on the ethical responsibilities of doctors working in research is published in our booklet Good Practice in Medical Research – The Role of Doctors[15].

GMC Good Medical Practice, paragraph 52

Many activities which extend the foundation of knowledge on which the discipline of general practice is based may be viewed as research. However, as a GP, you may also take part in more formal research, either as a collaborator or an investigator. These roles carry obligations and responsibilities.

When you collaborate in research for others, you should be satisfied that the research has been approved by a research ethics committee, and that you will not compromise the care of your patients by taking part in the study. If you are doing research for others, the financial rewards involved should be an appropriate reimbursement of your time and resources, and not an excessive influence on your or your practice's agreement to collaborate in the research. You may accept only those payments which have been approved by a research ethics committee. Particular care should be taken when participating in research conducted by commercial companies.

The consent form and patient information leaflet you are asked to use should set out the purpose of the research, what it entails, and what the patient is agreeing to. Risks and potential benefits should be explained. Patients must be clearly informed that participation is voluntary, that they have the right to withdraw from the study at any time, and that withdrawal will not prejudice their continuing medical care. Adequate time should be allowed for patients to decide whether they do or do not wish to participate in the study.

Where research involves adults who are not able to make decisions for themselves or children, further advice on the research methods and ethical decisions may be needed. Such research should only be undertaken after careful reflection and consultation.

You need to be particularly careful about patient confidentiality. Normally patient consent is required for researchers to have access to medical records. In exceptional circumstances where this is not the case, it needs to be clear that the research method has the approval of the ethics committee and complies with current law, which may change as a result of current legal debate.

15 Further advice is provided in *Medical Research: the roles and responsibilities of doctors*. Available at www.gmc-uk.org

Once you have agreed to take part in a study, you should make reasonable attempts to comply fully with the agreed research protocol. You must be sure that the data being gathered for the research are, as far as possible, accurate and complete. Falsifying research data is regarded as a serious disciplinary issue by the GMC. If you suspect fraud or misconduct, you must communicate with a responsible person in the researcher's institution or the chairman of your local ethics committee.

Authorship of the research must not be unreasonably requested or offered. It is not normal for a GP to be offered authorship if he or she is helping to recruit patients and collect data, but has no role as investigator. However, acknowledgement is often appropriate.

Sometimes, you may carry out your own research. This carries additional obligations and responsibilities.

If you are a GP investigator, you must ensure that you and your co-researchers have the resources, knowledge, and skills to carry out the research effectively. It is unethical to involve patients in research which is unlikely to answer the research question.

If you carry out research from your practice base, it is useful to have a research group with whom you can consult and share ideas. This group can help to ensure that the protocol is of a high standard and that appropriate ethics committee approval has been sought. You will usually find it valuable to seek expert advice at points during both the design and execution phase of your study.

The excellent GP

- ensures that research carried out in his or her practice is done to a high standard;
- protects patients' rights, and makes sure that they are not disadvantaged by taking part in research;
- provides accurate data;
- preserves patients' confidentiality.

The unacceptable GP

- ignores his or her responsibility to protect patients during research studies;
- does not obtain consent from patients before entering them in research studies;
- provides inaccurate or false data;
- is motivated primarily by personal gain when deciding whether to take part in research;
- requests payments for participating in research which have not been approved by a research ethics committee;

Additional observations relating to doctors working in prison:

Special care should be exercised when involving prisoners in research. Not only should the usual requirements for voluntary, fully informed consent be met, but any pressure, even if perceived rather than real, should be avoided. Where the doctor working in prison believes there to be any possibility that the prisoner could perceive that taking part in research might help with future assessments, for example for parole, or that the prisoner could perceive that failure to take part might lead to future withdrawal of care or any other sanctions then the prisoner should not be entered into a research study and those perceptions addressed with the relevant prison authorities.

16. Financial and commercial dealings

You must be honest and open in any financial arrangements with patients. In particular:

- *You should provide information about fees and charges before obtaining patients' consent to treatment, wherever possible.*
- *You must not exploit patients' vulnerability or lack of medical knowledge when making charges for treatment or services.*
- *You must not encourage your patients to give or lend or bequeath money or gifts which will directly or indirectly benefit you. You must not put pressure on patients or their families to make donations to other people or organisations*
- *You must not put pressure on patients to accept private treatment.*
- *If you charge fees, you must tell patients if any part of the fee goes to another doctor.*

You must be honest in financial and commercial dealings with employers, insurers and other organisations or individuals. In particular:

- *If you manage finances, you must make sure that the funds are used for the purpose for which they were intended and are kept in a separate account from your personal finances.*
- *Before taking part in discussions about buying goods or services, you must declare any relevant financial or commercial interest which you or your family might have in the purchase.*

Conflicts of interest

You must act in your patient' best interests when making referrals and providing or arranging treatment or care. So you must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect your judgement. You should not offer such inducements to colleagues.

