

○ Setting Standards

**THE VIEWS OF MEMBERS OF THE PUBLIC AND
DOCTORS ON THE STANDARDS OF CARE AND
PRACTICE THEY EXPECT OF DOCTORS**

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1 Executive Summary

1.1 Background

1. *Good Medical Practice* (GMP) presents the General Medical Council's (GMC) ethical guidance to doctors, which they are obliged to follow. First published in 1995, the latest version is currently under review to ensure that it is appropriate to the circumstances under which medical care is given and received today.

1.2 Study aims

2. The overall aim of the research was to assist the Standards and Ethics Committee of the GMC in its review of *Good Medical Practice* by obtaining the views of patients and the public as well as the profession itself.

3. Specifically, the study looked at: what are the key duties of a doctor for inclusion in *Good Medical Practice*; the balance between the roles of patients, doctors and other health professionals; the balance between clinical and organisational duties; and whether or not it is reasonable to expect doctors to adhere to all duties all the time.

4. A fifth theme to emerge through the fieldwork concerned the extent to which wider contextual issues are relevant to GMP.

1.3 Method

5. The study used qualitative methods in order to explore in depth participants' views of good medical practice and to assess and understand in their complexity the perspectives of members of the public and doctors on some key issues for *Good Medical Practice*.

6. Data collection from doctors and the public took place in three different geographical areas: a London borough, Oxford and Yorkshire. Research ethics committee approval was obtained for interviews with fourteen doctors (both GPs and hospital doctors) and a focus group with medical students.

7. A total of 85 members of the public took part in focus groups. They were recruited to reflect a cross-section of the public in terms of age, sex, and socio-economic status.

8. Twenty-three people were interviewed from harder to reach communities via a residential home for older people, two community groups, and a hostel for homeless people.

9. All interviews were transcribed and analysed using QSR NVIVO 2.0 software. Results of a card sort exercise for members of the public were analysed using SPSS.

1.4 Findings

10. There was a broad range of views about what constitutes good medical practice among members of the public, doctors and medical students. This reflects the variety of contexts and situations in which medical practitioners operate.
11. There was a general consensus that the majority of the 'duties of a doctor' in the new version of *Good Medical Practice* are important and should be included in the document.
12. Providing a good standard of practice and care, and technical competence, maintained by keeping professional skills and knowledge up to date, were clearly perceived as fundamental to good practice by both the public and doctors.
13. Listening and good communication skills were widely seen not only as a useful means to improve the patient experience, but also as assisting diagnosis and patient concordance, enabling medical professionals thoroughly to investigate symptoms and their causes.
14. The term 'partnership' was seen as ambiguous by research participants, ranging from a style of interaction to shared decision-making. There is no clear consensus about the extent to which patients' views should prevail over those of the doctor. Where patients' and doctors' views diverge, this is seen as a difficult area which puts the concept of partnership to the test.
15. While honesty and trustworthiness within the doctor-patient relationship are perceived as important by the public, most people no longer appear to expect doctors to demonstrate moral excellence in all aspects of their lives, and it is widely recognised that they are 'only human'. Some doctors also felt that expectations of probity, as set out in the draft document, are no longer appropriate.
16. Confidentiality is seen as a necessary adjunct to the development of trust between doctor and patient. Members of the public tend to assume that confidentiality will be maintained by doctors although there are some grey areas where other family members may want to be informed. Lay people appear willing for information to be shared where clinically necessary and with their consent.
17. Both public and doctors perceived obstacles to doctors reporting concerns about practice or conduct, but for different reasons. While lay people were sceptical about doctors' capacity to recognise their own limitations and their willingness to report their own or others' shortcomings, doctors focused on the difficulty of obtaining satisfactory evidence and doubts about the support available to whistle-blowers.
18. Discussions with medical students revealed the value of providing opportunities for them to explore the concept of good medical practice and the potential tensions which might arise in complex, real life situations.
19. The study revealed the significance of the social and organisational contexts in which healthcare is provided for people's understanding and expectations of good medical practice. Availability, accessibility and continuity of care were frequently perceived as important elements of good medical practice, although they are usually outwith doctors' control.
20. There is very limited knowledge of the guidance and its contents amongst the general public. While doctors and medical students were familiar with the document, they had used it only to a limited extent.

21. The research highlights the challenge of writing such guidance given the diversity and complexity of views among the public and doctors. The findings illustrate the important role of judgement in resolving some of the tensions inherent in good medical practice between the needs of the individual patient and the wider population.

1.5 Recommendations

A number of recommendations emerged from the findings:

22. Ensure that the revised guidance when published is made available not only to the medical profession and medical students but also to the general public.

23. Review the opportunities for medical students to discuss the application of the principles of *Good Medical Practice* to complex real life situations, and the tensions these may raise.

24. Consider the omission of 'respect for human rights' from the duties of a doctor.

25. Clarify the definition of 'partnership'.

26. Reconsider which aspects of 'probity' are included in *Good Medical Practice* and ensure that they are written in plain English.

27. Promote further research into the factors which ease or impede working to the standards of GMP.

28. Encourage further debate about the practical implications of some of the standards, such as giving patients information about risks and uncertainties, or about who may have access to information about patients.

2 Introduction

2.1 Background: *Good Medical Practice*

Codes and guidance inform members of a professional organisation about how they should behave in their professional capacity. Their function is to set out the standards of knowledge, competence or moral conduct expected of members registered with that organisation. Guidance may be developed for various purposes: to demonstrate to the outside world that the group constitutes a profession; to show others – including potential clients – that the group can be trusted; to improve its public image; to inform aspirant members of the way in which they will be expected to behave if they join the group; or to make clear to members the type of conduct expected of them.

The number of bodies issuing guidance and codes for doctors has proliferated rapidly in recent years, perhaps because of growing numbers of members, the more complex environment in which medicine is practised, including an increasingly litigious society, a need to justify their position, to control their members and to show how they can be held to account.

The type of duties or standards included in codes and guidance for doctors often seem like common sense, but they contain inherent tensions and ambiguities. First is the tension between making standards sufficiently specific that they can be a guide to action in real situations and sufficiently general that they can apply to most – or all – members of the professional group. The second tension is between the complex and sometimes competing functions of doctors; for example, their duties towards individual patients and towards the wider community or society. The third lies in the changing and often complex or ambiguous relationship between doctors and either other health or care professionals, or patients. For example, being “patient-centred” means something different these days compared with twenty years ago, when it might have been happily represented as having your patients’ best interests at heart. Now it is widely seen to mean working with one’s patients in a more egalitarian fashion (Coulter, 2002). Compiling guidance documents, and regularly updating them, is therefore a challenging business.

Good Medical Practice (GMP) presents the GMC’s ethical guidance to doctors, which they are obliged to follow. It sets out the principles of good medical practice and the standards expected of all doctors registered in the United Kingdom. It represents guidance to doctors, rather than a strict code, since a single breach of its advice would not necessarily require a sanction. Its flexibility allows doctors to depart from the guidance provided they can justify this departure.

GMP is an important document with a number of uses: it guides not only individual doctors but also medical education as it informs undergraduate curricula; regulation in the form of NHS appraisal and, if it goes ahead, will underpin revalidation; and it serves as a benchmark in considering fitness to practise cases. It also forms the basis from which the Medical Royal Colleges have developed their own more specific, specialist guidance.

First produced in 1995, GMP was revised in 2001 and is in process of further review to ensure that it is appropriate to the circumstances under which medical care is given and received today. *Good Medical Practice* provides a hierarchically structured account whereby twenty-four "duties of a doctor" summarise good medical practice. The main body of the text sets out the standards and principles expected of doctors, and sits above six other core guidance booklets (e.g. seeking consent, confidentiality), supported by a further level of supplementary guidance (often in the form of frequently asked questions) which apply the principles to more specific situations. When looking for advice on a particular issue, the GMC would expect doctors to consider the relevant information at all these levels to inform their decision.

This report is based on qualitative research which explored views on the redrafted document which presents proposed changes to the 2001 version. Some sections of the report cover views of the twenty-four duties of a doctor, and others cover the full document. It forms part of the patient and public involvement strategy for the review which will feed into the revised draft of the guidance.

Good Medical Practice (GMP) is a complex document. In considering our brief and designing the research we found it useful to summarise and categorise its contents in order to identify our research priorities and plan the scope of the enquiry. Both the 'duties of a doctor' and the overlapping but very much more detailed 'standards' can be divided into six categories (see table 1).

Through this classification one can see that the qualities required for conformity to the standards are: clinical competence, probity, social competence, organisational and administrative competence.

Good Medical Practice is similar to other generic guidance for medical practice, for example the *Physician Charter* in the USA, and *CanMEDS Roles Framework* and *Four Principles of Family Medicine* in Canada, though it does not cover as explicitly some standards which can be found elsewhere. For example, some place more emphasis on the following responsibilities:

- To the healthcare system, the just distribution of resources and access to care
- To building and maintaining a relationship with families and/or communities, and understanding and treating patients holistically
- To promoting good health among individuals and/or communities.

These elements were included in our enquiry.

Table 1: Categories of duties and standards of *Good Medical Practice*

<p>To carry out the core clinical responsibilities of a doctor competently</p>	<p>Competently and appropriately assess, investigate, diagnose, give treatment, prescribe, listen to and inform patients, and alleviate any pain and suffering</p>
<p>To carry out clinical responsibilities in such a way as to accommodate the interests or preferences of patients</p>	<p>Act promptly when necessary, treating anyone who is your patient (or anyone else in an emergency), without prejudice or personal views colouring judgement. Respect patients' dignity and their rights to be informed, making sure that they understand and have consented to any treatment. Keep patient data confidential. Be polite, but do not use position to pursue closer personal relationships with patients or pressure them to use your services. Be open and honest about any financial aspects of care. Refer on to, or consult, colleagues when necessary, working competently in teams with colleagues and sharing information with them with patient's agreement. When delegating care, referring on or arranging cover, assure yourself of the competency of that care. If things go wrong, explain and apologise if appropriate. If you have a health problem which might affect patients seek advice and follow it.</p>
<p>To maintain fitness and ability to practise as a competent clinician</p>	<p>Keep knowledge and skills up-to-date, but recognise your limitations. Take part in appraisals and assessments and respond appropriately. Be fully insured. Do not accept inducements which affect your judgement and be open about your professional financial interests. Only publish information about your health care services which are factual and true.</p>
<p>To carry out statutory duties and duties to employing authorities</p>	<p>Report adverse drug reactions to monitoring authorities. Sign or write official documents as required. Make efficient and appropriate use of the resources available to you. Take part in audits or enquiries as requested. Adhere to legislation relevant to medical practice. Be willing to contribute to the education or assessment of others. Investigate, and if necessary report, any concerns you may have about colleagues. Take part in formal/legal enquiries when required.</p>
<p>To carry out duties to state or employers in appropriate ways</p>	<p>Keep clear records. Report it if your resources are inadequate to treat patients safely. Be honest and objective in assessing other staff. Help to ensure that mechanisms are in place for handling concerns about colleagues. Be honest in documents you write or sign. Be honourable to your employers when you are offered a job (such as taking up a post you have accepted).</p>
<p>To have good working relationships with colleagues</p>	<p>Treat colleagues fairly. Do not make malicious or unfounded criticisms of them. Work well with them in a team or when you share responsibilities.</p>

2.2 Research aims and objectives

Aim

The overall aim of this research was to assist the Standards and Ethics Committee (SEC) of the GMC in its review of *Good Medical Practice* (GMP) in ensuring that the next version is better informed by the views of patients and the public as well as the profession itself.

Objectives

The objectives of our investigation were to assess and understand in their complexity the perspectives of patients, members of the public and doctors on some key issues for GMP, including the duties and standards of practice and care they expect of doctors.

Specifically:

- What are the key 'duties of a doctor' which should be included in GMP?
- Is the balance in GMP between ends and means and between clinical and organisational responsibilities about right or not?
- Is the balance in GMP between the doctor's, the patient's and other health professionals' role about right or not?
- Can doctors be expected to adhere to all standards/duties all the time or not?

An additional question emerged from the fieldwork through an inductive approach the analysis of the transcribed interviews and focus groups:

- Are there any wider contextual issues of relevance to GMP?

The project obtained the views of a range of members of the public, including those who had and had not recently been patients, and groups which are harder to reach and whose views are seldom heard. We also assessed the views of a range of members of the medical profession, including hospital doctors and general practitioners, and of medical students.

2.3 Research questions and themes

We divided the issues described in the research brief into four research questions, to be operationalised into discussion topics for our research participants:

1. What are the key duties of a doctor which should be included in GMP?

For example, is the list of duties included in the current version of GMP about right or should some be omitted or others added? Which are the most important duties and what does that mean (for instance should some receive more attention than others during training or be stronger grounds for questioning fitness to practise in cases of non-adherence)? Are there any duties which may cause confusion or require clarification?

2. Is the balance in GMP between ends and means and between clinical and organisational responsibilities about right or not?

For example, if a doctor is clinically competent does it matter how he or she communicates with patients? Is listening and communicating actually part of the clinical role rather than just a means to an end? When – if ever – should responsibilities to the organisation, health care system or the patient population come before responsibilities to individual patients or to health care colleagues? When – if ever – should doctors break patient confidentiality? When should they report concerns about colleagues' competence or probity? If a doctor acts honourably does it ever matter, if for instance, s/he does not keep clear records?

3. Is the balance in GMP between the doctor's, the patient's and other health professionals' role in the production of health care about right or not?

For example, to what extent and in what circumstances should patients' views prevail over those of the doctor? Should the patient always have the final say about the choice of his/her treatment, place of care, etc? When – if ever – should doctors tell patients what they think is best for them? When is the doctor's role to lead or not to lead a team or to take final responsibility for decisions over other health professionals? And should GMP make these matters clearer?

4. Can doctors be expected to adhere to all standards/duties all the time or not?

For example, are there some circumstances when it would be unreasonable to expect doctors to be clinically, socially or administratively competent, and to act with probity? Should higher standards be expected of doctors than of other people? Do some of the duties or standards conflict with each other, and how should doctors deal with this? If work and non-work identities, roles or beliefs conflict, how should doctors deal with this (e.g. are doctors ever 'off duty')? Can patients trust doctors even if they do not adhere to all duties/standards all the time? How should doctors demonstrate that they are adhering to the duties/standards (e.g. clothing, demeanour, explicit testimony)?

A fifth additional theme emerged from analysis of the data:

5. Are there any wider issues of relevance to GMP?

For example, are there wider social or organisational factors which affect the ability of doctors to provide good medical practice? How aware are lay people of the existence of GMP?

3 Previous Research on standards of medical practice

3.1 The qualities of a good doctor

A good deal is written about the qualities a person must have to be a good doctor. Whilst the NHS Careers Service says, “*there is no single set of characteristics that makes a good doctor*” (NHS Careers, 2006), it goes on to mention the importance of: a concern for and interest in people, an enquiring and open mind, a rational approach, imagination, being willing to work hard, ability to handle pressure, patience and determination, decisiveness and humility. This is a mixed bag of qualities, but somehow they need to be blended. Patients also value a mixture of qualities involving both interpersonal relations and technical skill and, as Coulter (2002) writes, they want a doctor whom they can trust to be honest as well as supportive and reassuring. Although we know a good deal about what are considered to be the qualities of a ‘good’ doctor (Jung et al 1998, Corrado 2001, Judge & Solomon 1993, Carroll et al 1998), the views of patients and lay people specifically about the standards of conduct they expect of doctors has received little previous research attention.

3.2 Awareness of *Good Medical Practice*

These standards are clearly set out for UK doctors in *Good Medical Practice* (GMP). Most doctors are of course aware of GMP, whilst most lay people are not. For instance in a questionnaire study of a representative sample of UK doctors McManus, Gordon and Winder (2000) found high awareness of *Good Medical Practice*, with ninety percent of the sample saying that they had received a copy of it, although only 17% claimed to have read it ‘at least fairly carefully’. A repetition of the study two years later (McManus, Winder & Gordon, 2001) found that awareness remained extremely high, and that as many as 27% of doctors now claimed to have read GMP at least ‘fairly carefully’. The study also found broad agreement with the stated ‘duties of a doctor’, although on some items, particularly those to do with doctor-patient communication, there were very mixed views about whether failure to uphold them should be grounds for restriction of registration (see below). Few differences were found between older and younger doctors, hospital doctors and GPs, or UK and non-UK graduates.

3.3 Prioritising standards/duties

There is evidence that people see clinical competence, knowledge and technical expertise as crucially important in a doctor, but that they also rate highly standards concerning the relationship between doctor and patient and the moral stance of the doctor. Whether clinical competence is rated more highly than other standards depends on the

circumstances. For example, Hutchinson et al (1999) carried out a survey of directors of public health and complaints managers of all UK Health Authorities and boards, Local Medical Committee (LMC) secretaries, Community Health Council chief officers, and medical directors and complaints managers of a sample of NHS hospital trusts. Respondents were asked to consider whether the doctor's consultation skills (manner and attitude to the patient, and communication skills) were of as much significance as technical skills (prescribing, diagnosis, management and outcome) when considering how to act on a consistent and serious error in clinical practice. They found that problems relating to technical skills were consistently considered to be more serious than problems with communication, manner and attitude. There were some differences in emphasis: for example, LMC secretaries perceived problems with manner and attitude to be considerably less serious than did any of the other groups.

However, respondents also reported that problems with manner and attitude constituted the more frequent type of problem and the authors point out that complaints from patients often arise as a result of communication problems. They say *"It must be of concern that even senior NHS professionals hesitate to view consistent and serious errors in consultation skills as requiring local action, in contrast with their more definite notions about action in the face of technical problems."*

The frequency of communication problems in patients' negative experiences with doctors has also been found in other research. For example, in a recent MORI study most participants in a series of focus groups (Corrado et al, 2005) had had negative experiences with individual doctors, which often related to communication skills, recognised by both patients and doctors as being important. They included not being listened to, doctors not taking the time to talk to them, a lack of rapport, insensitivity and, in the case of older patients, being treated "like idiots." Key attributes looked for in a doctor (and whose presence helps foster a relationship of trust) were seen as the ability to listen, the ability to understand, the ability to discuss and the ability to offer continuity of care. Most doctors recognised the importance of these attributes and of having a relationship of trust with their patients. It was stressed by the doctors in the MORI study that technical skills and medical knowledge need to go hand in hand with good communication. However, there was a view that the emphasis on communication skills in training could be to the detriment of technical skills. Doctors also expressed the view that patients' perceptions of doctors were changing and that younger patients in particular were less trusting and more ready to question their judgement (Corrado et al, 2005).

Studies which are less context-specific are harder to interpret. For instance, Grol et al. (1999) carried out a cross-national survey of 3,540 patients to explore their priorities with respect to general practice care. Patients in all countries valued confidentiality of information, doctors telling them all they wanted to know about their illness and allowing them the freedom to talk about their problems. They also valued doctors offering preventive services. They placed lower value on GPs helping patients to deal with any emotional problems related to their health problems. The items included in the questionnaire were classified as relating to either availability and accessibility; information and support; medical technical care; doctor-patient relationship; and organisation of services. In apparent contrast to the findings of other studies, items in the medical/technical care category were ranked eighth (a GP should not only cure diseases, but also offer services in order to prevent diseases) and ninth (a GP should go to courses regularly to learn about recent medical developments). Three of the top six items related to availability and accessibility, and the other three were about the doctor-patient relationship and information.

Wensing et al's (1998) systematic review of the literature on patient priorities for general practice care identified "informativeness", "humaneness," "competence/accuracy" and "patients' involvement in decisions" as important to patients. This review draws on research carried out in North America and mainland Europe, and included studies from the 1970s and 1980s so may not reflect contemporary concerns of people in the UK. A survey in the USA suggested that patients valued doctors' interpersonal skills more highly than their training and knowledge (Harris poll for WSJ, 2004). Schattner et al (2004) conducted a questionnaire study to identify the most important attributes of a doctor from the patient's point of view and found clinical expertise, respect for autonomy, humaneness and support to be patients' priorities. However, this study was conducted using hospital patients in Israel so the generalisability of the findings to patients in the UK is questionable. Further, the usefulness of survey methodologies to explore such complex areas is limited. Other studies explore patient preferences in particular aspects of doctor-patient relationships, e.g. communication style (Law & Britten, 1995) and for particular conditions or services such as breast cancer (Alderson et al, 1994) or smoking cessation (Butler et al, 1998), but the research evidence is patchy.

