

Good medical practice for physicians

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Part 1.

Good medical practice for physicians

Introduction

In *Good medical practice*¹ the GMC has set out the standards of competence, care and conduct expected of all doctors in their professional work. Each branch of medicine has now extended this guidance in respect of their particular discipline. The Federation of Royal Colleges of Physicians in the UK (the Federation) has produced *Good medical practice for physicians*. This should be read in conjunction with the GMC's document and may be referred to during a physician's annual appraisal and revalidation. It is applicable to all aspects of clinical practice, including private practice and periods spent in locum appointments, and is relevant to non-consultant career grade doctors as well as to consultant physicians. The standards and evidence for the individual medical specialties for which the Federation is responsible are set out in online Appendices which are available at:

www.rcpe.ac.uk

www.rcpsglasg.ac.uk

www.rcplondon.ac.uk

Although this guidance given in this document is applicable to all doctors, the particular scope of the roles and responsibilities of doctors in training are clearly listed in the relevant training curricula. Training records that accompany the curricula will provide a permanent record of the trainees experience and competencies.

The duties of a physician

Physicians have a wide range of responsibilities in respect of maintaining and improving the quality of patient care. In addition to providing direct clinical care, these include respecting the rights of patients, teaching, training and research, maintaining lifelong learning and continuing professional development, participating in clinical governance and providing sound advice to managers and policy makers, both individually and when working within a multidisciplinary team

The Federation appreciates that inadequate resources and support may impact on a physician's ability to provide good clinical care. If a physician has good reason to think that their ability to treat patients safely is seriously compromised by inadequate premises, equipment or other resources, they should put the matter right, if that is possible. In all other cases physicians should draw the matter to the attention of their Trust, or other employing or contracting body. Physicians should record their concerns and the steps taken to try to resolve them.¹

Good clinical care

Providing a good standard and practice of care

The physician's first responsibility must be to the patient and their safety. At the heart of a physician's practice is the consultation. The patient's history must be carefully elicited and recorded, physical examination and investigation must be thorough but appropriate, therapy prompt and suitable.

The patient's right to participate fully in decisions on their care is paramount and the physician must ensure that they are sufficiently well informed to do so.

Physicians must keep clear, legible and contemporaneous patient records as an essential part of good clinical practice, including care outside the NHS, and must sign and date all entries.

- Clear records must be kept of diagnoses and actions, including 'do not attempt resuscitation' statements, and the reasons for them.
- A record must be kept of information given to patients and their relatives, including a summary of all discussions between physicians and patients.
- There needs to be a balance between general medical practice and specialisation, particularly in the delivery of acute care. The strength of the physician lies in the ability to make decisions in the face of uncertainty. All physicians should therefore maintain a broad understanding of general medicine whatever their primary specialty.
- Physicians should refer to other colleagues when an opinion from another specialty or a more specialised physician would be in the patient's best interest.

- When sharing care, colleagues must be kept well informed.
- For inpatients there should always be a single physician or clinical team taking responsibility for continuing care.
- Physicians who undertake practical procedures must ensure that they are competent to do so.
- Although physicians are accountable for their individual conduct and practice, they rarely work in isolation. When they work in teams they must show respect for the knowledge, skills and judgement of their colleagues.

Maintaining good medical practice

Physicians must participate in an annual appraisal of their performance, linked to the setting of personal development objectives.

Keeping up to date

Physicians have a duty to keep their knowledge and skills up to date throughout their professional working life. Evidence of continuing professional development (CPD) must be verifiable in order to demonstrate that they have met the national minimum annual requirement of approved CPD. Physicians should register with the Federation of Royal Colleges of Physicians CPD scheme in order to demonstrate that they have completed 50 hours of nationally approved CPD. CPD should reflect the range of practice of the physician, including teaching and training, research and management.

Maintaining performance

Physicians must work with colleagues to monitor, maintain and improve the quality of care provided. This includes accepting regular professional assessment and peer review, and full compliance with processes implicit in clinical governance. These may include:

- regular and systematic local and national audits appropriate to their practice
- confidential inquiries
- critical incident reporting

- risk assessment for any service for which they are responsible
- validated patient surveys
- peer review schemes
- National Service Frameworks, consensus documents, national indicators to monitor local standards of care and authoritative guidelines (eg National Institute for Clinical Excellence (NICE), Scottish Intercollegiate Guideline Network (SIGN), Specialist Societies, Royal Colleges of Physicians)
- review of complaints.