Financial interests in hospitals, nursing homes and other medical organisations

If you have financial or commercial interests in organisations providing health care or in pharmaceutical or other biomedical companies, these must not affect the way you prescribe for, treat or refer patients.

If you have a financial or commercial interest in an organisation to which you plan to refer a patient for treatment or investigation, you must tell the patient about your interest. When treating NHS patients you must also tell the health care purchaser.

Treating patients in an institution in which you or members of your immediate family have a financial or commercial interest may lead to serious conflicts of interest. If you do so, your patients and anyone funding their treatment must be made aware of the financial interest. In addition, if you offer specialist services, you must not accept patients unless they have been referred by another doctor who will have overall responsibility for managing the patient's care. If you are a general practitioner with a financial interest in a residential or nursing home, it is inadvisable to provide primary care services for patients in that home, unless the patient asks you to do so or there are no alternatives. If you do this, you must be prepared to justify your decision

GMC Good Medical Practice, paragraphs 53–58

These paragraphs in *Good Medical Practice* outline in some detail what is required of doctors. Most GPs are independent contractors and operate small businesses. They are sometimes at greater risk than other doctors of straying into areas where their personal interests may conflict with their professional ones. Your professional standards must therefore be and be seen to be honest in all financial matters.

Examples of unprofessional conduct in financial and commercial dealings include:

- accepting a fee from a specialist or clinic for a referral without informing the patient;
- abuse of funds provided for practice expenses or patient treatment;
- defrauding the NHS or any organisation you work for; and
- exerting pressure on patients to enter a nursing home which you own.

Your decisions about the treatment of patients must always be based on their best interests. Financial inducements, gifts, or hospitality must not colour those decisions. Avoiding a conflict of interest is particularly important where you (or your close relatives) have an interest in treatment facilities such as nursing or care homes for the elderly or in commercial companies with an interest in pharmaceuticals or related products. You must arrange your affairs so that there can be no suspicion of such impropriety.

Accepting gifts and lavish hospitality is an area of danger. You should not accept gifts other than trivial ones and you must never demand fees to see sales representatives. Drug company sponsorship of educational events is acceptable, but the level of that sponsorship should not be capable of misinterpretation.

If you dispense drugs to your patients, you should not accept inducements that might influence your prescribing.

As a GP you are frequently asked to sign or countersign forms and certificates. Even though they are often considered a chore, you must always fill these in or append your signature with care, and verify the information they contain.

You must carry out your practice in an atmosphere of professionalism that is beyond reproach and incapable of misinterpretation by any outside audit or scrutiny. Where you encounter areas of doubt you should consult colleagues with knowledge and experience, or a medical defence organisation.

The excellent GP

- is an example of financial probity in society;
- ensures that his or her financial affairs are capable of withstanding searching outside audit;
- never seeks inappropriate personal gain in the pursuit of practice;
- provides truthful and honest information on certificates and other documents.

The unacceptable GP

- seeks personal financial gain from his or her patients other than the normal remuneration expected from his or her job;
- carelessly attaches his or her name to documents or certificates;
- knowingly provides false information on such documents.

Additional observations relating to doctors working in prison:

The doctor working in prison needs to be clear on contractual issues, informed consent and the requirements of probity before agreeing to provide a report on a prisoner, whether money is involved or not.

17. Providing references

You must provide only honest and justifiable comments when giving references for, or writing reports about, colleagues. When providing references you must include all relevant information which has any bearing on your colleague's competence, performance, and conduct.

GMC Good Medical Practice, paragraph 14

GPs usually work within partnerships and come to know their colleagues well. If asked to provide a reference, you may be in a uniquely privileged position to pass on information when colleagues and members of your staff apply for new positions as either partners or employees.

Just as you expect to receive honest information about a doctor that you intend taking on as a partner or members of staff you are considering employing, you should give full and honest information on those who leave. When a partnership has not been easy, you must resist the temptation to give a glowing reference through misplaced loyalty to a colleague or in order to facilitate the end of an unhappy relationship. Likewise, when you have had a difficult personal relationship with a partner or member of staff, you must try to be objective about their abilities.

References that do not fulfil these criteria damage professional credibility and may put future patients at risk either from a doctor's poor performance or from dysfunction in a new place of work. Changes to the Data Protection Act now mean that people have a legal right to see references which you have written about them.

The excellent GP

- takes care with references, bearing in mind his or her responsibility to future partners or employers and, most importantly, to a doctor's future patients;
- is honest and objective in comments made in references, and does not miss out important information.

The unacceptable GP

- gives dishonest, untrue, or biased references;
- omits important information from references;
- includes comments in references (favourable or unfavourable) which are based largely on personal prejudice.