Perhaps not surprisingly, doctors tend to give priority to competence over other qualities. For instance in a recent BMA report from their cohort study of doctors who graduated in 1995 (BMA, 2005), competence was ranked as the most important value, "followed by integrity, compassion, caring and responsibility". During the nine years since their graduation this cohort of doctors has changed, now placing more importance on integrity and less on commitment than they did in 1995.

3.4 Grounds for deregistration

Research on this subject shows the importance doctors placed on moral stance and clinical competence. But it also shows a lack of consensus among doctors. McManus, Gordon and Winder (2000) measured doctors' attitudes towards the fourteen specific 'duties of a doctor' by asking doctors "*Do you agree that the GMC should restrict or remove a doctor's registration solely because of persistent and serious failure to*", then listed each of the duties. It was emphasised that they were being asked whether failure on each single item should be sufficient reason to restrict or remove registration. But the question did not allow respondents to give other alternative courses of action for such failures, such as the less punitive approaches of education, further training or other remedial action. They found that few doctors (<10%) disagreed with restriction of registration on the grounds of doctors abusing their position, failing to be trustworthy, to respect confidentiality, to recognise the limits of their competence, or to keep their professional knowledge and skills up to date. On the other hand quite a large minority (25% or more) said they disagreed with restriction of registration on grounds of failure to respect the rights of patients to be involved in decisions about their care, failure to give patients information in a way they can understand, and failure to treat every patient politely and considerately. So there was no clear consensus on this issue, but doctors who demonstrated technical failings or misdemeanours were considered by a large majority of doctors to be more deserving of restrictions to their license than those who did not involve patients well in their care.

This study of doctors' awareness and views was repeated in two subsequent years (McManus, Winder & Gordon, 2001). Interestingly the authors found almost no change over the three years in doctors' perceptions of whether serious and persistent failure to

comply with the duties constituted grounds for restriction or removal of license. Increased awareness of the procedures was not accompanied by an increased consensus on the relative seriousness of failure to comply with the duties.

Peters, McManus & Hutchinson (2001) asked 1,949 members of the public and 199 GPs whether doctors' failure to fulfil the 'duties of a doctor' should lead to their removal from the medical register. Their findings were similar to those of McManus et al (2000 and 2001), with the general public and GPs holding similar views on reasons for doctors being removed from the register, although with the public's threshold being somewhat lower than the doctors'. More than half replied that doctors should definitely be struck off for failure to 'respect and protect confidential information' and around a third thought that doctors who let 'their personal beliefs prejudice the care of their patients', or failed to keep their 'professional knowledge and skills up-to-date' should face the same fate. What the survey also showed, however, was that people do not expect all failures to be dealt with through license restriction and that the 'duties of a doctor' do not carry equal weight. Thus more than half of the respondents thought that a doctor's failure to give 'patients information in a way that they can understand' was not sufficient reason to strike him or her off the register.

The rank order of the duties was similar for both groups. Removal of registration was viewed as a more appropriate response to neglect of duties classified as relating to professional values (33-55%) than of those classified as relating to interpersonal values (9-24%). This was true for both patients and doctors. Not protecting confidential information was the only duty seen by more patients than doctors as "definitely not" grounds for de-registration.

An earlier qualitative study carried out for the GMC by MORI (MORI, 2000) found that most people believe that: repeated and serious offences such as abuse, misdiagnosis, gross professional misconduct, drug abuse and forging prescriptions should lead to doctors having their licence to practice revoked; but that mistakes due to doctors' long working hours should be treated more leniently; and that a doctor having sexual relationships with her or his patients is a relatively minor offence.

Most people who complain about a doctor do not want to see him or her de-registered. They would like measures taken to prevent the problem happening again, including regular reassessment of competence. For example, a Which survey (1999) showed that only 27% of people who had made a complaint against a doctor wanted the doctor to be struck off the register. Most people wanted to receive a formal apology and recognition that a mistake had been made. The most common complaint was a poor attitude or rudeness, although in almost half of those complaints other problems were also raised including poor standards of care and dissatisfaction with treatment.

The combined qualitative and quantitative study of members of the public and doctors, recently conducted for the Department of Health, explored attitudes towards medical regulation. It found that, for both the public and GPs, the key element of any potential assessment was evidence that doctors are keeping up with medical developments. Ninety-three percent of the general public said that it was important that the competence of all doctors is checked every few years. This figure was lower amongst GPs at 71%. (Corrado et al, 2005)

The studies cited here are interesting but show how difficult it is for people to prioritise the duties of a doctor. They offer little insight into the reasons behind people's views. Neither do they explore their perceptions of the rest of *Good Medical Practice*.

3.5 Any other standards which ought to be included

There is little research addressing this issue, but it is interesting that in the BMA report from their cohort study of doctors (BMA, 2005), respondents were asked to name any additional values for today's doctors apart from those already mentioned by the BMA (these being 'commitment, integrity, confidentiality, caring, competence, responsibility, compassion, spirit of enquiry and advocacy'). Suggestions included 'communication, empathy, humility, honesty, patience, resilience and a sense of humour', none of which appear very original.

3.6 Tensions or conflicts between standards

We have said in Section 1 that there are some inherent tensions within guidance documents for doctors' practice, particularly those concerning (i) the competing functions of a doctor, and (ii) their changing relations with colleagues and patients.

On tensions within the doctor's role, Berney et al (2002) carried out a qualitative study using interviews and workshops with 24 GPs and interviews with 18 patients to explore decision-making in primary care and patients' perceptions of, and attitudes towards, the allocation of scarce resources in the NHS, and their aspirations for involvement in decision-making.

They found that GPs and patients saw patient involvement in decisions about allocation of scarce resources as a positive thing but understood it differently. Patients tended to see involvement as an end in itself – they were glad to have been involved in the process, even if the outcome was not what they had originally been seeking. For some GPs, involvement served a more instrumental purpose and was used as a tool which assisted them in managing or persuading patients. Most GPs identified very strongly with the role of patient advocate, but their other roles created tensions and contradictions, particularly with respect to wider responsibilities to budgets, populations and wider society. Although GPs appeared to have an implicit understanding of the key ethical principles of triage, equity and explicitness they had difficulty articulating these principles. This militated against clear communication with patients about their personal priorities in relation to rationing decisions. Ultimately this was seen as a barrier to patient involvement.

Patients were anxious about issues of scarcity and wanted to be told if resource limitations affected decisions about their care. There was a widespread perception of scarcity in NHS resources, and patients wanted to be informed when treatment decisions are influenced by resources. However, most patients stated that cost was not something which was discussed with their GP. The characteristics of involvement that patients most valued were: explanation, listening, continuity of care and not feeling rushed during consultations. There is little other research on this topic though plenty of recognition of its importance and of the fact that the doctor-patient relationship is under threat in "the current healthcare environment" (Gallagher & Levinson, 2004).

On the tension between supporting colleagues and putting patients first when a colleague is suspected of poor practice, in the MORI focus group study (Corrado et al, 2005), doctors acknowledged that reporting colleagues' bad practice was difficult, despite

increased pressure to do so, especially in the context of reporting on more senior colleagues or within small practices.

On changes in the evolving role of patients, there is little doubt that patients' expectations have grown. The Picker Institute's (2005) surveys of NHS patients in 2004 found that 47% of inpatients, 30% of outpatients, 36% of A&E patients, 32% of primary care patients, 39% of coronary heart disease patients and 59% of mental health patients would have liked more input and choice in decisions about their care. The surveys also found that many patients would like to be given more information about their conditions or treatment.

More detailed research can add depth to findings such as these. For example, McKinley & Middleton (1999) studied the expectations of patients who consulted their GPs, by asking patients to list all the concerns which had brought them to visit their GP and describe what they wanted to gain from it. They found for instance that two-thirds of patients wanted an explanation, over half wanted treatment, about 60% *"expressed underlying ideas that were offered as explanations"*, and almost 40% offered opinions about what they thought was wrong. These findings *"complement much previous work on patients' expectations of the consultation, folk and health belief models and consultation theory. They demonstrate that the consultation is, at many levels, a meeting between experts, both of whom can learn from the interaction."* For although *"patients' ideas about causation may be different from those of doctors, they are useful to the latter in improving their understanding of the patient's presentation and sometimes in making the diagnosis"*. In other words, patients are not passive: doctors must listen to them, involve them and understand the expertise they bring to the consultation and the expectations they have for its outcome.

Despite this evidence there are still ambiguities in doctors' views. For instance in the BMA cohort study (BMA, 2005), whilst almost all doctors agreed that *"the patient/doctor relationship should be a partnership based on mutual trust and openness"*, nonetheless more than half also agreed that *"there are circumstances where a doctor may decide that it is in the patient's interests to withhold from them information about their illness."*

3.7 Conclusions

This summary of previous research shows the lack of good quality evidence on how patients, the public and doctors perceive current professional guidance, standards and codes of practice in medicine. As can be seen, one of the key problems is that most research is really about the qualities of a good doctor rather than about standards (whether these are aspirations, ideals or mere levels of performance necessary to be a competent and safe doctor). Even on regulation the evidence is scant and often these complex issues are explored in only fairly superficial ways. At a time when a major regulating body is looking to update and improve those standards and guidance, the need for further research evidence on key critical issues is clear.

4 Methods and Sample

4.1 Sample and recruitment

Data collection from doctors and the public took place in three different geographical areas in order to avoid bias from any specific local issues and to capture the views of people whose health care is provided in different kinds of setting. Focus groups and interviews were held in Oxford (a medium-sized urban area), the London borough of Lambeth (a large conurbation with significant ethnic mix) and a rural area in Yorkshire. Tables 2, 3 and 4 below summarise the samples of the public and doctors who participated in the study.

Members of the public

Focus group participants were recruited by a specialist research recruitment agency and selected on the basis of age, sex, location and socioeconomic status (determined by present or most recent occupation). A total of 85 people took part in these focus groups.

Members of three harder-to-reach communities were recruited to interviews via a residential home for older people in North Yorkshire, two community groups in Lambeth, and a hostel for homeless people in Oxford. In total twenty three people from these groups were interviewed. The homeless people in Oxford had access to particularly good primary care services, so their reported experiences, while unlikely to be representative of the wider homeless population, throw light on the perceptions of a vulnerable group in an area where targeted services were provided.

Participants were asked to complete a short questionnaire to collect basic information about their health status and recent health care use. It showed that, of the 68 focus group participants for whom there were data, nearly 20% had not seen a doctor at all in the last six months, just over half had seen one up to three times, while 25% reported having seen a doctor four or more times in this period. A little over two-fifths of participants (41%) had had at least one outpatient appointment in the previous six months, with 8% having attended more than four in the same period. Two thirds reported that they had spent no nights in hospital as an inpatient over the previous two years, while one in ten (10%) had spent more than four nights.

Ten percent worked in the NHS, or had worked in the NHS in the last ten years, and 43% had a close friend or family member who did, or who had in the last ten years, worked in the NHS. These factors were shown in the study by Peters et al (2001) to predict people's tolerance of doctors' failure to adhere to the 'duties of a doctor.' Two thirds (66%) of participants said they had never had reason to make a complaint about a doctor and 4% said they had actually made a formal complaint.

Doctors

Approval to carry out the study of doctors and medical students was obtained from an NHS research ethics committee, local R & D committees, and the university ethics committee and dean of medical students for the students.

Doctors were recruited through Oxford City PCT and the local Postgraduate Deanery, and through a hospital trust (Leeds Teaching Hospitals Trust) in Yorkshire. Medical students were recruited to a focus group by responding to a poster displayed in the Student's Union of a medical school in London. A total of 25 doctors and medical students took part.

Table 2: Participant members of the public

Location	Sex	Age	Socio-economic group	Number
Oxford	Men	50-59	Manual/Skilled non-manual workers	8
	Women	30-39	Manual/Skilled non-manual workers	8
	Women	70-79		8
London	Men	30-39	Manual/Skilled non-manual workers	8
	Women	20-29	Manual/Skilled non-manual workers	8
	Women	50-59	Professional/Managerial workers	6
	Mixed	16-19		8
North Yorkshire	Men	20-29	Professional/Managerial workers	8
	Women	30-39	Professional/Managerial workers	8
	Women	40-49	Manual/Skilled non-manual workers	7
	Mixed	70-79	Manual/Skilled non-manual workers	8

Table 3: "Harder to reach" participants

Location	Group	Number
Oxford	Homeless people	7
North Yorkshire	Older people (over 70) in residential care	5
	in the community	3
Lambeth	Black and minority ethnic group residents of Lambeth	8

Table 4: Doctor and medical student participants

Location	Type of doctor	Other details
Oxford	7 GPs	4 male, 3 female
North Yorkshire	7 hospital 3 surgeons	1 SHO (male) 2 consultants (male)
	4 physicians	1 consultant (male) 3 specialist registrars (female)
London	11 Medical students	7 male, 4 female

4.2 Data Collection

Interviews and focus groups were carried out by experienced qualitative researchers and followed a topic guide (see Appendices 1 and 2) based on the research questions. They were designed to elicit participants' views on aspects of the revised draft of *Good Medical Practice* as set out in 1.3. We paid particular attention to standards which were:

- significantly different from the previous version
- particularly pertinent to the participant group (either doctors or public)
- apparently ambiguous or potentially controversial.

Members of the public

The majority of interviews with people from the harder-to-reach groups were carried out individually, although five interviews were conducted with pairs of participants. This was valuable where language or other communication problems arose. Interviews lasted between thirty minutes and one hour each. The majority of focus groups included eight participants and each lasted about two hours.

In both interviews and focus groups, 'flashcards' with quotes from the revised document were used to focus the discussion. Towards the end of every interview or focus group, each participant was given a set of cards, each card listing one of the 24 'duties of a doctor', and was asked to sort them into four categories: 'Most important,' 'Quite important,' 'Least important,' and 'Unclear / confusing.' Participants were asked if possible to assign at least three cards to each category apart from 'Unclear/ confusing' to avoid a ceiling effect with most duties in the 'Most important' category.

Doctors and medical students

Individual interviews were conducted with doctors: twelve face-to-face and two by telephone. Doctors were sent the topic guide and extracts from the revised draft of *Good Medical Practice* in advance, and interviews lasted between thirty minutes and one hour each.

One focus group lasting 90 minutes was held with eleven medical students who were at various points in their training. This focus group used a similar topic guide to that employed with other groups, but also covered some issues particularly relevant to students.

4.3 Data analysis

All the interviews and focus groups were transcribed verbatim and analysed using QSR NVIVO 2.0 software. The topic guides and research questions provided *a priori* themes which formed the basis of the qualitative analyses. Other themes emerged during the process of analysis.

Descriptive statistics in SPSS were used to analyse the quantitative data from the card sort exercise.

5 The Views of Members of the Public

Talking about doctors was something people found easy to do. They readily understood the issues they were being asked to discuss, though comments frequently started from accounts of peoples' own experiences, rather than views about doctors in general. Some of the more general points people made therefore include personal anecdotes, as will be seen in the quotes used below. The findings reported here are based on an analysis of the transcripts and the participants' card sort exercise.

We begin with the results of the card sort before going on to examine views in greater depth.

5.1 Key duties of a doctor

Participants in the interviews and focus groups were asked to categorise the twenty-four "duties of a doctor" into: most important, quite important, least important, and unclear. The results are shown in Table 5.

Making the care of your patient your first concern emerges strongly as the most important duty, followed closely by listening to patients, and keeping professional skills and knowledge up to date. Looking at those duties ranked as most important by more than 60% of the participants, it is interesting to note that, as with other research evidence, these did not exclusively relate to the technical aspects of clinical practice, but also covered duties concerned with communication, such as listening and providing information. Some aspects of probity, such as honesty, and not abusing the doctor's position also emerge as very important to the majority. These quantitative responses correspond well with the views expressed in the qualitative findings from the interviews and focus groups. Much less likely to be ranked as very important were duties relating to professional relationships, health promotion and informed consent.

There was a range of views about the key duties of a doctor although the dominant view was that all the duties specified in the revised guidance are important.

'They all really ought to be important didn't they, don't you think?'

Manual/skilled non-manual mixed group aged 70-79

The duties of a doctor were widely taken as given and there was some surprise that they needed to be spelled out in guidance:

'Yeah because for me it's commonsense all these things, we shouldn't even be talking about it.'

Manual/skilled non-manual male group aged 30-39

Table 5: Relative importance of “duties of a doctor” by members of the public (n=98)

	Most important %	Quite important %	Least important %	Unclear/ confusing %
Make the care of your patient your first concern	78.0	19.8	1.1	1.1
Listen to patients	72.9	20.0	4.7	2.4
Keep your professional skills and knowledge up to date	66.3	28.3	4.3	1.1
Give patients the information they want or need in a way they can understand	65.2	29.3	5.4	0.0
Be open with patients especially if something goes wrong	65.2	25.0	6.5	3.3
Respect patients' privacy and maintain confidentiality	64.1	32.6	2.2	1.1
Provide a good standard of practice and care	63.0	33.7	3.3	4.3
Never abuse your position as a doctor	63.0	26.1	6.5	4.3
Be honest and trustworthy	63.0	23.9	10.9	2.2
Act without delay if you have good reason to believe that you or a colleague is not fit to practise	62.0	25.0	9.8	3.3
Recognise and work within your professional competence	50.0	37.0	5.4	7.6
Respect each patient's dignity and individuality	46.7	41.3	6.5	5.4
Treat every patient politely and considerately	45.1	41.8	13.2	0.0
Never discriminate unfairly against patients or colleagues	38.5	38.5	18.7	4.4
Respect patients' right to reach decisions with you about their treatment and care	38.0	47.8	12.0	2.2
Make efficient use of the resources available to you	35.9	37.0	21.7	5.4
Work with patients as partners in their care	35.3	36.5	22.4	5.9
Act with integrity	34.1	44.0	16.5	5.5
Respect human rights	33.7	31.5	21.7	13.0
Make sure your personal beliefs do not adversely affect patient care	33.7	37.0	22.8	6.5
Obtain informed consent where appropriate	26.1	38.0	29.3	6.5
Protect and promote the health of patients and the public	25.0	38.0	32.6	4.3
Never act in ways which undermine public confidence in the medical profession	23.9	46.7	22.8	6.5
Co-operate with colleagues	15.2	40.2	38.0	6.5

In discussions, it was clear that the phrase “make the care of the patient your first concern” attracted wide consensus and that, for many, this captured the essential ingredients of good medical practice.

A few of the duties were perceived by some participants as problematic. For example, there was some scepticism about requiring doctors to work within their professional competence, as they might not always be aware of the limits of their competence. Equally, acting ‘without delay if you believe that you or a colleague is not fit to practise’ was seen as difficult to implement. This may reflect doubts about the ability and willingness of doctors to blow the whistle on colleagues or to recognise and admit their own incompetence.

Informed consent was not seen by some participants as very important (both in discussion and the card sort exercise), although this was partly explained by the context. In emergency situations, informed consent would not always be possible. It may also be that people interpreted informed consent as a tick box exercise, and that where all the other aspects of good practice are in place, informed consent effectively occurs.

‘It’s difficult, I thought there were loads of very important and quite important comments and I just had to make a decision. ‘Obtain informed consent where appropriate’ I mean obviously that is important but I think when you’re getting... showing respect and you’re listening and you’re communicating well I think that that goes... this happens in a way.’

Manual/skilled non-manual female group aged 20-29

Views on the importance of co-operation with colleagues reflected the relatively limited awareness people had of doctors operating as part of a wider health team. In the one discussion where the wider health team was referred to, the phrase ‘co-operate with colleagues’ was seen to be ambiguous:

‘They do need to co-operate but that doesn’t really mean anything because who are their colleagues? It can be absolutely anybody and what does co-operate mean? Does it mean that you actually speak to them or does it mean that you work together with the multi disciplinary team to provide the best possible care for the patients? That doesn’t mean anything at all.’

Professional/managerial female group aged 50-59

It was also seen as confusing:

‘Cooperate with colleagues I find a little bit confusing.’

Manual/skilled non-manual mixed group aged 70-79

However, the need to seek a second opinion where a doctor is operating outside his or her competence was recognised by participants.

Most of the duties in the draft guidance were clearly understood by those taking part in the research, although some of them were considered unclear or confusing by some participants and it was suggested that some terms could be simplified. For example, some struggled with the meaning of partnership:

‘Mind you, a lot of these could go over your head!’

Manual/skilled non-manual male group aged 50-59

'If good medical practice guidelines are going to state to a doctor, use plain English and make sure that the patient fully understands everything and don't use abbreviations and things like that.'

Professional/managerial male group aged 20-29

'Work with patients as partners in their care'. I just don't understand what it means.'

Professional/managerial male group aged 20-29

'Never act in ways which undermine public confidence in the medical profession...No, I find that confusing.'

Female group aged 70-79

Respect for human rights was another duty that some found either confusing or too abstract to be meaningful. This may explain its relatively low ranking in the card sort exercise.

'I wondered why respect human rights was particular to doctors and not to everybody.'

Female group aged 70-79

5.2 Interpersonal skills

Some participants were willing to tolerate poor communication skills, as long as their doctor was technically competent, particularly in emergencies or for patients with life-threatening conditions. Technical competence appeared to be accepted as of pre-eminent importance; but in the everyday context of the GP's surgery, good communication skills were seen by many as intrinsic to good medical practice. This is also reflected in the results of the card sort exercise.

'I know I am of a generation where things are important that are not important now, and I am quite willing to feel that if a doctor's more skilled, it doesn't matter if you think he's a little bit rude.'

Residential home interview 1

'I think a large part of being a good doctor is being kindly and warm to the patients, and then get the medical bit. Get the confidence of people.'

Residential home interview 4

'As long as they'll listen to what you're saying and you don't feel as if you're being rushed out the door and they're quite pleasant and whatever, you know, you can't really expect that much from them can you really.'

Professional/managerial female group aged 30-39

Good interpersonal skills were seen by some participants as not just desirable but essential to achieve good clinical outcomes, as an aid to diagnosis and patient concordance. A number of times participants provided illustrations of the importance of listening, not just as an end in itself, but as a means to a better medical outcome for the patient:

'...if they can't listen and communicate, how are they going to find out, you know, how to diagnose what's wrong with you or your children, you know, I mean they can have passed all their exams and you know, be qualified and everything but if they can't listen to you, you know...

Professional/managerial female group aged 30-39

'I was in a medical tribunal about a lady who lost her child because of one of those doctors who was from locum and didn't listen properly what was happening.'

Black/minority ethnic participant interview 2

'I feel confident and comfortable with them you know. Before I used to go to doctors and not really tell them all what's going on you know, even though I was supposed to, but I just didn't feel close enough sort of thing. But with them, if I have a little problem or something or... just curious, I feel that they're quite accessible you know, which is quite nice.'

Homeless hostel interview 4

'I think when you go to a doctor, you want to open yourself up and be comfortable with that person and you can speak confidential thing and if you are being involved with a doctor and you can't open yourself up, you can't tell your internal things from embarrassment and shame, then you are like losing out and you're going to become more ill and delay things. So I think it's really important to be able to open up.'

Black/minority ethnic participant interview 1

Interviewees and focus group participants frequently talked of 'feeling comfortable' with a good doctor. The precise meaning of this is difficult to pin down, but appears to encompass a willingness to listen and a sense that the doctor will take the time needed to investigate thoroughly what is wrong and not rush the patient:

'It's their responsibility to make people feel comfortable enough to talk about what's wrong anyway because that's their job isn't it, you know.'

Manual/skilled non-manual female group aged 20-29

'When I started to talk with him, as I started, 'let me tell you first', he said 'you have to make it quick because I have to go for another patient.' This doesn't encourage patients. It felt very uncomfortable.'

Black/minority ethnic participant interview 2

Participants also mentioned the importance of a doctor having the right manner. This was sometimes associated with the need to make people 'feel comfortable':

'That Dr M's like that, she'll sit and she'll talk to you even if it's only for five minutes because we know she hasn't a lot of time, but she'll sit and she'll tell you more and you take more in you know, and realise what it is, and it makes you feel a lot better that she's thinking about what's the matter with you. I think they should have a good manner, I think really that's half the battle. But they don't really, they maybe haven't time, but I think they should make time.'

Older person in community interview 2

'...you know it's like they're trained... they know all about the drugs and they know about everything, you know all these little diseases and what they can do to your body, they know all the biological and the chemistry behind it, but do they know how

to talk to someone properly and how to, you know, if they can talk to someone in the right manner and the right way and relate to them, calm them down and make sure that 'yeah you're going to be fine', it's easy peasy. Whereas if you're just... I don't know, silent, I guess I'm just going to worry I'm being a problem more than anything.'

Mixed group aged 16-19

Basic courtesy was seen as contributing to a good manner and not particularly difficult for doctors to apply:

'I don't see my doctor very often, but when you... it doesn't matter whether you know me or you don't know me, you can see my name on the screen, you know I'm coming in to you next, have the courtesy of addressing me by my name.'

Manual/skilled non-manual female group aged 30-39

'He is a very rude man and he makes you feel like you are completely wasting his time. He has a very unfortunate manner.'

Professional/managerial female group aged 50-59

There was an understanding among participants of the time pressures on doctors, but most who discussed this wanted their doctors to take time to listen to them and not rush them. Even if they had only a short length of time with the doctor, they expected to have the doctor's full attention for this time.

'Well I suppose that would be how busy is their surgery, because if they have to see 60 people and they have them 5 minutes or 10 minutes to... for every one and a lot of people they go there because they're sneezing or they have a bit of... then they have to really hurry up to see people.'

Manual/skilled non-manual mixed group aged 70-79

'I don't think they have time to be personal with people and you know, stand and discuss, I mean I know it's an awful thing to say but they're... it is like a conveyor belt...'

Professional/managerial female group aged 30-39

'I think an important thing is for a doctor to have time, which they don't seem to have, to sit down and talk to people and to let people talk, I think that's important.'

Residential home interview 4

'I mean even if they have a lot of patients, I mean they only have one patient at a time haven't they, to see to? So, I mean, they should be able to give full attention shouldn't they?'

Older person in community interview 2

'How dare you look at your watch, you will sit there and listen to me if I want to sit in here for half an hour. Like you said, we pay our National Insurance, we pay our right to be there.'

Manual/skilled non-manual female group aged 30-39

One participant identified the need for doctors to be able to judge how much time each patient needed and to respond accordingly.

Some participants felt that a good doctor-patient relationship took time to develop. Participants who had been going to the same general practitioner for some years perceived this long-term relationship as fostering rapport:

'I was just saying that my group practice is really good because I have been with the same practice for about 24/25 years and there is only three in my group practice, so you normally get to see the same person and you build up a relationship. So I don't find that going to the doctors is a big thing for me because it is just like talking to someone that I have known for years who knows my children, so I feel quite relaxed. So I have only had good experiences.'

Professional/managerial female group aged 50-59

'As soon as you see someone different, you don't immediately have that relationship that you've got with them because you've seen them a few times before, so there's always that uneasiness about you meeting someone new, you've never met them before, you know are they going to start prodding you in your back and... they don't know you, you don't know them and that's just a bit awkward but it's not coldness.'

Professional/managerial male group aged 20-29

Giving information in a form that people can understand was also perceived by those taking part in the research as an important aspect of good medical practice. As well as being desirable in itself, this could contribute to patient adherence to medication:

'We've had another one here,... but he was a specialist on bones and he was exceptionally nice 'cos I like a doctor that explains things to you. Some of them don't say a word! And he was very nice.'

Residential home interview 3

'I mean well, if you know what a certain course of treatment does to you, or what side effects you may get through the doctor's mouth, it does allay and it calms a hell of a lot of fears. And that is what may benefit... I think it makes it more beneficial for the patient.'

Homeless hostel interview 5

'I had to go to [name of hospital] a couple of weeks ago and I was most impressed in how I was dealt with. Everything was explained to me fully. Normally, I used to find the doctors were quite condescending and they would speak in jargon whereas the person that I saw actually spoke to me as a person and explained things in layman's terms so that I could understand them, put my mind at rest over certain issues and I came out and sort of thought, "Oh great, I actually know what is wrong with me", whereas before I think they kept it to themselves basically, the notes were sent to your doctor and it was hit and miss if you actually found out what you were suffering from. So I think that has greatly improved.'

Professional/managerial female group aged 50-59

Some groups discussed how much information people wanted to have and whether, in some instances, doctors provided too much information:

'I think it was good that she explained a lot; she had a lot of explaining to do, but sometimes that explaining could be a bit too much as well. I found that she did explain, she has given me a lot of information on what I needed, but it was a bit too much actually.'

Black/minority ethnic participant interview 1

Where the topic came up, participants mostly wanted to be told if there were treatments with which they were not being provided because of financial limits, but their experiences were that there was no discussion of these constraints between them and their doctor.

Straight talking was also welcomed by some participants when combined with respect, but not by all:

'There is a doctor at our practice, I think he is great, he is very blunt and to the point. He doesn't pussyfoot around and I had to take my daughter to see him for her acne and she didn't like what he said.'

Professional/managerial female group aged 50-59

In addition to the more affective aspects of communication, practical and functional elements were also mentioned by some participants:

'I really don't trust him at all, I mean, apart from the fact that we have some major communication problem, because we are both in a foreign country and he talks a very difficult English. You know, I really struggle because I think, maybe he's telling me that I'm dying and I don't understand it.'

Manual/skilled non-manual male group aged 30-39

'I must admit sometimes that I cannot understand the doctor, I haven't had a clue what they were saying.'

Professional/managerial female group aged 50-59

'So it's very, very important that wherever doctors come from that they understand the idiomatic language people use when they're talking about pain, irritation, parts of the body and so on.'

Manual/skilled non-manual male group aged 30-39

A willingness to go the extra mile through making an effort to give people their full attention and fit patients into busy schedules was something that distinguished the best doctors in the eyes of some:

'I was in the waiting room and he'd noticed me, as he was coming out, it was before they had these bleeps things, but he was coming out and calling his patients and he noticed I'd been sat there for a long time and he wasn't seeing me that day and he came out and he said to me 'who are you waiting to see?' and I told him and he said 'come with me' and he saw me straight away and then let this other doctor know that he'd seen me. And I thought that was really nice...'

Manual/skilled non-manual female group aged 30-39

'I didn't get much information from the hospital about what help I could get when I left hospital. My GP at [name of practice] put me onto the speech therapist and dialability. If he doesn't know something, he'll find out for you. He makes time.'

Homeless hostel interview 2

'...they don't normally do home visits but I... they never questioned a home visit, I had a visit nearly every day.'

Female group aged 70-79

Most of the discussions around communication skills focussed on GPs. On the whole, people had had more positive experiences of GPs' communication skills than hospital doctors':

'I've found GPs a lot... tend to listen and speak to you more than doctors in hospitals. If you're actually going for an operation or something, I find them a lot more stand-offish and not willing to actually get into conversation with you. They'll tend to tell you what they're going to do, and then they're off again.'

Professional/managerial female group aged 30-39

Overall, participants considered younger doctors had better communication skills:

'And what's surprised me is their attitudes to various things that has changed and it's mainly the younger doctor whose attitude has changed; the older ones stay in their old ways. And how willing the younger GP's are to explain things, in depth, to allay your fears.'

Homeless hostel interview 5

'And they all say exactly what they're going to do or whatever they think is wrong. I mean some doctors in the past that I've known, you know that sort of gloss it all over and don't say a word and just go and you're still as wise as when they first came.'

Residential home interview 3

However, this was not always the case:

'Two young men I didn't like at all. I think they required a little patience with their patients. They were bumptious. I feel sorry for some people who are intimidated by it, and I think they must be. It was awful. They were offhand. Not sympathetic, not kindly.'

Residential home interview 4

'Our young doctors and nurses they don't seem to understand culturally about their patients. It's really important, especially if they're Muslim or Indian. A husband might not allow for male doctor to even come near their wives. Things like that, people should be aware of.'

Black/minority ethnic participant interview 2

5.3 Partnership

There was some variation in the understanding and expectation of partnership among those taking part in the research. Participants' understanding of partnership was uncertain, and it was felt that not everyone always wanted the responsibility of partnership and shared decision-making. Clearly, the doctor's task is a difficult one in trying to ascertain the nature of the relationship required by individual patients:

'I can't really see what that means because you are confiding your troubles to your doctor and he is working with you, so it is automatic. I don't think I would have to say to them "Am I working in partnership with you?". He'd think I'd gone mad!'

Residential home interview 1

'Well you work together to get to the root of the problem. You give him so much information and then he thinks, ah well, it could be so and so and so and so, and then maybe you give a bit more information and he says, ah it's... whatever.'

Manual/non-skilled male group aged 50-59

'It could involve lots of things like you said, like involvement in decision-making about what treatment I'm to receive, my right to turn down a decision, the reason why, listening to me as a patient, my right also to ask questions.'

Black/minority ethnic participant interview 2

Equally, participants' expectation of partnership varied, with some very positive and others, less enthusiastic. While most participants clearly favour being offered choices about treatment in situations where time allows for this, there was also a feeling that they are consulting a doctor for their expertise and look to him or her to make decisions which they (the patient) are not qualified to make:

'[Reaching decisions] Together, yes and sort of telling the patient what the options are and listening to your patient, the person that's coming in saying 'this aches, this hurts' or 'this just doesn't feel right' you know, working together in that respect, that you both come at it and meet somewhere in the middle, their knowledge, expertise, the things you trust in them, and your knowledge of your own body and how it works and how it feels different when you've gone to see them.'

Manual/skilled non-manual female group aged 20-29

'So I think the doctors do know what they are doing and again they are very skilful but I would leave it. For myself personally, I would leave it that I don't know what is best for me. I am very well, but if I became ill I would expect the doctor to know. I wouldn't expect him to ask me really because I can't think when you are very ill and you are very old that you are in a position to.'

Residential home interview 1

'The reason you've gone to the doctor is because you can't make the right decision... well you don't know what the best decision is, so you go to him because you want the right decision.'

Mixed group aged 16-19

'...negotiation isn't it, between parents and children, between employers and employees and now it's between doctors and patients and I don't think it works because it assumes that patients have expertise, which we don't, that's why we go to the doctors and...'

Manual/skilled non-manual male group aged 30-39

However, where participants cited examples of partnership and shared decision-making that they had themselves experienced, they were generally positive:

'I always go to make an appointment with the same doctor if I can because she... she's very keen on... I trust her to make a good diagnosis and she'll... you know, she'll tell me what the issue is or what the condition is and then she'll say, 'Sarah what are we going to do about it?' and she really kind of hands it over to me, not in the way that makes me feel sort of abandoned, it's like oh I don't know, you're the doctor, but she'll say, 'You know these are the options, you could do this, this or this' and you know fairly kind of brusquely, she doesn't sit around and chat for too long, but I always feel if I go and see her that she's quite good at letting me take as much control as I want to for what we're going to do about it.'

Manual/skilled non-manual female group aged 20-29

'I've got a friend, her husband's just been diagnosed with prostate cancer and he was terrified of an operation, and this is obviously what happened with his doctor,

the doctor took him for an extremely thorough consultancy and they thrashed it all out and they've gone for like medication because the doctor and he between them decided he would be better to try the medication route, although Peter agreed in the end it might... push might come to shove and he might have to have an operation, but he's so frightened of it, obviously the doctor's manoeuvring with him, to save him having the operation.'

Female group aged 70-79

There was a strong preference for being offered a choice of treatment where it existed and time allowed for a choice to be made, along with the appropriate information to enable people to make an informed choice:

'I think the doctor should explain to the patient that these are the options which one you want and if he choose something else and he's not very sure about this, he should explain that this is not good.'

Black/minority ethnic participant interview 2

'I think a doctor should give you a... maybe a list of possibilities or ways of dealing with a problem and then yeah, you can choose from that list, but you can't choose that list yourself, I would rather not, you know I would rather have a doctor say 'Right, these are your options, which would you prefer?' Definitely.'

Manual/skilled non-manual male group aged 30-39

'I think mostly it is a positive thing, I would like it if the doctor said "You could do this and this might happen or you could do that". I have been with my sister-in-law to the specialist who very clearly explained that you could have surgery and these might be the outcomes or you could not have surgery and these might be the outcomes.'

Professional/managerial female group aged 50-59

The desirability of a choice or treatment appeared to be to some extent context specific, particularly around childbirth. Options about the treatment of terminal diseases and the extension of life were also mentioned as important:

'They did with my sister when she was having chemotherapy, you know she always had the choice, whether she had had enough.'

Female group aged 70-79

In other instances, this aspect of partnership was not seen as so important:

'You can't be involved with someone who's come with flu or fever so much. There has to be like limits. Like you'd be involved if someone was going to have an abortion and doesn't know what to do. It depends on how serious the situation is.'

Black/minority ethnic participant interview 1

One participant felt that it was possible to give people too much choice:

'Sometimes people find it very difficult when you are given a choice because it used to be that the doctor would say "Right this is what we are going to do" and he would do it, whereas now people might be given a choice and can't cope with it and find it very difficult. They will go to the nurses and say "What do I do" and the nurses are going to say what you do, and sometimes people find that difficult as well.'

Professional/managerial female group aged 50-59

Real partnership may be contingent on the degree of equality between the partners. There was some scepticism among those taking part in the research about how equal the relationship between doctor and patient could be. In part, this appeared to reflect the historic position of doctors in society, and in part the difference in the roles of the doctor and patient.

'Also it is an equality thing as well. Partnership to me would mean that it was equal. You would work together to arrive at a decision, not one person having the final say.'

Professional/managerial female group aged 50-59

'I think the word partnership is the wrong word, isn't it, because that does imply a sort of spurious equality...'

Manual/non-skilled male group aged 50-59

'I put a doctor on a quite high pedestal if I'm honest. I put them there.'

Professional/managerial male group aged 20-29

'How do you work in partnership with a doctor? I mean does... it's like saying children should work in partnership with parents or you know, the driver should work in partnership with the man who repairs the car or something.'

Manual/skilled non-manual male group aged 30-39

However, even though the relationship was not always perceived as equal, it was not acceptable for doctors to 'look down' on their patients. Some examples of perceived ageism and sexism by doctors were mentioned with disapproval by participants. For example, more than one older woman felt that her doctor did not take her ailments seriously because of her age and sex:

'I think the trouble with being a woman, everything's put down to your age. 'Oh well...' and it can't possibly be your age every time.'

Manual/skilled non-manual mixed group aged 70-79

Respect was also mentioned by those taking part in the research as an important aspect of good medical practice. This encompassed maintaining patients' dignity (for example, not leaving people undressed), privacy, and patients' knowledge of their own bodies.

'I think it's implicit that you should treat the patient with respect, I mean why have you got to say that?'

Manual/skilled non-manual male group aged 50-59

'I think all of these things really do need to come in, it is about listening, it is about mutual respect, but it's about them respecting you, the fact that you know your own body...'

Manual/skilled non-manual female group aged 30-39

Partnership might also involve responsibilities for the patient:

'I would say it boils down to the fact that they can only help you as much as what you're going to tell them.'

Manual/skilled non-manual female group aged 40-49

'We were both saying that our last occasion at a doctors was a very positive experience, the doctor was very good, but we were also saying that it is up to you to

say what you want from the doctor and to a large extent that affects the outcome of the issue with the doctor.'

Professional/managerial female group aged 50-59

'And also if the doctor says you shouldn't smoke so much or drink so much or whatever, if you were totally ignoring it, you're not working in partnership with them. You've got to keep your end up, you've got to do your part of it.'

Manual/skilled non-manual male group aged 30-39

'But why have you got to spell it out, it's kind of implicit, I mean if you don't like what... if you've got strong feelings and you don't want to do what the doctors says, it's up to you! You don't have to do what the doctor says.'

Manual/skilled non-manual male group aged 50-59

Patients now are more likely to have access to alternative sources of information and some groups referred to use of the internet as a means of finding out additional information:

'They'd prefer people to look it up on the internet after they've spoken to them about it, because we don't remember what a doctor tells us half the time and if you write things down and then you can go away and look them up.'

Manual/skilled non-manual male group aged 30-39

'I mean we're more fortunate now because we do have things like the internet so we have access to things we might have been told by a doctor, you know symptoms or a diagnosis of some sort that we can further research ourselves.'

Manual/skilled non-manual female group aged 20-29

It was felt by some participants that where they were unhappy with their doctor, they always had the option to choose another doctor. In some cases, however, it was seen as difficult to change doctors due to limited choice:

'And like you say, if you do get a bad doctor, you change.'