No additional observations relating to doctors working in prison.

Health and the performance of other doctors

18. Protecting patients when your own health or the health, conduct, or performance of other doctors puts patients at risk

You must protect patients from risk of harm posed by another doctor's, or other health care professional's, conduct, performance or health, including problems arising from alcohol or other substance abuse. The safety of patients must come first at all times. Where there are serious concerns about a colleague's performance, health or conduct, it is essential that steps are taken without delay to investigate the concerns to establish whether they are well-founded, and to protect patients.

If you have grounds to believe that a doctor or other healthcare professional may be putting patients at risk, you must give an honest explanation of your concerns to an appropriate person from the employing authority, such as the medical director, nursing director or chief executive, or the director of public health, or an officer of your local medical committee, following any procedures set by the employer. If there are no appropriate local systems, or local systems cannot resolve the problem, and you remain concerned about the safety of patients, you should inform the relevant regulatory body. If you are not sure what to do, discuss your concerns with an impartial colleague or contact your defence body, a professional organisation or the GMC for advice.

If you have management responsibilities you should ensure that mechanisms are in place through which colleagues can raise concerns about risks to patients. Further guidance is provided in our booklet Management in Health Care: The Role of Doctors[16].

If you know that you have a serious condition which you could pass on to patients, or that your judgement or performance could be significantly affected by a condition or illness, or its treatment, you must take and follow advice from a consultant in occupational health or another suitably qualified colleague on whether, and in what ways, you should modify your practice. Do not rely on your own assessment of the risk to patients.

If you think you have a serious condition which you could pass on to patients, you must have all the necessary tests and act on the advice given to you by a suitably qualified colleague about necessary treatment and/or modifications to your clinical practice.

GMC Good Medical Practice, paragraphs 26–28, 59, 60

Protecting patients is not simply important, it is one of the prime directives of medicine. Patients have a right to compassionate, competent, and safe treatment from doctors. The safety of patients must therefore come first at all times.

You have a responsibility to do something if patients are being put at risk through poor performance or because the doctor is ill. This applies both to your own care, and to that of other doctors. You must seek advice if you think your own health may be putting patients at risk. Equally, if you are concerned about another doctor, you need to take some action. It used to be regarded as unprofessional to 'tell' on a colleague. You now risk an allegation of misconduct if you know a doctor is unsafe and you do nothing about it. There are now local procedures for dealing both with minor problems that can be simply resolved at local level and with more serious problems that may need to be referred to the GMC.

16 *Management in Health Care: The Role of Doctors* see under 'More about standards of practice' at www.gmc-uk.org

Ill heath can lead to patient risk, either from the condition itself or by its effect on the performance of the individual concerned – for example, dependence on alcohol or drugs seriously limits a doctor's ability to function effectively. Over-stressed or 'burnt-out' doctors often feel pressurised into continuing at work, and may need help from others to recognise that there is a problem.

If you are in doubt, take advice. Sometimes this will be from one of your partners. Outside the practice, you can talk to your Local Medical Committee chairman or secretary, or to your defence society. Health authorities and boards also now have panels to address poor performance by GPs – you could speak to the chairman of your local panel. If you are concerned about a hospital colleague, you can talk to the medical director of the NHS trust, and GMC staff are always happy to give confidential advice to doctors who are concerned about themselves or a colleague.

If an issue is too serious for local action, you should have no hesitation in referring the matter to the GMC. However, when you have done this, you have a duty to provide further information which may be requested to enable the GMC to conduct their enquiries. The GMC will take no action under any of its fitness to practise procedures until the matter has been considered fully by experienced medically qualified members.

The excellent GP

- is aware when a colleague's performance, conduct, or health might be putting patients at risk;
- quickly, and discreetly, ascertains the facts of the case, takes advice from colleagues, and, if appropriate, refers the colleague for medical advice or local remedial action;
- provides positive support to colleagues who have made mistakes or whose performance gives cause for concern;
- realises when his or her own performance is unsafe, e.g. through illness;
- seeks advice from a suitable colleague and follows that advice, taking any action required to reduce patient risk.

The unacceptable GP

- ignores his or her own or a colleague's unsafe behaviour;
- takes no advice, nor offers any to the colleague concerned;
- denies or actively conceals his or her own ill health.

Additional observations relating to doctors working in prison:

Good Medical Practice for General Practitioners **says that: "The safety of patients must therefore come first at all times". While this is clearly true, there is also an imperative to ensure the safety of doctors as well as others who work in the prison setting. A risk assessment, with adoption of safe practices, is necessary to ensure a safe environment for consultation.**

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This document is also available on our website:
www.doh.gov.uk/prisonhealth

CHLORINE FREE PAPER