Manual/skilled non-manual male group aged 50-59

'It seems that once you are assigned that's your lot, because everywhere else is full so even if you wanted to change doctor you couldn't because they're all full!'

Manual/skilled non-manual male group aged 30-39

In certain contexts, the choice of doctor was of particular concern, for example, women who for a variety of reasons want to see a female doctor. This was illustrated in one of the focus groups:

'Sometimes when you go for a personal problem you don't want to see a male doctor and we have got a female doctor now that comes. Especially when your daughter's friendly with the doctor's son!'

Professional/managerial female group aged 30-39

Some participants thought that it was difficult for partnership to develop without continuity:

'Well the way my surgery's ran, there's no way in the world at the moment there's ever going to be a partnership because there's probably 10 doctors and it's a lottery who you get.'

Professional/managerial male group aged 20-29

Participants identified some practical obstacles in relation to implementing partnership and shared decision-making, for example, what happens where doctor and patient disagree; and how realistic it was in the context of the NHS because of resource limitations:

'I mean if you go to the doctor and he says, 'well you could do this, you could do this, or you could do this' and you say 'I want that one' and that's not really working in partnership really is it? If you're working in... you know if... partnership for me says, 'okay, you can do this or this' and you go 'well actually I've heard about this, this and this, what about that' and then maybe he goes away and looks it up and gives you his professional medical opinion on it, but you know it's a free service... well that's not right. It's a service but you know perhaps if I was paying a lot of money to go and see a doctor I'd expect that kind of service but I think considering the pressure they're under already, that kind of thing is a little bit too much to expect.'

Manual/skilled non-manual male group aged 30-39

There was also some scepticism about whether doctors themselves want a partnership with patient:

'...the doctor certainly doesn't want a partnership with us, does he really?'

Manual/skilled non-manual male group aged 50-59

'If I go to any surgery, are they going to listen to me? No. So how can it be a partnership? Partnership is only applicable if it suits them...'

Black/minority ethnic participant interview 2

5.4 Obligation to treat

Although there was a widely held view that doctors could not be expected to be on duty all the time, most participants felt that in an emergency, a doctor would offer assistance as the following discussion illustrates:

'They've got to be, they can't be a 24/7 doctor.'

No.

Off duty yes, but if you were a doctor and you were driving down the road and you saw a car accident...

Yeah that is different, they would stop.

...that's different. Exactly. So in a sense they're never off duty, but then they're not at work sometimes.'

Professional/managerial male group aged 20-29

However, not everyone thought it was reasonable for doctors to be expected to get involved in emergencies when not at work, partly because of the need for them to be able to switch off, but also because of the risk of prosecution if things went wrong:

'When someone is not in his profession then he's completely off and they[doctors]...need to cut off as well to give a break to themselves.'

Black/minority ethnic participant interview 2

'Yeah, I was going to say, I would say if you were a doctor, why should you feel obliged to have to go to every emergency?'

Manual/skilled non-manual female group aged 30-39

'But isn't there a thing about that though like if they choose to swear they're a doctor, at the scene of an emergency they're responsible and if the patient dies and they've got to give all this... I'd keep my mouth shut.'

Mixed group aged 16-19

There was a general consensus that doctors should not be obliged to treat violent and abusive patients. In the context of a casualty department, this was seen as a potentially trickier situation; where patients might be under the influence of alcohol or drugs:

'If I was a doctor I'd refuse if someone was racist to me...'

Yeah they definitely should [refuse to treat], yeah.'

Mixed group aged 16-19

'I mean some of it, I mean, I've been to A&E. I've heard some of the abuse people have dished out to them. I don't care what job I was doing, be it my calling or not, I wouldn't stand for it.'

Professional/managerial male group aged 20-29

Some participants made a distinction between abusive and rude. While the former was not acceptable, they thought that rudeness should be tolerated, as it could be a manifestation of a health problem, or the consequence of a long wait:

'If they're violent then I don't believe they should be treated. But you've got to remember if you're ill and you're waiting in a waiting room for 5 hours, I'd be as rude as I want to be.'

Mixed group aged 16-19

'What happens is they will say, "if you are rude, we will not treat you" but he's going to be rude if he's suffering from something. If he has a pain he cannot sit tight there. He must be thinking, "I want to see the...doctor right now." In these circumstances, I don't think they should ever refuse to treat anyone.'

Black/minority ethnic participant interview 2

Generally, participants felt that doctors have an obligation to treat patients regardless of their lifestyles, and whether or not they followed the doctor's advice (for example, giving up smoking), however annoying or frustrating it might be:

'Like if you say to someone "lose weight, that's why you've got high pressure", you can't be like 'if you're not going to lose weight, like get out of here' do you know what I mean. I think that must be an annoying part of the job, but that really does

come under being a doctor. You have to still treat someone to the best of your ability and like the patients' welfare should be number one priority.'

Mixed group aged 16-19

Where discussed, those taking part tended to think doctors should not be constrained by resources in the choice of treatment for a patient:

'I'd rather my doctor was a doctor, and not an accountant.'

Manual/skilled non-manual male group aged 30-39

'Well that bugs me, that a doctor is looking at what I might have wrong with me and thinking about the monetary terms on it.'

Manual/skilled non-manual male group aged 30-39

'I think every patient should be treated. Because of cost they should not be turned down, and they should use the best medicine there is. If you use cheap medicine it doesn't affect very much.'

Black/minority ethnic participant interview 2

However, there was less certainty in situations where major and limited resources were involved, for example, in the case of a transplant. Other examples of where it might be a grey area were also mentioned:

'It is more difficult the further up the chain you go, for example if you get as far as needing a lung transplant and you are still smoking 30 a day then surely they have got the right to say "Well look there is a five year old child there who is not smoking 30 a day". So, I think with the GP it is probably a less grey area but the further or the more chronic the illness is, and with hospital consultants it must be a very difficult ground to tread.'

Professional/managerial female group aged 50-59

There were mixed views about a doctor's right to refuse to treat a patient on grounds of conscience. Some felt strongly that a doctor was duty bound not to deny any treatment on grounds of conscience:

'Surely, as a doctor they're supposed to be non-judgmental anyway, aren't they?'

Professional/managerial female group aged 30-39

'Well, you're saying because of a religious barrier, the doctor doesn't want to go ahead, but a doctor is a doctor, you don't have any kind of barrier when you're a doctor.'

Black/minority ethnic participant interviews 1

Other participants thought that doctors were entitled to refuse to treat, but had a responsibility to refer their patient on to another doctor in such an instance:

'I think he should consider it if there was any conflict of interest between what he thought and what somebody else thought, then he might suggest go and see this person, they probably...'

Another like opinion.'

Professional/managerial male group aged 20-29

5.5 Technical competence

A clear finding from the focus groups and interviews is that participants considered that technical competence should be a pre-requisite for a good doctor, even if they lacked communication skills:

'I would rather have a good doctor who knows what he is doing, even if he is a bit rude.'

Residential home interview 1

'I mean it's better to have a rude and arrogant doctor, who's competent, than a nice one who's incompetent isn't it?'

Manual/skilled non-manual male group aged 50-59

'I don't care if he doesn't look me in the eye, as long as he gets it right, you know.'

Manual/skilled non-manual male group aged 30-39

'I was saying he has a kind of hard balancing line because you can have somebody, maybe that comes across as dismissive and doesn't listen to you, but they could be a brilliant surgeon or a brilliant doctor and have a lot of knowledge in their hand, and then in that kind of instance, well which one would you pick necessarily, he might not come across as having the best bedside manner, but you know, for actually doing something, he might actually be very good and very competent.'

Manual/skilled non-manual female group aged 20-29

It was also seen as important for doctors to be able to recognise the limits of their competence and to seek advice from specialists where appropriate:

'I just thought, the doctor is after all a human being, he has his limitations, yeah, and the fact of asking information of other people, that shows that he recognises himself his limitations, which was good yeah, rather than you know, start doing trial and error for something he didn't understand it was, yeah. I liked that, yes.'

Black/minority ethnic participant, refugees interview 1

'I think a doctor that I saw with the skin, what I liked about it was the fact he openly admitted, he said 'I can't tell you what's wrong with your skin' but more or less I know a man who can.

And I felt quite confident in that, that he wasn't trying to fob you off...

Yes, he was honest.'

Female group aged 70-79

Technical competence was also linked by participants to trust. Those taking part in the research mostly expressed the view that doctors have to be trusted to be technically competent:

'I guess it's like going to a plumber, you kind of trust that they've got the skills to fix your leak or whatever, it just has to be, doesn't it?'

Manual/skilled non-manual female group aged 20-29

'Oh you have to have trust in your doctor, I mean if you haven't trust in the doctor it's no good, because I mean there's lots of medicines that they give you, you have to depend that they've got it right by you. You know, otherwise it'd be no use.'

Older person in community interview 2

However, a surprising number of clinical errors were described in some focus groups and one participant commented on how trust in doctors' technical competence had lessened.

'I think the doctors' role has changed. Before, you know, I think probably like 20/30 years ago, every time you went to the doctor, you know, you put everything in his trust, anything that he would give you, any diagnosis he would give you, you would just take it, now you take that information, you might think about it and then obviously some of us will, you know digest it, all of it and listen completely to what he says, some of us will think, well hang on, well maybe I'll go to my... you know my chiropractor, it's like you said about choice, and you know, or maybe go and see an acupuncturist or herbal or this or that, you know, so I think that way his role has changed and hence, in relationship, what you expect from a doctor, probably you know, has automatically changed as well.'

Manual/skilled non-manual male group aged 30-39

Taking time to examine patients thoroughly was mentioned by a number of participants as an important part of what they perceive as good medical practice. There could be benefits in efficiency, as thorough examination reduced the chances of misdiagnosis and repeat visits:

'You need to see the bigger picture in order to make sure that you're making the right, coming to the right conclusion and you know, a patient might not be telling you the right things unless you're probing deeper and... or they might already have formed... you know, half of the analysis by themselves if you've got a condition and you're asking some questions and they're giving you some answers and telling you more things, it's easier. But I suspect that a lot of doctors kind of hear five symptoms and come to a conclusion, and sort of forget to double check with their patient if they feel that that's right.'

Manual/skilled non-manual female group aged 20-29

'Yeah he's judged it well and he's asked the questions when the questions were needed to and he's got a practice in the middle of Brixton which is just thumping busy so... and he still takes time, if it's needed.'

Manual/skilled non-manual male group aged 30-39

Failure thoroughly to investigate patients' symptoms was seen as a cause of clinical error, and specific examples of this were provided in some focus groups:

'Jay hasn't had a good experience with her doctors on her last sort of visit, because she went a few times and had to see a locum, she had really bad pains in her stomach and that and she kept saying oh it was.....gastroenteritis, yeah and fobbing you off with that, wasn't it. So she kept leaving it and then she went back a few days, got fobbed off, and in the end, you know she something wasn't right, couldn't have been, so she actually managed to get an appointment with her own doctor and he felt her tummy and said 'oh no, you've got appendicitis' got her rushed up the hospital. She was actually leaking poison, instead of a fifteen minute operation, it took three hours because they had to clean all her organs as well...'

Manual/skilled non-manual female group aged 30-39

'We're talking about minor problems but yet, problem that you know could have been solved in a week, and after four weeks they were still going on, because you know it was the wrong stuff and I think you know, as I said to you, I would... I had been rushed far too much basically and so you need to, for me you know, I'm not a doctor, but to me certain things are just common sense to ask and even you know, to look!'

Manual/skilled non-manual male group aged 30-39

Keeping up to date was considered an important responsibility of a good doctor although participants also recognised that this could be difficult because of the time pressures that some doctors are under:

'I want a doctor who knows what they are doing and that is why I chose a young doctor when we came here. I thought he would be up-to-date and he was.'

Residential home interview 1

'With the pressure of work, it's impossible...I don't know how they do it unless they've got some sort of information in their computer that they can.....just press it and see...I think lawyers and doctors should be up to date but....have they got time?'

Black/minority ethnic participant interview 2

There was sympathy for the difficulty which doctors face in keeping up with advances in medicine and pharmacology:

'I think it's very hard for them really, to keep up with it all, I mean they... everything changes all the time, practically every day, and they've got to be up with it.'

Female group aged 70-79

A few supported the idea of some kind of MOT or assessment of doctors' fitness to practice on a regular basis or as they get older:

'I don't know whether you have sort of refresher courses and things, but I mean if a doctor has been qualified for a lot of years and is older, methods and things do change and I don't know what's available to doctors to sort of have... like, for example: if you were a hairdresser, you have ongoing [training] in different techniques and stuff and it makes you wonder where they're actually briefed on things like that coming out and are fully aware of what's going on really.'

Professional/managerial female group aged 30-39

One participant raised a point about the lack of patient evaluation of doctors' treatment:

'The problem, doctors get... they don't get any feedback. I don't think doctors ever ask you what you think of what they've said. The next time they don't ever say to you 'when you came in 3 months ago or 6 months ago how did we do? Did we fix it or did you not feel any better?' They never, ever do that. And what's wrong with that?'

Professional/managerial male group aged 20-29

5.6 Probity

With few exceptions, focus group and interview participants appear to take a fairly relaxed approach to some issues of probity. The perception of doctors as 'only human' is

widespread, and there seems to be considerable tolerance for misdemeanours in their private lives:

'I know very little about doctors' waywardness outside the surgery hours. As long as they're doing their job properly I'm not concerned, it's their affair.. I don't think they should conform to rigid rules. No-one else does. Other people do their own thing in their own spare time.'

Residential home interview 1

'I think they're just human at the end of the day, I mean it's like if they had an affair with their receptionist or fell in love with one of their patients, it wouldn't really... I mean as long as they're doing their job.'

Professional/managerial female group aged 30-39

'I think it is a good thing that doctors have come off their pedestals. Frankly, the more they are treated as ordinary human beings the better, because they are not Gods. They are just the same as the rest of us, but happen to be trained in one particular skill.'

Professional/managerial female group aged 50-59

However, there was concern that anything which affected a doctor's clinical capacity should not spill over into their practice:

'I don't think it's fair in the sense that, you know, they're off duty and they've got a... they're entitled to relax as much as anyone else, but on the other hand, you know, you could argue that, you know, that they'll have a big hangover and it'll affect them when they go back to work, so... I don't know.'

Manual/skilled non-manual male group aged 50-59

'It would be a bit worrying if it was drugs, because then we'd wonder whether they were all right when we were consulting them.'

Female group aged 70-79

'I disagree on that point, if they want to go out and take drugs and I don't know, be completely irresponsible, as long as they care about their patients and they're a good doctor when they're at work...'

Manual/skilled non-manual female group aged 20-29

The main areas of concern around probity were where doctors take advantage of their position, act dishonestly, or make serious medical mistakes which they do not acknowledge.

Some participants felt that overall integrity was important in a doctor because someone who was dishonest in their private life would not be trustworthy in their professional life either.

'Yes I think it is really important that the person who is responsible for your, possibly your life, is honest and trustworthy. Because if they are not honest and trustworthy in their personal dealings, there is suspicion that they wouldn't be honest and trustworthy with anything else.'

Professional/managerial female group aged 50-59

"Be honest and trustworthy" - well that goes without a doubt as well doesn't it?'

Homeless hostel interview 1

Abuse of doctors' privileged access to other peoples' bodies and prescription drugs was something that people mentioned as unacceptable, although relationships with patients where both were consenting adults were generally regarded as not grounds for removal from the GMC register. However, there was some variation in views on this aspect of behaviour:

'But basically a doctor can't have an affair with his patient because on the odd example where he can use that power, but there has to be a common sense shown by the medical board when they're reviewing cases, so if they know for a fact it was a consenting relationship, the law isn't there because it's a law that's to be abided by black and white. We're all adults, we all realise that, it's about trying to protect the doctor patient relationship. Now it's been established that it was a consenting relationship, thereby to me there's no problem whatsoever.'

Professional/managerial male group aged 20-29

'And fair enough if you've got the doctor patient relationship where there should be the big trust thing, sure enough don't abuse his position.'

Professional/managerial male group aged 20-29

Trust was not only linked to technical competence. A number of participants associated trust with continuity of care and the development of a relationship over time:

'I always would rather go to my usual doctor because I know him and I trust him and I always feel that I'm, yeah, listened to and taken seriously.'

Manual/skilled non-manual female group aged 20-29

'Oh I did trust them, yes, because I think they do know what they are doing and they'd saved his life before.'

Residential home interview 1

There were a number of references to Harold Shipman, but this case did not appear to have undermined the trust of participants in their own doctors.

Linked to trust is confidentiality which participants, when talking about their own medical history and records, appeared largely to take as a given. However, some of those taking part in the research felt that there might be situations where it is appropriate to pass information on.

'I think it's important. I think there is never a set rule for anything and I think there are probably times where it would be helpful if they did break it. Depending on the doctor really. It comes down to trust. You've got to trust people.'

Residential home interview 4

'If he needs further advice, so be it. I'm happy for him to talk to someone else if he needs to. I trust him.'

Older person in community interview 1

'As far as I know, I mean if they need to liaise with other things, then they usually ask me, so usually if it's for my better health and stuff like that, either physical or you know, mental or whatever, it must be a good thing but they usually ask me, you know. Would I mind if they get in touch? It's like 'no'. I'm pretty cool with that you know.'

Homeless hostel interview 4

Discussions revealed conflicting views about confidentiality in relation to young people and their parents, and other groups in wider society:

'She is entitled to confidentiality as well.

It depends on how old she is and what her problems are and'

Professional/managerial female group aged 50-59

'I do think that young girls, especially if they get into... have problems, the parents up to a certain age should be told. Their children should be... even if it's sixteen, the parents or mother should be told.'

Female group aged 70-79

'Yes it is a very woolly area. You would think there would be a particular age. I think as long as the doctor is acting in the interests of the patient. But then there is also society that if the doctor knows this person might do something which is a danger not just to themselves but to other people then what happens about confidentiality?'

Professional/managerial female group aged 50-59

'The only way that comes into a bit of a grey area, and I don't really know whether I agree or not, is when you get like suspected child abuse or suspected domestic violence, you know what do you do with that? Do you report it? Do you not? Should it be confidential, should it not? You know and it's a bit of a grey area that and I'm not really sure where I stand on that.'

Professional/managerial female group aged 30-39

Computers were seen as having the potential to both strengthen and weaken confidentiality:

'With regards confidentiality, I think perhaps it's more confidential using computers, because you'll have to have a password to get in. If it wasn't for that, you'd have a filing cabinet somewhere, and in the old days you could see this rotary filing system, everyone could have access to that, whereas only the ones with the password, and I don't think receptionists will have the password to get into the computer...'

Manual/skilled non-manual mixed group aged 70-79

Only one participant raised the question of independence from the drug companies.

5.7 Patient's circumstances

There is widespread variation in expectations of good medical practice according to the patient's circumstances and the context of their consultation. This is related to a number of factors, specifically: the severity of the illness; the location – the GP's surgery, accident and emergency, or in-patient care, and equally in rural or urban contexts; the doctor's age, experience and specialty. In treating serious ill health, people are clearly more concerned about technical competence than communication skills:

'For something that you know is just a niggle, that to take some drugs would get rid of it, you want to be in, you want to be out, and you want to get that prescription. Then again, on the other hand, if something's really serious you want that time taken.'

Manual/skilled non-manual male group aged 30-39

'I think it depends on what your need is. I haven't been to see my doctor for two years and the last time I went, it was because I had something very urgent. So I just went and presented myself and I saw who was available. But the time before that was probably a year before that and like you, you go along with your shopping list and I would happily wait for two or three months until that doctor was back from whatever and available.'

Professional/managerial female group aged 50-59

'You see when you go to hospital, you don't care who sees you, do you? Like you're just dying for any doctor's help...'

Manual/skilled non-manual female group aged 30-39

Equally, expectations of good communication and partnership appear to be lower in the hospital context, and there are lower expectations of continuity of care in urban locations:

'And I get a feeling that hospital doctors are looking after a lump of flesh that's come in that needs to be mended.'

Female group aged 70-79

'From my personal experience I've found GP's a lot... tend to listen and speak to you more than doctors in hospitals. If you're actually going for an operation or something, I find them a lot more stand-offish and not willing to actually get into conversation with you, they'll tend to tell you what they're going to do and then they're off again.'

Professional/managerial female group aged 30-39

'...on that level, I don't expect to be engaged or have a kind of relationship with my doctor, especially living in London'

Manual/skilled non-manual male group aged 30-39

'The doctors sometimes are a bit aloof when they're a bit older so. So you feel like the younger people or younger doctors relate to your lifestyle as well, in London I think.'

Manual/skilled non-manual female group aged 20-29

Experiences of communication in hospital were sometimes better than with general practitioners:

'I've found in the past, that the doctors that you tend to get at A&E do tend to be like a bit more helpful than the ones that you get locally.'

Professional/managerial male group aged 20-29

In some instances, younger doctors are considered to have better communication skills:

'My practice has a mixture of old doctors and younger doctors and the younger ones seem to have more time and more of an understanding of your kind of life in a fast, big city.'

Manual/skilled non-manual female group aged 20-29

'Since I've moved area, the doctors there are slightly younger, 30's and seem to have a little bit more of a positive mental attitude about treating you and a bit more... I mean maybe just a little bit more understanding, a little bit more chatty, a little bit more, let's find out, let's get some leaflets out, let's look at this.'

Manual/skilled non-manual female group aged 20-29

But not always:

'There was a condescension they had about them. It's not good for older people, especially. When people are in trouble it's not the sort of attitude they should have. An older man, older doctors, they were lovely. Like a father figure. Some of these younger ones, they need a good smacking. Proper little clever clogs.'

Residential home interview 4

5.8 Organisational and institutional context: access, availability and continuity

The wider changing social context in which medical practitioners operate was noted by the research participants. They perceived some of these changes as affecting the quality of medical practice. For example, repeatedly and largely unprompted, access to, the availability of, and continuity of doctors emerged as key elements of perceived good medical practice in the interviews and discussions.

Simply being able to see one's doctor relatively quickly was seen by some participants as what made them a good doctor:

'I'm really happy with my doctors, because it's you know, you can get an appointment the same day, whereas I found with the previous ones, it was like the day after and like it's just not good enough you know, if there's something wrong, there's something wrong to me, but I'm really happy with them.'

Manual/skilled non-manual female group aged 30-39

'You want to see them moving along though, don't you, because if you're sitting in the waiting room and your doctor's having a chat about your mate's life or something, you don't want to hear that do you, you want in, out, because I think the biggest problem in... with the doctors themselves, it is the waiting and it is the getting there and getting an appointment quick.'

Manual/skilled non-manual male group aged 30-39

'It's such a big effort to actually get an appointment and then go and do it. I would crave to have a surgery that was more in tune with a working person's lifestyle...'

Manual/skilled non-manual female group aged 20-29

'It's the only practice where I've ever had a doctor, the first time I sent... I think it was a blood test, something like that and they said 'oh ring such and such a time' and I was absolutely floored when it was the doctor that answered.'

Manual/skilled non-manual mixed group aged 70-79

'It takes so long to get there and sometimes you don't go because you think, oh what's the point, I'll be feeling better in seven days I won't bother to book an appointment. Because I'll be better, by the time I get in there I'll be better.'

Professional/managerial male group aged 20-29

Continuity repeatedly surfaced as an important issue of concern to participants. Although not part of the topic guide, it was one of the most frequently mentioned aspects of medical care:

'I'm in a good practice, but I do... if I possibly can see the doctor I always see because I just feel he knows me and I know him.'

Female group aged 70-79

'I think it's something that you sort of yearn for, like on the inside, that you wish that you had some sort of a relationship with the doctor and you... every time you went back for whatever it was, be it flu like symptoms or a gash on the arm or whatever, you see the same person because you think that, yeah he knows about you, you know about him, you feel a bit more sort of secure, safer, but in the end I think it's just about... just like I said about that first step, you just want to go in and out when it's purely for something minor... on that level that's fine, but I think deep inside I probably would wish that I could see the same GP but obviously that doesn't always happen.'

Manual/skilled non-manual male group aged 30-39

'I've got a very lovely, lovely doctor who I go to at my regular surgery and yeah, I think he's an excellent doctor and I've been with him since I was a kid so, I really know him well and trust him. But whenever I can't see him because he's booked up or he's away on holiday and I have to see other doctors, most of the time they're good but every now and again I get one that's not and I just... like I always would rather go to my usual doctor because I know him and I trust him and I always feel that I'm, yeah, listened to and taken seriously.'

Manual/skilled non-manual female group aged 20-29

However, there was a willingness to trade-off continuity in return for more immediate access to a general practitioner:

'I've got a particular doctor I see most often but like the lady said, if I just want a doctor I just go. But this particular one I do know in the practice, Pat will tell you about her, I get on really well with.'

Female group aged 70-79

Continuity was important partly in order to build up a relationship of trust and confidence, but also to save the amount of time spent going through a patient's history although computers have helped in this respect. In addition, there was a feeling that seeing a different doctor often resulted in different treatment which could be either good or bad:

'I kind of always question my doctor's words. Probably because I haven't really had any time to build up trust with my current doctor, well my current GP practice you know.'

Manual/skilled non-manual female group aged 20-29

'I'd prefer to see the same one only because of the experience I've had recently going all the time. I feel as though... having to explain myself again, I know they've got the notes there but you still have to go through things again, so having to see the same one would have been quite good really.'

Professional/managerial female group aged 30-39

'Yeah, but sometime I think there is a sense of continuity, you know if you... you know if a problem is chronic then you will... you are talking with the same doctor and the doctor knows what's been doing the last time with you but then if you are sent to another doctor and another doctor, everyone has got, apparently, his own idea about what's going on and every time you know, people start something new every time, you know it's like really hard.'

Manual/skilled non-manual male group aged 30-39

'If you see three doctors I'm not saying it's you know, it's great for a chronic condition but in terms of, you know, throwing mud at the wall and see what sticks, you're more likely to get a variety of opinions, you're more likely to get better if the first and the second one hasn't worked, then I would say it's more likely... I'd rather go to someone else, if the first few guys haven't fixed me up...'

Manual/skilled non-manual male group aged 30-39

'I must be the odd one out then, because I like... I like going to a different doctor to get a different opinion.'

Manual/skilled non-manual mixed group aged 70-79

In some discussions, contextual issues were mentioned, for example, a participant with a chronic condition felt happy to see any doctor for their regular six-monthly appointment, while at other times would want to see their particular doctor. Equally it was recognised that in hospitals, continuity was less easy to provide. For children, one participant thought that continuity was especially important:

'I think it's nice for children to see the same one because they sort of see the history and I know they can sort of read it but it's quite nice you know to see the same one.'

Professional/managerial female group aged 30-39

Since the original guidance was introduced, there have been a number of changes in the wider social context, particularly the greater use of new technologies as a source of information both for doctors and patients. The introduction of information technology was seen by some of the research participants as providing reassurance and a guarantee that a degree of continuity can be provided in spite of not always being able to see the same doctor.

In some cases however, doctors were criticised for looking at their computer screens rather than the patient:

'I don't really like the way they always just look at the computer now and like they'll just type and not really talk to you that much.'

Mixed group aged 16-19

'I agree with you, there's little difference between talking to your Bank Manager and talking to your doctor now because they both sit playing on damn computers.'

Manual/skilled non-manual mixed group aged 70-79

5.9 The doctor's role

There was a commonly held view that the doctor's role has changed. The traditional family doctor, while popular, was a thing of the past. Doctors were perceived as having to deal with more paperwork, more abuse and more time pressures:

'Doctors have to deal with much more now.'

Homeless hostel interview 1

'I think there are some who will always go the extra mile but I think what tends to happen with those doctors is that they get burnt out very young because the pressure of the work is so great, the work load is so immense that if you did that for everybody you would be burnt out before you were 40 and it is just not possible and I think they have to, they can't get as involved with patients as they used to on a personal level because so many people use their doctors now as replacements for their family because they don't have families. They don't have extended families so whereas when I was a child, if I was sick the first person my mum asked was her mum or her sister, well people now don't have that sort of contact so they come to the doctor.'

Professional/managerial female group aged 50-59

Overall, there was limited discussion of the doctor's role in health promotion and prevention:

'For least important, I got 'protect and promote the health of patients and the public' not so much for the protect, more for the promote. I don't think it should be a doctors' job to promote [health].'

Professional/managerial male group aged 20-29

'Everybody knows smoking is bad these days. They should explain, but they should not stop treating.'

Black/minority ethnic participant interview 2

There is little perception of the leadership role of the medical practitioner, and equally there appears to be little recognition of the wider health care team. In this sense, it seems that the public are lagging behind practitioners in their grasp of the doctor's role:

'That's the nature of the job now surely but you know it's... I'm not saying it's right or wrong or but you know surely now the nature of being a GP it's all encompassed, it's about treating your patients, working in the practice, working within the confines of a budget like many other professions have. It isn't just the face to face contact they have with people, it's you know their job encompasses a whole range of other skills etc.'

Manual/skilled non-manual female group aged 20-29

Also concern about litigation by patients was perceived to affect the doctor's role.

5.10 Role of Good Medical Practice

There appears to be very limited awareness of the guidance among those that we talked to. This highlights a need for an effective publicity campaign when the revised guidance is published, especially as some participants were sceptical about the value of guidance:

'I think we're probably the few people who've ever scrutinised... are likely to scrutinise these provisions.'

Manual/skilled non-manual male group aged 50-59

'But who reads this stuff anyhow? To be honest, I mean I know... I mean who goes along and... as an average person and goes along and ploughs through that?'

Manual/skilled non-manual male group aged 50-59

'Well if you start doing sort of really bad things then everybody thinks all doctors are like that so it's trying to... you sort of set a standard for doctors and there's a public image to them. It's a bit woolly though the way it's written.'

Professional/managerial female group aged 30-39

5.11 Conclusion

'A good doctor is a good doctor isn't it?'

Manual/skilled non-manual male group aged 30-39

In conclusion, the comments from the focus groups and interviews reveal the difficulty of defining good medical practice in a manner that is both sufficiently far-reaching and meaningfully specific. The majority of elements of the guidance are perceived as highly important by participants in the research, although more work may be needed to clarify the language and ensure that it is widely disseminated.

There seems to be a range of views about the key qualities and responsibilities of a doctor that are often context-specific. Some of the key characteristics of what people perceive as good medical practice are to a certain degree outwith the control of the medical profession, such as availability, accessibility and continuity of care. Some, but not all, participants recognised that doctors face a range of competing demands, for example, between the need to spend time with individual patients, and to see as many patients as possible.

Of major interest is the emphasis given by those taking part to the intrinsic importance of some of the 'softer' aspects of medical practice, such as listening to patients and giving information clearly, to achieve successful clinical outcomes. Patients want to be able to take technical competence for granted, but this will often be effective only where doctors have appropriate communication skills.

6 The Views of Doctors and Medical Students

In this section we report on the views of the fourteen doctors and eleven medical students. Although a small sample, the detailed discussions allowed us to gain deeper understanding of some of the key issues for members of the medical profession.

6.1 Good Medical Practice

Doctors' familiarity with *Good Medical Practice* varied. As with previous research, most said that they knew of it, but were not *au fait* with its detail. One doctor's explanation for this was that it seemed common sense so did not need to be read frequently. Those who had read it recently and knew what was in it had particular reasons for having read it: one was involved in teaching GPs, one was studying it as part of a law degree, and another had the 'duties of a doctor' on his notice board for reference.

'Well I'm familiar with it, yes. I would have had a copy once and have still got it filed.'

GP 3

'It's once of those things that's in the pile of things to be read, but probably never gets to the top. So you might have a quick flick when it arrives and think I must sit down and read that one day and it doesn't happen, to be honest.'

Hospital doctor 6

'The previous one... is something I've read a year or two ago, not since then I don't think, partly because it all seems very good common sense.'

GP 7

Some said they had used *Good Medical Practice* alongside other sources of advice to clarify situations about which they were uncertain, or for exam preparation, and as a prompt when writing a reference. It was also used to support a performance concern or criticism with a trainee, colleague, or student.

'I think one time when we used it was when one of the partners in our practice we felt wasn't performing terribly well and it was mainly about communication skills and listening to patients, it was more... you know they were very doctor-centred and it was actually looking through this for the sort of words that you could find that would express our concerns to that particular doctor, by showing him examples of what we meant.'

GP 4

Although doctors generally did not speak negatively of it, they tended to see *Good Medical Practice* as of limited use, either because it was not specific enough to guide practice, or – as stated above – because it was just obvious common sense. It was not generally regarded as the primary influence on doctors' practice. Most doctors looked elsewhere for guidance when they felt they needed it – to peers or their defence union, or other documents such as *Good Medical Practice for General Practitioners*.

'To get advice, well there's the BMA, there are ethics committees, there are other colleagues, there's the law, I think you'd take this in addition to all the other guidance that's out there.'

Hospital doctor 4

'I think they're more statements of principle rather than specific advice on what to do in an individual situation, so I can't recall a situation where I've gone and actually looked up this document. The other advice on the website yes, because that's much more specific and it gives you, you know, specific things to do in relation to what you're doing at the moment.'

Hospital doctor 4

'I find [Good Medical Practice for General Practitioners] because it's done in the sense that it has the, you know, the excellent, the unacceptable, it makes it very easy to look for specific examples, if you've got a specific example that you're thinking about.'

GP 4

'I don't think there are any surprises in there and I wouldn't go looking for guidance on how I should be practising from that. It's a kind of motherhood and apple pie but you do need to lay that out.'

GP 6

Some doctors regarded it as an aspirational document rather than as something they would expect to adhere to at all times.

'There's a problem living it sometimes but that's how it is. I don't think it's a problem at all (if you see it) as what you're aiming for.'

GP 7

Apart from its lack of specificity there were few other general criticisms, though two doctors felt it was too patient-centred and that it did not sufficiently recognize the difficulties faced by doctors in their practice.

'I think it's so difficult. It's so difficult because so much of the emphasis is this on protecting the patient and patients' rights and in a sense it feels almost falling over backwards to do that and possibly to the detriment of the doctor.'

GP 5

'I think it would help if practising doctors felt that the view of the GMC was not just for patients but recognising the conflicts that doctors have to actually face and giving support also for us in some of the decisions we have to make. So if you're saying they understand that there are occasions when we might be frustrated, then wouldn't that be nice if it was actually put down. But then they put in italics or bold, however, "your prime treatment is for the patient though in front of you" and you're not allowed for it to affect you or influence your decision making process... But a recognition of the difficult situation we find ourselves in on occasions would help.'

Hospital doctor 2

And interestingly, after the focus group discussion one medical student said that he had always seen GMP as just common sense, but the discussion had helped him see that there were debatable issues and tensions within it.

All doctors felt most of the 'duties of a doctor' were appropriate, although the duty to respect human rights was seen as redundant, and the duty to protect and promote the health of patients and the public elicited polarized responses: it was too high a demand, and it was self-evident.

'I don't think you add much by saying respect human rights... I would lose that one, not that it's not important but that it's said elsewhere.'

GP 3

'Perhaps respect humans right seems a bit PC.'

GP 4

'A duty of a doctor being to promote health is perhaps difficult in all circumstances, such as if you're not doing it, you're not doing your duty.'

GP 5

'Then put your little bit about... blurb about the patients protection at the very end put... because if doctors don't know that already then they need shooting.'

Hospital doctor 3

Many doctors said that the duty to make the care of your patient your first concern encompassed all the others. One, however, argued that this duty was problematic for two reasons: that not all doctors have one-to-one relationships with individual patients, and also that doctors with managerial or organizational roles have responsibilities to patients collectively not just to individuals.

'Actually I disagree with make the care of your patient your first concern, I'd just say 'make the care of patients your first concern' or even 'make the care and safety of patients your first concern'. But of course if this is meant to apply to all doctors and not just doctors who have patients in front of them, you could say well all these people in public health medicine who don't have one to one relationships with patients, if you then say that this has to be patients in general and safety issues as well, then those that are organising services and have a legal responsibility for organising services, then they're going to have to take into consideration best use of money and best use of resources as well.'

Hospital doctor 3

6.2 Doctor-patient communication

The changing role of patients, together with the question of communication as end or means, were key issues for this study. So it was interesting to see if doctors were aware of any tensions. Communication between doctors and patients was felt to be very important by nearly all doctors and medical students; in fact the medical students agreed that they were picked to become medical students partly because they were good communicators:

'Clinical practice is communication... A certain amount can be taught, but you've got to be a good communicator to start with - good at empathizing and putting that empathy across.'

Medical student

Communication was seen to encompass several important areas of doctors' practice, and it was spoken of very positively. Not only was an ability to exchange information with patients – both to convey it to them and to elicit it from them – seen as an integral part of good practice, it was also said to be a key means of building trust between the two parties. It was accepted that patients want to be well informed, and that doctors need to gain information from patients in order to understand the problem and suggest the right treatment.

One hospital doctor felt that informing the patient about their treatment and its potential limitations would make them more likely to co-operate with it, and his account suggested a one-way flow of information from doctor to patient. From other doctors, there was a recognition that communication skills were needed for information to flow both to and from the patient.

Some doctors identified the importance of communication for understanding more than the presenting symptoms and to get a more holistic view of the patient's needs. This understanding was believed, in turn, to have implications for 'concordance' and clinical outcomes.

'[A colleague] sent round this great email the other day. He said 'communicating well is both a means and an end' and I think that sums it up really. It is part of the job. It isn't just a way of getting the information, but as much as anything it's about understanding why the patient has come along to see you'

GP 7

'In so many cases poor communication means that the patient does a completely different thing from what you thought they were going to do and there was no point in prescribing those tablets anyway... however clinically competent your decision was, it negates it.'

GP 3

On the other side communication was said to have its problems. For example, some people said that the requirement to share information with patients which included associated risks and uncertainties was possibly too stringent because this took time, was unnecessary, or not always wanted by patients. But others said that the wording of the standard was good because it allowed for the degree of communication to vary between patients:

'I think there's one statement which I thought was very relevant, was the sharing of information with patients which they want or need to know. Because I think, certainly recently, we've been encouraged very strongly to sort of tell the patients everything. And a lot of... certainly a lot of patients I deal with don't want to know everything and you know it's, again it seems essential in communication to actually work that out, what they want to know and often you end up telling the relatives sometimes more than you tell the patient but... so I think this is phrased very well because it's actually phrased giving a little bit of... well giving your judgement on an individual basis...'

Hospital doctor 5

The amount of time communication can take up was frequently mentioned:

'The other thing you've got to think about is time – giving lots of information can double or triple our time. It may be an ideal, but should it be set as a standard?'

Medical student

Or the doctor may not be in possession of all the facts or does not want to overload the patient:

'Yeah I hope I always manage to achieve them. I'm not sure I do because when it talks about associated risks and uncertainties, I'm not sure I always have that information adequately at my fingertips, but I'm sure they're qualities that most people would aspire... that I would aspire to.'

GP 4

It was argued that in some hospital situations, doctors themselves do not always give patients the information they want or need, but that some member of the team would ensure that the information was given to the patient:

'It's not achievable within the outpatient setting, but we work as a team so we have written information. We also have colorectal nurses who would be in contact with the patients and we work as a team and will then pass the information through to the nurses. The nurses might talk at length to the patients, they may bring concerns back to us.'

Hospital doctor 2

However, this could cause problems, especially with lack of continuity of care. Thus, a hospital doctor described an incident in which a patient's management had been complex and had had to change many times in response to her changing condition. The doctors had worked hard to give her the best care that they could, but organisational factors had impeded the flow of information to her, and they felt aggrieved when she lodged a formal complaint stating that she felt she had not been cared for well because the reasons for the changes in her care had not been explained to her.

Some argued that communications skills were more important in some contexts than in others. For example, they may be more crucial in general practice than in other areas of medicine:

'There aren't right and wrong answers in medicine most of the time. It depends a lot on what people think themselves, what patients want and you know, what resources are available and unless you talk those things through, you can't possibly know what's going to be right for each individual person. And I suppose with General Practice that's probably more the case than it is in most things.'

GP 4

'One immediately thinks of surgeons and it depends whether you see them as technicians, and obviously the person doing the operation under the anaesthetic, at that moment, communication is probably not high on the list. But deciding whether or not to have it is an equally difficult part of their job, and I think there's been a remarkable sea change in both the attitude to consultants and also their relationship with patients is a much more rounded one.'

GP 7

Doctors regarded their communication skills as more important for understanding the patient than specifically for making them feel at ease or comfortable (though the latter had been mentioned by our lay research participants; see Section 4). There were very few references by doctors to putting patients at ease, suggesting perhaps that patients value this more than some doctors realise.

'I think some... certainly the elderly population generally, they'll come and say to us 'you know just do what you want doctor, you know you're the doctor'. And people feel quite uncomfortable when you start putting a lot of the 'decisions' on them.'

Hospital doctor 5

Confidentiality

The ways in which doctors nowadays work with colleagues and others has implications for patient confidentiality. One hospital doctor found that explaining to a patient early on how information about them would be shared was beneficial. What governed how information about patients was shared between professionals, and to what extent patients were actively informed of this sharing, was often implicit to some extent, although doctors were prepared to make it explicit if the patient asked.

'My experience is that if you tell patients what you're trying to do and why you're doing it and the process of how you make those decisions, particularly a group of professionals making a decision about how a patient's care then they usually are on board at the outset. I mean a good example as far as I'm concerned is the management of cancer, which I deal with a lot. And I tell the patients that these things will be discussed amongst a group of professionals and we'll come back to them with a treatment plan which I then discuss with them.'

Hospital doc 2

Some doctors felt that it was not always necessary to spell out to patients how information about them would be shared and who will have access to it; they assumed patients would expect that information would be shared within a team and that a receptionist might have access to it. The issue was not considered to be very controversial, and it was thought to be reasonable that the onus was on the patient to ask if they wanted to know exactly where information went, and to tell the doctor if they wanted information to go no further. Doctors themselves were not always sure who had access to what information.

'I suspect that people actually just take it as read that if you're part of a multi-disciplinary team and you're talking to the doctor, then not only does the doctor get to know that but also the nursing staff, the physiotherapy staff and everybody else...'

Hospital doctor 3

'I don't tell the patients whether receptionists or secretary or whatever look at this information. I assume they know that I don't type my letter so the secretary will write it but I don't say this, I don't explain that and I don't explain who has access to different parts of the medical record. I don't know whether that would be helpful or not.'

GP5

Doctors were clearer about their responsibility not to share information about a patient with members of the patient's family without the patient's consent.

'But quite often people will say, and it's mostly in relation to, you know, if you see a teenager, you know, 'will my mum find out?' and that sort of thing, so you quite often have fairly explicit discussions about exactly what my duties are and their

reasonable expectations are that, you know, none of this will go beyond the practice.'

GP 7

6.3 Partnership and shared decision-making

The term partnership features several times in the draft of *Good Medical Practice*, and the participants were asked to say what it meant to them. Interestingly, it was understood in a number of ways.

First, but not commonly, it was described as a style of interaction between doctor and patient which included eye contact, introduction, giving time and space to the patient, exchanges of information, etc.

Secondly, and much more commonly, it was described as a relationship of equality:

'I mean partnership means to me that you're effectively working as equal humans in an interaction and that partnership you have to have a reasonably equal relationship and to ensure that both parties are happy and comfortable with the decisions that are made, so that you have got pretty much an equal consensual plan which isn't coerced on either side, so there's got to be sort of a balance there. So it's not one party dominating the consultation or the decision making.'

GP 2

Even more common was the view that in a doctor-patient partnership, the term meant that the participants had complementary roles. For example, one GP understood partnership to imply a relationship in which the patient is encouraged to take some responsibility and assume an active role in their care, as well as in which the doctor is sensitive to the patient's lifestyle and priorities. Partnership was seen not just as a superficial matter of etiquette or demonstrating respect, but responding to individual patient preferences, values and needs, with implications for management:

'I think it means using a patient-centred approach to care, so it means finding out what the patient knows about the condition, what their expectations are, what their concerns and expectations are. But I think that's what one does everyday. I mean you find out what's important to the patient, you find out what they do think is going to happen, you find out what they're worried about and then you try and use that information to share with your own information that you think is important to come to a conclusion and to work out what you're going to do. But if you don't use their understanding you won't get very far because they won't take any notice of what you say, so I suppose... it's so fundamental to the way one consults.'

GP 5

Or more specifically, partnership could be taken to mean that patients are presented with choices and have a role to play in making a decision:

'And to me, working in partnership means a patient should be offered choices. Like this is the diagnosis, and this is plan A, this is plan B and having... if you go for plan A these are the risks and these are the complications, plan B or treatment B is the other complications... that's I think what means patients .. working in partnership'

Hospital doctor 1

For some doctors the notion of helping the patient make a well-informed decision and respecting patient autonomy was central to the concept of partnership. Partnership both made for a more effective consultation and protected the doctor if something goes wrong.

'Rather than this is the doctor deciding what's going to be done to the patient because it's in that person's best interest, the person's best interest might not be anything like what the doctor thinks is in their best interest. And so unless you find out then you could probably be going down the wrong track and if something does go wrong, then certainly you really are going to be in deep trouble potentially.'

Hospital doctor 3

Desirability of partnership

Most doctors felt that working in partnership with patients was both realistic and desirable:

'Yeah they are [realistic]. I mean they're very difficult to achieve because of time constraints and all that sort of stuff, but yeah they're, you know, I don't think anybody could argue with that.'

GP 4

Some doctors said partnership was a good idea because it was necessary to move towards a more patient-centred mode of practicing and it was important to spell this out for some doctors.

'I think what you're trying to do is shift the balance more towards the patient end of the scale than the doctor and I think that's right. I think if you look at the sort of disasters that have happened in the last sort of ten years, the big enquiries that have come, and you read the, particularly the patient feedback that's always done as part of these, that that's the one thing that comes through time and time and time again, is that this move away from sort of paternalism is just something we have to do.'

Hospital doctor 4

Asked what was the value of having statements about partnership in the guidance, one doctor said:

'So one would hope that with the change in the profession, it won't be necessary, but not everybody does always think like this because that's not a... perhaps a way of thinking they've been exposed to... it probably is helpful to say 'this is the bottom line, this is what we think is important now.'

GP 5

On the other hand, several of the medical students said they thought 'partnership' was not the right word, because

'You don't have equal status and expertise, though you are working together.'

Medical student

And one doctor similarly objected to the equality implied by the term partnership:

'There still does need to be a doctor patient role rather than you both on an equal level.'

Hospital doctor 5

Feasibility of partnership

Many participants spoke of partnership as feasible, though it requires working at:

'Well I think it's reasonable to expect everybody to treat everybody as equals but when you sort of train as a doctor and you're in any sort of professional relationship, there's always a tendency for the relationship to become unbalanced and certainly to start with it's quite difficult to maintain that sort of partnership. So I think it's something that does require work, I don't think it's something that just comes... It does require work to make sure that it is a partnership rather than one sided.'

GP 2

Some thought that it was not feasible because not all patients wanted it or were capable of assuming such a role:

'To a certain extent I think that's a bit pie in the sky because there's only a limited amount of negotiation that you do with your mechanic when you take your car in. You pretty much take their word for what needs doing and then you decide whether or not you want to or have the means to pay for it, or decide to leave it for another year. And I think medicine can be pretty similar.'

Hospital doctor 6

One argued that putting pressure on patients to assume such a role could be damaging, and was sometimes done in situations in which the evidence for best practice was unclear and that getting the patient to decide on the course of action was like 'passing the buck'.

'Well it means you have to explain to the patient what the clinical situation is, what investigation they need to go through and what treatments would be available. You have to inform them and then they have to make reasoned, educated decisions about how they want their health care to be taken forward. That works fairly well most of the time but you do see a number of patients who simply don't want that.'

Hospital doctor 7

'I think a lot of the time people actually don't want to sit and talk about the intricacies of everything and they want advice and they want to be told and I think sometimes to put too much pressure on the patient is not the right thing to do.'

Hospital doctor 6

'I think the biggest worry I've got is that this work in partnership will almost pass the buck a little bit and it will stop doctors from actually... I think doctors often have to make really quite hard decisions sometimes or state quite a firm opinion when they don't believe it's in the patients' best interest and to say why. And I think you always should be able to justify everything you say as well... I think sometimes, especially recently, it can be used as a little excuse to sort of not face the complex problems or the difficult decisions and things.'

Hospital doctor 5

Some doctors thought partnership was becoming more feasible nowadays because patients have a higher level of expertise – partly due to the increase in accessibility of information, and partly because they know about their own preferences and values and lifestyles. Patients may have different priorities from their doctors – for example in a trade-off between quality and quantity of life – and doctors should be aware of this. One GP acknowledged that medical school training does not necessarily equip doctors to value

a patient's expertise about themselves. However, there was an optimism that this situation may be changing.

'It's probably not something that does come naturally, because you have this idea that you know you train and go to medical school, learn about things and then it doesn't come naturally to think that somebody else would know more than you would about it so it...'

GP 2

'I think they're quite reasonable in the sense that patients are quite well informed these days, they can go on the internet, they can do some homework to know as to what operation they're going to have, what procedure and if they have any known diagnosis, they go on the internet and do some study as to what it is called, what causes it, what is the management.'

Hospital doctor 1

One hospital doctor said that one of his jobs was to help the patient distinguish between reliable and unreliable evidence, suggesting a role in promoting health literacy (which is not covered in GMP).

However, the access patients have to information was not necessarily always viewed as a positive thing: it could lead to extra work for the doctor who has to find time to read material brought in by the patient.

'Well I suppose a good example would be when they come armed with sheaths and sheaths of paper from the internet and I have to try and dissect some of this out and try and explain what we think is professionally appropriate and that which is anecdotal derived from the internet. I mean the majority of patients are relatively ignorant of what is on offer but they're not relatively ignorant about their own position and their own symptoms.'

Hospital doctor 2

It was also thought that partnership could lead to raised patient expectations or to conflict between the doctor and the patient. One doctor had a patient with chronic fatigue syndrome who brought in information and made a specific treatment request on the basis of it. She gave an account of how she had been open with the patient that her treatment request may not be justified on the basis of the evidence she had brought. When the patient's view of what is appropriate treatment conflicts with the doctor's, this could raise difficulties:

'Yeah, she had it written down, she's got a lot of time to think about these things this woman. So it was very interesting because I said to her 'well you know, okay I mean I'm fine... I don't know whether there's any evidence that magnesium is helpful for Chronic Fatigue Syndrome, but I'll look at the stuff, what you've brought, but it might put me in conflict with you' I said. 'Because I might think that it's not justified and you know, that would be difficult, because I'm not going to necessarily agree with you about whether I should doing this or not.'

GP 4

'The patient's assessment of their needs may be different to your assessment. So something as simple as antibiotics for a cold, which is very common, that the patient may think they would work and you think they won't work, so you've got a conflict there.'

GP 2

A hospital doctor observed that patients' expectations of involvement in their care have increased while their trust in doctors' omniscience has declined. However, not all patients want to share decisions, and this may be due to the deferential culture of their generation or the fact they are unwell or frail. For example:

'A fair amount of patients don't. You know we see it a lot in the clinic and in the hospital, on an in-patient basis. I mean more and more nowadays they're... if it's an elderly person... it's because of the generation of them growing up with the doctor and patient role being very distinct. I think as people get older in this generation, it's going to change and reverse...'

Hospital doctor 5

It was sometimes difficult to involve patients in a partnership because there were limits to the complexity and amount of information some could absorb. Doctors acknowledged that patients differ in this respect, but one said that it is best to start out with the assumption that they will be interested and want to be involved.

'I think you shouldn't assume that people are daft and you know you should assume that someone is going to be interested and want to know, although they're not always interested and don't want to know, but you should start off assuming that they're interested and want to know.'

Hospital doctor 6

Partnership and decision-making

A specific problem with partnership was the question of who ultimately takes the treatment decision. For example, partnership might mean that patients take unwise decisions. One GP said:

'You know how serious a condition is, I think you really ought to go to hospital now, but if you really want to wait six weeks and see if it happens again, okay that's not my idea of the best thing to do. But what happens if you do that? Well the risks of this happening are this.' 'Okay that's the risk I want to take.' 'Okay that's the risk you want to take'. It's not comfortable because you have to carry the uncertainty of their decision.'

GP 5

One doctor underlined that shared decision-making should not become a case of the patient making decisions without the doctor's support.

'Now what I don't think it means is... and this I know is... a lot of people do mean this, I don't think it means neutrally presenting a series of arguments and leaving the decision up to the patient. I mean it may mean that in some cases, but certainly for a serious illness, many, many patients have written that that is not what they want. They want a recommendation, they want information, but they want the doctor to say 'I think this is what you should do'. So I think it should be a partnership, I don't think that means that the doctor is absolved from the responsibility to advise the patient as to what they think the best way forward is.'

GP 6

Another GP described clinical decision-making as a messy process, not strictly rule-governed, but influenced in ways that were more or less legitimate by the patient and

other factors. The patient's influence sometimes felt like manipulation, and the suppression of the doctor's own strong views could feel uncomfortable.

'I know those things can be very arbitrary as well because it might depend how I feel that day, or how the discussion goes or she might say something that - I may have made a decision, but I may change it. It's a bit arbitrary all of that isn't it?... It's sometimes very difficult when you know that your own views are getting in the way, because I know from experience that in some situations I have given people things and then after a bit I begin to resent the fact that I feel as though I've been... manipulated into a situation that I don't want to be in..'

GP 4

A hospital doctor identified the difficulties that sometimes arise in ascertaining patients' wish for involvement in decision-making and said that these issues are closely bound to communication, and patients' receiving and understanding information.

'They say down here 'listening to patients, respecting their views.' Yes because if you don't do that then you can't make... they can't be involved in choices, they can't be involved in decisions. It is very difficult to explain complex things to them and you often get this... you've spent five minutes trying to explain the benefits of Warfarin over Aspirin, give them lots of numbers and then they say 'Well, what would you want Doctor?' (Laughs). You don't know whether it's just the fact that they haven't understood it completely so you sort of start again, or whether they just do genuinely - some people just don't want to take those sort of decisions.'

Hospital doctor 3

Another doctor made the same point using the analogy of the car mechanic again:

'They're realistic up to a point but the patients haven't been to medical school. They don't have medical training and if I was taking my car in to get fixed, I'd assume the mechanic could fix it, I wouldn't want to be involved in the decision making, but I understand very little about the mechanics of cars, just the basics. So equally if it's a complex cancer case which is what I treat all the time, I would expect the doctor, i.e. me to explain what needs to be done and get on and do it in a very competent way. I don't think the patients really have got an awful lot of say so in what is done in that situation for obvious reasons. They could hardly discuss the differences between a high and a low anterior section for instance.'

Hospital doctor 7

Doctors understood that, in most circumstances, the patient had the right to decline treatment.

'I mean even if you're utterly convinced that they're taking the wrong course of action, so long as they have taken on board what information you're giving them, and have the capacity to make that decision, then that's their decision.'

Hospital doctor 6

'Oh I think there are a lot of occasions when they [doctor] would tell them what's best for them. I mean in a way they might have the last say because you might say 'what's best for you is to take these tablets and to lose weight' and the patient goes home and eats egg and chips and throws the tablets down the loo, so you're still having the last say, the patient has to do it.'

GP 3

Sometimes a request for treatment which the doctor feels is inappropriate would have implications for resource allocation or rationing. In this context, one GP felt their gate-keeping role sometimes brought them into conflict with patients. Unsurprisingly, doctors generally seemed more ready to accept decisions with fewer resource implications than those which demanded more tests and treatments than what the doctor had recommended. This GP used language carefully so as not to assume that the GP's perception is necessarily right and the patient's wrong:

'People may have an inaccurate perception, or what I perceive to be an inaccurate perception, or they may want something that cannot be provided within the resources available. So I see the issue as a dialogue of trying to balance the patient's wishes and understandings with what is realistically available and what is needed.'

GP 6

"Well actually doctor I'd like a heart bypass, I'd like a heart valve and I'd like to be put on dialysis".... And sometimes things are totally inappropriate and under those circumstances, yes you might have conflicts.'

Hospital doctor 3

A hospital doctor raised the possibility that respecting a patient's decision to follow a course of action which the doctor believes is not in the patient's best interests could leave them open to criticism, and even legal action. He highlighted the need for good record-keeping particularly where a patient has made a decision the doctor feels is not in their best interests, to protect the doctor from allegations that the patient was ill-advised.

One doctor (who also had some legal training) argued that the draft of *Good Medical Practice* was well worded and struck the balance well between the doctor's and the patient's right to make a decision about treatment. Asked whether the patient should always have the final say about treatment decisions, they replied:

'No, not categorically, and again I'm afraid I have a bit of a legal perspective on this, but that's not what the law is and the law's not that for a very good reason. That you know, if you left doctors in this situation whereby they were compelled to do something that they felt was not in the best interests of the patient, that just wouldn't be a good situation. So I think there has to be some kind of agreement that what is being done, is you know both acceptable to both parties and that if there's disagreement, then you know no action is taken until some kind of compromise can be reached.'

Hospital doctor 4

6.4 Obligation to treat

Doctors' personal beliefs

Many doctors had confronted situations in which their personal and professional identities, values and roles conflicted, and they managed these conflicts in various ways. Some put aside their own values, while others would pass a case to another doctor. Two doctors said they felt it was very important that doctors had strong ethical beliefs and that they should not be expected to compromise them in the course of their work.

'As I say, for me it's about professional balance, I have to be able to step back and distance my own personal ethos from what's in front of me... That's how I look at it... if it's about the question about your values and my belief is you step back from there.'

GP 1

'I think it's quite all right to have self-beliefs because that's what makes people individuals but I don't think it should affect the patients' care.'

Hospital doctor 5

'There is a difficult ethical issue, but I don't think one can force doctors who hold very strong moral beliefs to do certain things, but on the other hand it would be quite wrong for a patient, through the lottery of who they happened to be registered with, to be denied appropriate advice and treatment.'

GP 6

One GP picked up on the phrase 'unfair discrimination' and was pleased that the guidance allowed for discrimination on the grounds of clinical need and likely outcome.

'I was trying to work out in that how do you fairly discriminate against somebody... Well I wondered if they were trying to say something there, that actually there is discrimination and it can be fair, partly on ability to benefit, partly on the magnitude of the benefit... so I think it's a quite well chosen phrase.'

GP 7

This doctor felt that discrimination was already ingrained in the system, regardless of what individual doctors did. He felt that the guidance should allow that it was not always within doctors' power to avoid being part of a discriminating system, and that the principles behind the discrimination should be made explicit, and that doctors should have an obligation to resist unfair discrimination where they see it.

'I suppose it's to re-word it to make it clear that there is going to be... there are going to be times when you will discriminate against people unfairly but it's not necessarily within the power of the doctor to do much about it other than to flag it up to people saying that if you do notice that there is unfair discrimination, that as a doctor your duty should be to say 'why is this happening?' perhaps and is there anything that can be done about it?'

Hospital doctor 3

Abortion was the most common example used to illustrate the potential conflicts. Most agreed that doctors should not be forced to compromise their beliefs by arranging a procedure they had ethical objections to, but that patients should not suffer as a consequence. Some felt this could be resolved easily by arranging for another doctor to take over the patient's care. However, some argued that it was impossible to avoid the tension completely: one GP thought patients suffered a sense of guilt simply from a doctor refusing to arrange an abortion, even if they refer them to someone else. Equally, doctors who refer a patient to someone else to arrange a procedure they objected to might still feel morally compromised.

'I think that they have just to make sure it doesn't adversely affect patient care, so they don't say 'you person you go out of this waiting room and keep that baby'. They say 'if you wouldn't mind I'll show you to my colleague down the road' and that's absolutely fine.'

GP 1

'The partner we have now, just says 'well I'm sorry, I don't believe in it, you know and doctor so-and-so will see you.' Even in that situation people perceive a judgment. And that's the best situation there can be... you still create guilt in patients about that situation by saying 'I don't believe in it'.'

GP 4

'They might consider that to be against their beliefs and I think the document is right not to make it an absolute duty to refer.'

Hospital doctor 4

Patients with conditions related to lifestyle

Doctors were sometimes frustrated by the added demands on the health service made by people whose behaviour or lifestyle they considered contributed to their condition. In particular, one doctor perceived patients' alcohol and drug problems to be self-inflicted, and the consequences of these problems made it difficult for doctors to deal with the competing demands on them. Another, in contrast, was more sympathetic to patients whose obesity affected their health, but who were unable to lose weight.

'I completely agree with the 'you must respect your patients' right to their life choices and beliefs' because you take away autonomy if you don't.'

Hospital doctor 5

'I mean I think it's sometimes very difficult when faced with the same problem over and over and over again and feeling that their lifestyle is bringing it on... Drug abuse would be another one where people who are intravenous drug abusers will come with abscesses. If they weren't intravenous drug abusers they wouldn't have abscesses and it's a frustration in that we are being pushed to achieve targets, be efficient in our bed utilisation and we have patients who come in and one feels slightly irritated that they're wasting bed space and wasting one's time... So yeah there is a conflict and the conflict is brought on by other groups that come with different sets of criteria and whose jobs depend on meeting targets. And the doctors sometimes are in the middle.'

Hospital doctor 2

The medical students were also interested in discussing this aspect and talked about it at some length. For example, they thought that a heavy smoker who continued to smoke was not fulfilling his or her part of the partnership with the doctor. But they ultimately agreed that the guidelines which stated that decisions to treat must be taken solely on grounds of need and likely effectiveness of treatment were right. They certainly thought there were times when a firmer approach with patients was needed:

'Some times you need to step away from the 'it's all right, it'll be fine' lovey-lovey kind of communication, and give some facts - for example, if you've got a very obese patient.'

Medical student

6.5 The importance of technical or clinical expertise

The interviews revealed differences in the use of the term 'clinical' and how communication related to clinical competence. Some used it to refer to the strictly technical areas of doctors' work, such as making a diagnosis on the basis of presenting symptoms, while others considered that it encompasses all aspects of the doctor-patient encounter including the process of building the relationship and gathering the evidence necessary to make a diagnosis.

Asked whether it was possible to be a competent doctor without good communication skills, most doctors thought you could not separate technical expertise from communication skills:

'I think it is possible to be clinically competent. But I don't think clinical competence is a whole competence. So I don't think it's possible to be a competent doctor, a completely competent doctor without good communication skills.'

GP 3

'I don't think you can be clinically competent without good communication skills. You may be technically competent but clinical competence clearly is, well to my mind, is completely dependent on adequate communication.'

GP 6

'You can have someone who has a very, very good text book knowledge of medicine, but actually unless they can communicate that to the patient, or they can extract the relevant information from the patient, then you know, what good is all the clinical competence they have? So as I say, I wouldn't try and divide the clinical competence and the communication. One is part of the other.'

GP 1

However, some doctors felt that communication skills were only important for doctors in clinical practice. Some were concerned that an over-emphasis on communication skills in the process of selecting trainee doctors exacerbated the shortage of doctors.

In fact technical competence was seen by all as crucial, and most doctors agreed that the requirement for them to keep up to date was also important, reasonable and feasible, and that the infrastructure was in place to facilitate continued education and development.

'You shouldn't be operating in 1970's style if you're working in 2000 should you? So yes you do have to develop your competence and performance to keep up to the times that you're working within.'

Hospital doctor 3

But putting into practice the principle of keeping up-to-date was seen as difficult:

'I think to be kept up to date either by going to conferences or often having good quality juniors coming in and telling us how things are moving on, that's no bad thing. I think if you adopt the attitude that you know best... you knew how good it was 20 years ago, that's how it's going to be, then that's actually quite a dangerous attitude to have. So lifelong learning, signed up for that.'

Hospital doctor 2

None of the participants expressed disagreement with the audit requirements in the guidance, and most were in favour of them:

'I think they're quite right. I fully agree with these and I think we... most Trusts or rather most of the unit... there's always one or two consultants in every speciality who are supposed to be looking after these. And they make sure that enough audit is being conducted in different specialities, such specialities every junior doctor does something like an audit or maybe go for some courses.'

Hospital doctor 1

However, it was argued that it was unrealistic to keep up to date with everything, and realistic to try to be aware of the boundaries of one's expertise.

'It isn't realistic, you can't keep up to date with everything, you just can't but I think what is realistic is that you would try to be aware of what you don't know. Because mostly in General Practice it doesn't really matter if you don't know something because you can always go and find out... So I think knowing what you don't know or knowing where you're not certain about things is probably all you can do. And I mean do your best to keep up to date. I find it terribly difficult to keep up to date.'

GP 4

'I think the only difficulty is and of course it's a difficulty that everyone's grappling with, is how you operationalise that. So as a principle it's fine, but it's pretty vague about what activities are involved and does this mean an annual chat with your appraiser, or does it mean re-sitting exams, or what does it mean?'

GP 6

Continuing medical education has recently changed in ways that some doctors felt made it more useful than the previous requirements just to attend a particular number of days' training a year.

'Well that's how it was for the ten years up until last April, April 04, was that we had to do... I can't even remember what it was, five days a year or something or five... or thirty hours or some figure anyway over five years or something. But the quality of it, or even what you took in from it... So then you know PDP's [Personal Development Plans] and these sort of things begin to come in and appraisal begins to look at what you're going to learn, which is moving in the right direction.'

GP 7

One GP felt that the current systems of assessing doctors' knowledge and skills were treated as formalities and were not always taken seriously. Another advocated that assessment processes should not involve too much bureaucracy, and should be formative rather than summative, and one felt the best place for learning was in the consultation as this is where the doctor had to face the gaps in his or her knowledge and skills.

'Really, it's very easy to say that you're doing all these things and more. I don't know how helpful it is writing this stuff down and saying 'you must maintain a folder... you must reflect regularly on your standards'... Really I think it's important to do this, but I think if you tell somebody to reflect regularly, it's difficult to take that really seriously. I'll do what I'm told, I'll do anything that I'm told and I'll tick the boxes because that's what you have to do as a doctor now, you have to tick boxes and keep everybody happy...'

GP 5

'There is a big danger that it could be more of just a form filling in, a hoop jumping through exercise rather than anything that's actually constructive. So I think there is a way of doing it which isn't like that and it isn't too over burdened with red tape, but I do think there perhaps should be a better structure in place and I think that should be formative and educational rather than... well rather than sort of more coercive and what's the word... binding I suppose.'

GP 2

Finding the time required for continuing education was a challenge, but still it was considered sufficiently important that the guidance was justified in making it compulsory:

'Again, I thought that paragraph had the balance about right. You know again from a sort of practical point of view these additional things can sometimes conflict with our clinical duties, they're things that we have to work into our day to day jobs and when you're working in a system that has the resources that we have, you know we don't have a lot of spare time to do these things, but I do agree that they are important.'

Hospital doctor 4

6.6 Probity and maintaining public confidence in the profession

The issue of probity was seen to relate closely to public confidence and trust in the medical profession. The OED definition of probity given in the draft of *Good Medical Practice* was thought not to be very clear, particularly if it was designed to be accessible to patients as well as doctors. Many doctors found it difficult to say whether it was reasonable to call on doctors to demonstrate 'moral excellence,' and one pointed out the difficulty of distinguishing minor misdemeanours which were of no real significance from signs that a doctor's integrity or judgment should be examined further. However, the definition of probity did not generate the levels of antagonism that it did amongst patients.

'Phrases like "moral excellence" just don't mean anything.'

Hospital doctor 4

'Can I get the dictionary out please? It needs to be kept at a level which probably you can get somebody off the street to be able to read through this and make sense of as well, not just somebody who's been educated to degree level.'

Hospital doctor 3

There was some ambivalence towards the statement of probity: two doctors found it somewhat risible, while others thought that it was valuable in that it recognised the responsibility of doctors to be worthy of the trust their patients are bound to put in them.

'Yes I shall be wearing my halo and polishing it daily! I think that's just that you would want to think that somebody who you are being treated by is a generally good egg, but I think it's probably a bit of a high standard isn't it?'

Hospital doctor 6

Given the level of trust patients had to put in their doctors, it was agreed that high standards of integrity were required. However, several doctors felt expectations of probity as set out in the document were too high and that it was unhealthy for the profession to be put on such a moral pedestal. Most felt that a distinction should be drawn between moral behaviour in the professional and private spheres, although the distinction was not completely clear as it was possible for behaviour outside working hours to influence the reputation of the profession.

One doctor argued that higher moral standards should be expected of doctors than of other people because of their unusual responsibilities and privileges, and that it was in the public interest to have high expectations doctors. However, others felt that the increasing trend away from blind faith in doctors was a good thing.

'Do you think that we should expect higher standards of doctors than other people?'

interviewer

'Yes I do... because of what you've got to do, I mean I assault people every day. In any other walk of life, put a knife into their belly and rummage around for three or four hours. That's an assault in any other walk of life...'

Hospital doctor 7

'I think the days have long gone where the consultant walked on the ward, everybody stopped what they were doing and this God came on the ward and you know, everybody followed him and anything he said was right. And I think that's only a good thing. What I wouldn't want to happen is for it to swing the other way and the respect lost.'

Hospital doctor 5

'I think, you know doctors are human, if they thought themselves perfect then they probably wouldn't be very good doctors.'

GP 5

'Should we have higher expectations than other members of society? Not really, no. We should have similar expectations of all members of society, but in terms of the profession it's not unreasonable to spell out what those are... I think probity is very important. It's important in life but I think it is very important in medicine.'

GP 6

However, other doctors argued that having high expectations of doctors' outside of their professional life while expecting them to respect patients' human rights and lifestyle choices was hypocritical and potentially an infringement of their civil liberties. It was possible to be imperfect yet still be a good and responsible doctor.

'With the medical students now, people are jumping all over minor disciplinary offences and wondering whether these require further investigation and I don't think if a kid has a caution for smoking dope when they're seventeen that that means they can't be a perfectly responsible and respectable doctor. So it just has to be a little bit careful about balancing the civil liberties of individuals with the notion of the ideal doctor.'

GP 6

Most participants drew a distinction between probity in professional and private life, and argued that a doctor should not be expected to behave morally differently from other people as long as their professional performance was unaffected.

'Moral excellence - I think at work you absolutely should have it and then I think what people do in their private life you know, may be very different.'

Hospital doctor 5

'It is only things that interfere with your ability to do your job that the GMC have the remit to cover.'

Hospital doctor 4

Other doctors felt that standards should be maintained whether at work or not, and that it was not possible to distinguish completely between the effects of one's private life and one's professional life. Even outside professional life, certain behaviours may indicate someone's unsuitability as a doctor.

'I don't think your standards should fall just because we're out at the weekend, to go and get drunk and cause trouble. So yes is the answer to that. I'm sure that would be contentious with some doctors but not most of my colleagues here.'

Hospital doctor 7

'You know if you go out and get drunk in a public place, are you undermining public confidence in the medical profession? I'm sure I've been drunk in a public place before now! (Laughs) I think that's... you know that's interesting isn't it?'

GP 4

'I think it's very difficult and I don't think the GMC should necessarily be involved with what happens out of work. I think if it affects your work, or it affects people's respect for you, you know if it goes around work that you were a drunken lout.'

Hospital doctor 5

Interestingly, one doctor raised relationships with the pharmaceutical industry as an area where probity was important, but which is not addressed in the guidance:

'I do think there should be clearer guidelines and statements about our relationship with the pharmaceutical industry and actually would be quite in favour of it being explicitly excluded in some ways, we shouldn't receive benefits from them.'

GP 7

6.7 Responsibilities towards colleagues, organisations and the healthcare system

Relationships with colleagues

Good Medical Practice was regarded as a valuable tool for addressing issues of practice or conduct in colleagues.

'Very often a lot of the problems that there are with colleagues are about attitudes rather than about... I mean the clinical side is often not a problem it's their values, their attitudes and their relationships with colleagues that create difficulties, so it's actually quite useful to have a framework to put it into.'

GP 4

Doctors were asked to consider the standards relating to concerns about colleagues' conduct or performance, and whether there were any tensions between them (duties of a doctor 8 and 22, and paragraphs 39 and 45 of the draft). Several doctors felt that difficulties could arise when there was insufficient evidence about the doctor's performance: that imperfection was inevitable and that judging the point at which behaviour became unacceptable was difficult.

'So all four of them make perfect sense, but obviously there is a tension because there's a chance that if... you've got a suspicion that there's something going wrong, but you don't really have evidence or there's not enough there to really do something without making an unfair criticism, then you're going to have a problem. So there is going to be a bit of a tension there.'

GP 2

Some GPs thought it more difficult in general practice than in hospital practice to identify poor performance in colleagues.

'It's very difficult in General Practice when you don't actually see what other people are doing, that you're always hearing third hand information and it takes a long time to have a feeling for how other people practice.'

GP 4

'GPs' Achilles heel really is how isolated we are in the consultation. You know hospital consultants on ward rounds and to a lesser extent in outpatients but still, tend to be making decisions and acting with their juniors around.'

GP 7

Given the ambiguities around judgements of other people's practice, doctors raised concerns about the risk posed to relationships with their colleagues if they challenged them.

'I think it's a difficult area and you also need to think about your colleagues and you have to think about your professional relationships with them and you have to think that, actually that's important because if you don't have good professional relationships, the system won't run.'

GP 5

'We can all find examples where we've made mistakes and so if everybody went around bad mouthing people you would... there would be no sort of respect or authority left almost... I mean I don't want to say you cover up in a mistake but you don't expose something which really won't make a difference and which might actually... it's probably a matter of opinion quite how you deal with something.'

GP 7

Some GPs felt the guidance on being open with patients would be difficult to follow if a mistake had been made by another doctor, or by a group or a system.

'Well I felt there was most conflict between be open with patients if something goes wrong but not criticise because presumably what they're saying is you can sit down with a patient and say 'this went wrong, doctor X did it', I mean whereas you're not meant to criticise so that's very difficult, a very difficult situation... You might well acknowledge your own mistake and I've done that, but I've never acknowledged somebody else's mistake.'

GP 3

Several doctors believed that recent cultural changes meant doctors were more likely to challenge their colleagues, and welcomed its inclusion in *Good Medical Practice*. Some argued that more specific guidance was required for how doctors should "take appropriate steps without delay, so that concerns are investigated."

'So do you think by having it spelt out explicitly like this, it will encourage doctors to speak out when perhaps they haven't done before?'

interviewer

'Yeah, yeah and it's interesting talking to the medical students and they all are quite clear that that is what they would do, which twenty years ago the thought that you would criticise a consultant as a medical student or as a junior doctor even, was pretty much unheard of and so it's been quite a radical change I think, and a good one of course.'

GP 6

'I think that the time has come... flagging up those people who probably do need to be flagged up and do something about them, because in the old days it was too much, oh well, you know, Joe Bloggs is like Joe Bloggs and he'll never change. But I'm afraid Joe Bloggs being like Joe Bloggs isn't acceptable these days. (Laughs) Something either changes or something happens.'

Hospital doctor 3

Some gave examples of how, as whistle-blowers, they had been ignored or worse. They felt that unless the system as a whole took these concerns seriously, guidance for individual doctors was of limited value.

'I think the biggest problem with sort of reporting of colleagues, you know there needs to be a sort of no blame culture and we still haven't got that in the NHS. There needs to be a really quite formal system that you know that if you do actually report something it will get taken seriously and followed up which again doesn't happen... So yes it's nice to have it down but it doesn't work in practice, it needs to work.'

Hospital doctor 5

Some GPs took exception to paragraph 54 "You must not make unfounded criticisms of colleagues as it may undermine patients' trust in the care or treatment they receive." Others thought it was valuable and well-worded.

'Well in a sense I think that belittles the patient. I think you know that doesn't seem to be treating the patient as an adult and in a sense... I don't know what that adds to the duties of a doctor. The fact that it's telling you don't make criticisms that are wrong about a colleague to a patient, because then they won't trust them. Well obviously you shouldn't do that because you're saying something that isn't true anyway and it's got nothing to do with whether the patient will trust them.'

GP 5

'I think that's phrased well. I think the key word there is unfounded. Now that should not be interpreted as meaning that doctors close ranks and don't admit when something's gone wrong, I mean that's an entirely different issue, but there in the past has been a certain type of doctor who has not, I think probably because of their own insecurity and need for personal aggrandisement has taken pleasure in telling patients what's happened before is sub-standard and other people didn't know what they were doing, and I do think that is completely unprofessional.... and I think having an explicit statement that that is not acceptable is actually quite helpful.'

GP 5

Working within resource limitations

The draft of *Good Medical Practice* states that doctors should make the care of their patient their first concern but also that they should make efficient use of the resources available to them. While some doctors said that concerns about limited resources had very little impact on their practice, many recognised the dilemma presented by these two standards. Some doctors were optimistic about the potential to resolve, or avoid, conflicts between what the patient wants and the doctor's assessment of their needs. Others were less sanguine and struggled with the tensions to various degrees. Some doctors accepted that making difficult judgements was a part of being a professional, and most felt that the dilemmas inherent in being a doctor were too complex to be eliminated by the guidance in *Good Medical Practice*.

'I think doctors in general are on the rack a bit... I do feel that one group come along and ask you to adhere to the very highest standards and the next group ask you to cut corners deliberately to get more patients through the system. And I think that conflict is something... And you do cut corners to try and keep all the balls in the air and it's no great surprise that just occasionally if you're not an expert juggler, that one of the balls goes on the floor.'

Hospital doctor 2

Some doctors saw no conceptual inconsistencies between the standards, while some found them conceptually irreconcilable. Others found them difficult to settle in practice because they lacked complete information about the extent of resources and needs, or because the needs of the patient in their consulting room were so immediate it was difficult to weigh them dispassionately against the needs of the wider population.

'I think that making efficient use of resources and basing on both the expectations and your expectations and assessment of their needs aren't two things which necessarily are mutually exclusive, although they often will conflict... I think that's again, one of the skills of being a good doctor, is to be able to resolve those dilemmas without creating any more.'

GP 1

'They're basically focussing towards patient care: we won't ask for any investigation which isn't essential or unless that helps in management in some aspects, so I don't think there is any contradiction between these two things.'

Hospital doctor 1

'I think this is a total conflict. This is the bit I find hardest... It's a complete conflict of interest. How can you do one and do the other? It's asking you to do two impossible things and I think it's difficult and I don't know what you do.'

GP 5

'It's very, very difficult that as a doctor you try to think about what's the best thing that you can do for the patient who's in front of you, that's been talking with you about their problems, compared to what's going on out there with the Health Service that's got billions of pounds being spent on it and how best can you use that billions of pounds for the greater good rather than the individual good, and that's when you get into conflict with these sort of things.'

Hospital doctor 3

There seemed to be a spectrum of responses to these tensions: some felt most strongly their responsibilities as an advocate for the individual patient and others to social justice and the health system as a whole. Some doctors chose not to engage at all with questions of resources and held their role as patient advocate above all else. Some said they made decisions based first on the patient's needs and evidence of effectiveness, then modified them if necessary on the basis of resource constraints. Others relied mostly on guidance from their local trust, but bent the rules on occasions at their discretion, while some doctors were very aware of their responsibilities to the system to be careful with resources. Some doctors felt unable to discuss resource issues with patients and, to avoid this, disguised decisions about rationing as clinical decisions. Interestingly the members of the public in this study said they wanted doctors to be open about their resource-use decisions, and most said they understood the tensions and would accept that they may not be able to have certain treatments on the NHS.

'I suppose you try and work within the framework that you're given, the guidance that you're given by your body, such as the PCT ... and you try and work within that with your individual patient. So you try and use the cheaper drugs and you try and restrict, you know be careful about the number of referrals you make, but sometimes you feel that it's in one particular patient's best interest to override that and then you prescribe a particular drug for a particular reason because they'd tried the other one and they don't like it or you'd refer someone because they're very anxious, even though you feel that it's not strictly appropriate. So you try and save the money and the resources but there are occasions when you don't stick to rules and protocols and whatever.'

GP 5

'I usually work on what... sort of what the evidence is and what the best is for the patient and then see if there's a problem with resources from there. I don't normally use resources as my decision making tool, it's normally you go with what you think is the best and then you take it from there really... Obviously you've always got to think about why you're prescribing things, but I tend to prescribe things based on evidence and what we think is best for the patient and then deal with the problem after that.'

Hospital doctor 5

'My job is to look after the patient that walks in through the door. They will get the correct treatment and investigation appropriate to their problem. It's not my job to manage the cost effectiveness of the health care, I'm not the Minister for Health, so I'll do what's right for my patient. Equally I won't put them through a whole series

of unnecessary investigations that I know will cost the Health Service X, but I will make sure they get the right investigations appropriate to their problem. And I'll fight for their rights every day.'

Hospital doctor 7

Most of the doctors interviewed felt that, while doctors should have some level of discretion about treatments and referrals, leaving decisions about the allocation of resources to individual doctors potentially jeopardized the doctor-patient relationship.

'I don't want to have to make that decision. There's a huge potential for conflict and destroying doctor patient relationship there and okay maybe it's a cop out but I'm glad to have that written down by somebody else, that I can use in that situation.'

GP 4

'That's what Local Priorities Forum does and you need to be able to refer to a higher authority which has said 'in these circumstances, this particular procedure is not necessary'.'

GP 7

Does GMP provide the answers?

Doctors realised that the draft of *Good Medical Practice* set out potentially incompatible standards on the issue of resource allocation, but made no attempt to resolve them. Most doctors felt that they could live with this, and there was a suggestion that the tensions should at least be acknowledged or extra guidance added.

'It tells you the two sides of the dilemma but it doesn't give you the answer, which I don't know how it could do really, but I think that it needs to go alongside a lot of guidance and lot of help. And I don't think it would be right for a guidance on Good Medical Practice to tell you what you should do in specific terms and I don't think it could really tell you which side of the... where to put the line on the balance. I think that does have to be up to individuals to a certain extent.'

GP 2

Some felt strongly that it was unfair to include irreconcilable standards in guidance against which doctors were to be held to account. One doctor argued that standards about the allocation of resources should be avoided altogether as it was of no help in resolving the tension. Another, in contrast, thought the document over-emphasised the doctor's responsibilities to the individual patient, and that it should focus more on doctors' collective responsibilities to all patients.

'I think the standard that we're an advocate for the individual is fair and I think that's a good principle and I think that's how most of us feel and most of us practice. The resource bit I would be tempted not to mention if I was writing this because I don't think it is fair to... I don't want to use the word threaten, but at the end of the day there will be a penalty for not upholding these standards or there is a potential penalty for not upholding these standards and I think you have to be very clear that the standards are fair and aren't putting us in an impossible situation, which two conflicting standards would do.'

Hospital doctor 4

'There does have to be some restriction on what one can do... I think certainly safety should come first and that's part of the care of patient... It is not your patient but

just patients in general then maybe they should be putting a different emphasis on it as a whole system approach to medicine rather than just looking at an individual doctor, individual approach to medicine as being the overarching duty. Because that is what sort of the overarching duty is effectively isn't it? So they need to re-write that to bring in everybody and not just that are on the one to one level but to make it more explicit that you're looking at a whole global system of all patients with all doctors.'

Hospital doctor 3

6.8 Conclusions: a doctor's role

While doctors spoke positively about *Good Medical Practice*, and endorsed most of the principles in it, their reflections and reported experiences showed tensions and problems with some of them, and a lack of consensus even within a small sample such as ours.

The patient-focused aspects were problematic: there was ambiguity in the meaning of 'partnership', and problems in working to such a standard: time pressures, having to work out what level of partnership patients wanted and were capable of, the need to educate and guide patients, potential conflicts between doctors and patients over treatment decisions.

Working with colleagues and in teams could also be problematic, such as in handling flows of communication. There was recognition that the old-boy culture was inappropriate, but awareness that there were still tensions between working productively with colleagues and responding to any concerns about their practice.

The rapid spread of knowledge in modern medicine presented challenges particularly in a more patient-focused environment, as doctors cannot be expected to be in possession of full information in order to tell patients of all risks and possible outcomes of treatments. There was pressure to keep up to date, and a tension between finding the time for continuing education and all their other obligations.

'We're setting up this perfect pedestal of good medical practice, but it's becoming more and more unattainable.'

Medical student

Doctors did not want to be placed on a moral pedestal but they were concerned about the heavy demands being made on them, which were implied in the standards of *Good Medical Practice*.

7 Discussion and Recommendations

In this section, we review the findings from the interviews and focus groups in the light of the original research questions and the review of the literature.

7.1 What are the key responsibilities of a doctor which should be included in *Good Medical Practice*?

Overall, the research has indicated that the proposed revision of *Good Medical Practice* has achieved as far as possible a reasonable balance between the need for guidance to be comprehensive, while also sufficiently specific to be meaningful. We encountered a very broad range of views about what constitutes good medical practice among members of the public, doctors and medical students. The research illustrated the range of patient preferences and the variety of situations and contexts which confront doctors in their practice.

However, there was a broad consensus that the great majority of the advice in the new version of GMP was important and should be included in the document. Technical competence and providing a good standard of practice and care, maintained by keeping up to date with developments in medicine, is clearly perceived as a fundamental of good medical practice and it is appropriate that this comes near the top of the list of duties, following 'make the care of your patient your first concern'.

While honesty and trustworthiness within the doctor patient relationship were perceived as important in discussions and interviews with the public, they were given somewhat lower priority than technical competence and patients being a doctor's prime concern. Most people no longer appear to expect doctors to behave 'like saints', and it is widely recognised that they are 'only human'. Consensual sexual relationships with patients were viewed as minor misdemeanours and not as grounds for being struck off.

The interviews with medical students raised the need for students to be involved in discussions about what constitutes good medical practice and the potential conflicts which might arise, for example, where medical professional and patient come to different conclusions about treatment or other options. The wide range of views and expectations about partnership demonstrate the importance of getting trainee doctors to think about the kinds of issues that this may raise.

Most of the specified 'duties of a doctor' were considered to be reasonably clear, although there was some criticism of terminology, involving 'buzz words' and 'political correctness' (such as with the term 'partners', which was seen as having a variety of meanings). There was scepticism about the ability to apply some duties, such as "acting without delay if you have good reason to believe that you or a colleague is not fit to practise." However, there was only one duty whose inclusion in the guidance was queried. This was the duty to 'respect human rights', which was seen by some participants as applicable to all people and therefore superfluous to the guidance. There were few suggestions of possible additions to GMP, though the requirement for doctors to maintain independence from drug companies was mentioned.

7.2 Is the balance in *Good Medical Practice* between ends and means and between clinical and organisational responsibilities about right?

Technical competence is a pre-requisite of good medical practice. In addition, competence in communication is perceived as necessary, not just for the benefits of putting patients at their ease and providing them with a positive experience of medical practice, but for sound clinical reasons. Good communication and interpersonal skills are seen as assisting diagnosis and patient concordance, enabling medical professionals thoroughly to investigate ill-health and its causes. Where patients are either not listened to, or not provided with information in a way that they can understand, some participants felt that the effect may be to reduce the effectiveness of treatment or even cause harm to health.

The findings corroborate many of the conclusions of the systematic review by Wensing et al (1998) about the emphasis given by the public to competence, giving information, and listening to patients. Equally, there is an overlap with the report by MORI to the Department of Health (2005) on the importance accorded by lay people to doctors keeping up to date. The doctors in our study considered this equally important, though our lay respondents were understanding of the time pressures under which doctors work, which could inhibit time for further study.

Doctors and medical students were very aware of the potential conflict between their responsibilities to individual patients and to the health care system, and the fact that they had to work within resource limitations. Some thought that extra guidance was needed on this.

Confidentiality is seen as a necessary adjunct to the development of trust between doctor and patient. The interviews and discussions with members of the public reveal a general assumption of confidentiality, but also a willingness for information to be shared where clinically necessary and subject to their consent. However, members of the public appreciate that there might be grey areas where there are wider interests at stake, or where other family members might want to be informed.

There is clearly some scepticism among the public about the willingness of doctors to report concerns about colleagues' performance or conduct, or to admit their own mistakes. Doctors, however, were more aware of other kinds of inhibiting factor, such as the difficulty of obtaining good evidence to back up any concerns they might have about a colleague, or a lack of faith in the reporting system or in the level of support available to whistle-blowers.

7.3 Is the balance in *Good Medical Practice* between the doctor's, the patient's and other health professionals' role in the production of health care about right or not?

The extent to which patients' views should prevail over those of the doctor emerged as a difficult area around which there was no clear consensus. While members of the public who have experience of being given treatment options appreciate this, there are clearly others who would prefer the doctor to have the final say and feel strongly that it is the doctor's role to make decisions about treatment and care.

Doctors too are divided in their preferences. Their views on partnership with patients were variable and to some degree were context specific. They certainly saw 'partnership' with patients as something which had to be worked at, and often as time-consuming and demanding, such as when assessing patient preferences or helping them to understand treatment options. Doctors were mostly happy for patients to refuse treatment, but where patients demanded what they saw as inappropriate treatment it was more difficult, especially when there were resource implications.

Both doctors and the public raised questions about what happens when patients' and doctors' views diverge. It was seen as a difficult area which put the concept of partnership to the test.

In relation to the wider health care team, members of the public appear to have little grasp of how the role of the doctor has changed in this respect, and consequently rarely expressed any opinions about the doctor's role in relation to other health professionals.

7.4 Can doctors be expected to adhere to all standards & duties all the time?

Ideas about probity were varied, but the definition of probity was found confusing by some participants who asked for clarification of the definition and in particular the meaning of rectitude. Several patients and doctors felt that expectations of probity as set out in GMP were too high and that it was unhealthy for the profession to be put on such a moral pedestal.

There appears to be a recognition by lay people of the changing environment within which doctors are operating, and the effect this has on their ability to deliver desired standards of care and practice. While people perceive that doctors are under pressure, particularly in terms of time and to some extent other resources, they continue to expect that doctors will make the care of the patient their first concern, although most understood that patient and population interests would sometimes conflict. Although expectations are clearly changing, as patients have access to more alternative sources of information about health and treatment options, and as the changing social status of professionals has weakened the authority of the doctor, high standards of care are still expected.

However, the changing status of the medical professional does appear to have resulted in a lowering of expectations regarding the private lives of doctors. While the research was confined to England, and there is some evidence that in other parts of the UK, attitudes among lay people have changed less, it seems that people are not overly concerned about what doctors do when they are off duty, so long as they do not take advantage of their privileged access to drugs and patients' bodies, or let their private behaviour affect the quality of patient care. Patients' trust appears to be more dependent on technical competence, respect for confidentiality, and continuity of care, than concerns about doctors' private lives.

There are mixed views about whether or not doctors are ever 'off-duty'. The growing litigiousness of British society was recognised by some lay people in the study, and concerns were expressed about its possible implications.

It was interesting that some doctors saw GMP as 'aspirational' rather than as a set of standards which must guide their day-to-day practice.

7.5 Are any contextual issues of relevance to GMP?

The research revealed the significant role of contextual issues in peoples' understanding and expectation of good medical practice. Many of these areas are outwith the control of doctors. Availability, accessibility and continuity of care were frequently perceived as important elements of good medical practice. Since doctors may only be able to exert limited influence on these contextual aspects of care, it would be inappropriate to include them as duties. However, it is perhaps worth reiterating the high value which patients ascribe to them. Recent surveys, events such as the Birmingham Citizens' Summit, and the publication of the White Paper on 'Our Health, Our Care, Our Say' (Department of Health 2006), also highlight the continued importance of these features of health-care in the eyes of patients and the public at large.

We found very limited knowledge of the guidance and its contents among the public; doctors and medical students were all aware of GMP but only used it to a limited extent. This corresponds with the findings of the study of attitudes to medical regulation (MORI, 2005) which found that few members of the general public are aware of these issues. When the revised guidance is published, it will be important for the GMC to ensure that the public as well as doctors are made aware of it. For example, one method of raising awareness may be to display GMP in the reception area of all doctors' surgeries.

In conclusion, the study has highlighted the challenge that writing such guidance represents in terms of the complexity and divergence of views about what constitutes good medical practice and the very varied situations in which it needs to be applied. The analysis of the views of the public, doctors and medical students reveals the tensions and contradictions between some of the duties of the doctor: for example, making the care of the patient the doctor's first concern and using resources efficiently. The findings illustrate the important role of judgement in good medical practice.

The revised guidance appears to balance well the varied demands and expectations of the public and the medical profession. Some minor changes are suggested. Most importantly, we recommend further public debate about some of the issues underlying GMP, and raising awareness and discussion of its contents among both the medical profession and students. It is right too that patients should be aware of the high standards expected of doctors and against which they can be held to account.

7.6 Recommendations

We end with a number of recommendations:

1. Ensure that the revised guidance when published is made available not only to the medical profession and medical students but also to the general public.
2. Review the opportunities for medical students to discuss the application of the principles of *Good Medical Practice* to complex real life situations, and the tensions these may raise.
3. Consider the omission of 'respect for human rights' from the duties of a doctor.
4. Clarify the definition of 'partnership'.
5. Reconsider which aspects of 'probity' are included in *Good Medical Practice* and ensure that they are written in plain English.
6. Promote further research into the factors which ease or impede working to the standards of GMP.
7. Encourage further debate about the practical implications of some of the standards, such as giving patients information about risks and uncertainties, or about who may have access to information about patients.

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9 Appendix 1: Topic guide for members of the public

1. Warm-up

In pairs, ask participants to discuss for three or four minutes either what they liked most or least about how their doctor acted or behaved during a recent visit. Possibly offer examples of info giving, communication style, warmth/politeness etc.

Ask them to briefly introduce themselves and report back to the group on behalf of the other person or themselves. Emphasise that they are not being asked to say what was wrong with them or why they went to the doctor.

Use this to make sure participants have understood that they are being asked about doctors' practice and not how good the NHS is.

2. Communication

- What do you think is important about the way a doctor communicates with patients?

Prompts:

Being polite and warm?

Giving you information in a way you can understand?

Listening to you?

Asking the right questions?

Understanding your social situation?

Demonstrating an interest in your well-being?

- Are these are more important in some situations than others?

Prompts:

If so, which aspects of communication are most important in which situations?

- Is it possible for a doctor with poor communication skills to be a good doctor?

Prompts:

Are good communication skills important in themselves, or are they a means to an end? What end?

Is this situation-dependent?

Are communication skills ever an integral part of being a good doctor?

Is the doctor's manner important, or only that the outcome of the treatment or care is good?

Is it important to separate empathy, kindness and "being nice" from exchanging information?

3. Partnership

USE FLASHCARD: *"To show respect for patients you must... work in partnership with patients."*

- What might it mean for doctor and patient to work in "partnership"?

Prompts:

Involve you in decisions about your care?

Being listened to and properly informed?

Acknowledge your expertise/preferences/values/experiences?

Taking your priorities into account?

Trying to reach agreement about the right investigations or treatment?

Equality of status?

Ongoing relationship?

Trust?

Being given options?

- Do patients want to work in partnership with their doctor?

Prompts:

In which situations?

Are there circumstances when this sort of partnership is more appropriate than others?

Does this depend on seriousness of condition?

Does it require capacity for partnership on part of patient?

Does doctor have a duty to facilitate this?

Should patient feel obligation to work in partnership?

- Can patient forfeit right to be involved in partnership?

Prompts:

Through their behaviour?

By making unreasonable demands?

By not following doctor's advice?

4. Use of resources

USE FLASHCARD: *“Make the care of your patient your first concern” and “Make efficient use of resources available to you”*

- Where resources are scarce, do you think patients should be involved in decisions about how they are allocated?

Prompts:

If a patient who needs a treatment which is very expensive, should the doctor involve the patient in decisions about whether or not to offer it? Or should the doctor make the decision herself?

If a patient asks for a treatment which is expensive, should the doctor ever refuse it on the grounds of cost?

Do you think patients should be told if limited resources affected decisions about their care? If a medicine that is available is too expensive to be prescribed, should the patient be told about this?

Do you think doctors are better placed than other people to decide how resources should be allocated?

- Do you think patients have a duty to use services responsibly?

5. Access to care

- Are there any circumstances in which a doctor would be justified in refusing to treat a patient?

Prompts:

Should patients' right to treatment ever be contingent on their good health-related behaviour/lifestyle?

If a patient is abusive or offensive to the doctor, do they forfeit their right to treatment or does the doctor still have a duty to treat them?

If a patient does not follow a doctor's advice, do they forfeit their right to treatment?

6. Keeping up-to-date

- Do participants trust that doctors are technically competent?
- Is it reasonable to expect doctors to keep abreast of new developments in medical science?
- Do they expect doctors to know everything, or to know how to access information?

7. Stringency

- Do higher moral principles apply to doctors even when they're not at work?

Prompts:

Should they be expected to model good moral behaviour?

Is it hypocritical of doctors to be overweight/drink/ smoke etc if they advise their patients to follow a healthy lifestyle?

Is it worse if a doctor has an affair/ gets drunk/ uses illegal drugs/ uses pornography/ breaks the speed limit/ dodges her tax, than if the rest of us do?

Is it worse, even when it doesn't directly affect patient care?

8. Relative importance of duties of a doctor

CARD SORT: Ask participants to separate the duties of a doctor into "most important," "quite important," "least important" and "unclear."

Try and have at least three cards in each category (apart from unclear)

Use this exercise to stimulate discussion.

Which are unclear?

Which are least important? Why?

Which are most important? Why?

Does it depend on the situation? Why?

Are any important duties of a doctor missing?

Collect up the cards, in order.

10 Appendix 2: Topic guide for doctors and medical students

Text in italics is extracts from the redraft of GMP which would be given on a “flashcard” to the doctor before asking the questions which follow. Where interviews take place over the telephone, these are either emailed to the participant, or summarised verbally by the interviewer.

1. Introduction

- Are you familiar with *Good Medical Practice*?
- Do you see it as a useful document?
- What is it useful for?
- How often do you refer to it (if at all)?

2. Communication

Good communication is essential to effective care and involves:

- a) listening to patients, respecting their views about their health, and responding to their concerns;*
- b) sharing the information with patients which they want or need to know, in a way they can understand, about their condition, its prognosis and the treatment options available to them. This should include associated risks and uncertainties;*
- c) ensuring that patients are informed about how information is shared within teams and between those who will be providing their care. (paragraph 20)*

- Do you think these standards are reasonable?
- Do you agree that good communication with the patient is always essential to effective care?
- If a doctor is clinically competent, does it matter how he or she communicates with patients?
- Can a doctor be clinically competent if his or her communication skills are poor? Or is listening and communicating actually part of the clinical role rather than just a means to an end?
- Do you think communication skills should be taught specifically, or are they either innate or absent, or do doctors pick them up through their careers?

3. Partnership/ shared decision-making

To show respect for patients you must... work in partnership with patients (paragraph 19d)

You must encourage and support patients to use their expertise to be involved in decisions about their care, and you should try, wherever possible, to reach agreement. (paragraph 29 - informed consent)

Good clinical care must include adequately assessing the patient's conditions, taking account of ... the patient's own priorities... (Para 1a)

The investigations or treatment you provide or arrange must be based on the assessment you and the patient make of their needs. (paragraph 5)

Respect patients' right to reach decisions with you about their treatment and care (duties of a doctor)

- What does it mean to you to "work in partnership" with patients?
- Do these seem like reasonable/ realistic standards?
- Do you anticipate that they would lead to conflicts or dilemmas?
- Is patient involvement an issue of demonstrating respect or of ensuring good clinical care or both?

4. Use of resources / Access to care

Make the care of your patient your first concern (duties of a doctor)

The investigations or treatment you provide or arrange must be based on the assessment you and the patient make of their needs, and your clinical judgement about the likely effectiveness of the treatment options. You must respect your patients' right to their life choices and beliefs, and you must not unfairly discriminate against them. (Para 5)

Make efficient use of resources available to you

- Do you see any tensions or contradictions between these duties?
- What principles guide you in making these decisions?
- Would it be helpful for the guidance to be explicit about the basis on which these decisions should be made? Or should it be left to the individual doctor's judgement?

5. Confidence in profession/reporting colleagues/ supporting colleagues

You must not make unfounded criticisms of colleagues as it may undermine patients' trust in the care or treatment they receive, or in the judgement of those treating them. (paragraph 45)

Act without delay if you have good reason to believe that you or a colleague is not fit to practise.

You must protect patients from risk of harm posed by another colleague's conduct, performance or health. The safety of patients must come first at all times. Where there are serious concerns about a colleague's fitness to practise, you must take appropriate steps without delay, so that the concerns are investigated and patients protected where necessary. (paragraph 39)

Be open with patients especially if something goes wrong. (duties of a doctor)

- What do you understand by these duties?
- Could they conflict with one another?
- Do these statements seem fair and reasonable to you?
- Do they present any tensions or contradictions?

6. Keeping up-to-date

You must keep your knowledge and skills up to date throughout your working life. You should be aware of relevant guidelines and developments which affect your work. You should regularly take part in educational activities which maintain and further develop your competence and performance. (paragraph 10)

You must keep up to date with and adhere to the laws and codes of practice relevant to your work. In particular you must:

b. reflect regularly on your standards of medical practice in accordance with GMC guidance on licensing and revalidation

c. take part in regular and systematic audit

- Do you think these standards are sufficiently/too stringent to ensure doctors are up to date?

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