Teaching and training, appraising and assessing

Teaching and training

Physicians have duties and responsibilities to support, supervise and contribute to the education and training of medical students, trainees and other members of the multidisciplinary team. Physicians should develop the skills to educate those who work with and for them. The physician with overall responsibility for clinical care must ensure that trainees are competent to deliver care delegated to them, and that wherever possible service delivery contributes to their experiential learning.

Assessment, appraisal and providing references

Assessment should, as far as possible, include an objective and honest measure of performance against defined criteria. To affirm competence inappropriately may put patients at risk. Appraisal should identify developmental needs of physicians and identify areas for specific action.

Physicians may need to be an assessor or appraiser. They should ensure that they have received training for these roles, give appropriate feedback and ensure there is a clear and agreed method of improving performance where necessary.

When providing references for colleagues, physicians must be honest and be able to justify their statements. A reference must include all relevant information that has a bearing on a colleague's competence, performance, reliability and conduct.

Professional relationships

Relationships with patients

Successful relationships between physicians and their patients depend on trust. To establish and maintain trust physicians must:

- respect the right of patients to be fully involved in decisions about their care²
- respect patients' privacy and dignity
- keep information about patients confidential³
- give patients sufficient information in a way they can understand and to enable them to accept or decline treatment²
- where this is not possible, physicians must be aware of their duty of care,² including complying with the wishes expressed in Advance Directives (Living Wills).
- respect the right of patients to accept or decline medical advice or treatment
- maintain good communication by regular explanations and updating on results and investigations, and on the response to treatment; this must include, where appropriate, discussions about 'do not attempt resuscitation' decisions.
- share information with relatives and carers provided that the patient has given consent³
- respect the right of patients to decline to take part in research or in teaching
- be accessible when on duty
- communicate with the general practitioner (GP) and others looking after the patients in primary care.³

If things go wrong

If a patient suffers an untoward incident or complains about the service they have received, the physician should ensure a prompt, honest and courteous response. An apology should be offered and action taken to put things right when appropriate. Physicians must co-operate with any complaints procedure that applies to their practice and must not allow a complaint to prejudice patient care.

Conduct or performance of colleagues

It is a physician's duty to protect patients. If there are serious concerns about the conduct, health or performance of a colleague or deficiencies in the provision of a clinical service, the physician must take appropriate action by informing a responsible individual (usually the clinical or medical director of the NHS Trust). If in doubt, the physician should discuss the matter with an experienced impartial senior colleague, with a professional organisation such as the Royal Colleges or contact the GMC for advice.

Working with colleagues

In order to deliver optimal care to patients, physicians often work in multidisciplinary and multiprofessional teams. An effective team requires strong clinical leadership and respect for the skills and contributions of all members.⁴

- Physicians must ensure effective communication within and outside the team.⁴ Relevant information about a patient's care and condition must be available to other members but with appropriate regard for aspects which should remain confidential. Good communication with general practitioners is important.
- Physicians who lead teams must ensure that all members understand their own roles and responsibilities, including that of confidentiality, and know who is responsible and accountable for each aspect of the patient's care.⁴
- Physicians may delegate tasks to junior doctors and to other healthcare professionals provided they are appropriately trained and supervised.
- Physicians must ensure that the care of their patients is maintained by appropriate colleagues during their absence.

Probity

Physicians must be honest and accurate in any document or report they prepare, including descriptions of services they provide.

Research Ethics Committee approval must be obtained for research activities. The care and safety of patients must come first. It is essential to ensure that

patients have given informed consent and that adequate time for explanations and questions has been given, as well as a clear understanding that refusal to take part in research does not compromise future care.

Discriminatory or financial considerations should never alter the way physicians prescribe or care for their patients. They must declare any financial or commercial interest in any organisation to which they refer a patient for investigation or treatment. Physicians must always act in the best interest of patients, and should not accept any inducement, gift or hospitality that may affect their judgement.

Where physicians undertake private and NHS practice, they should apply the same standards of care. The conduct of their private practice should not be to the detriment of patients in the NHS. They should never exploit patients for financial gain.

Health

Physicians must ensure that their own health does not put patients or colleagues at risk, and follow the guidance advised in *Good medical practice*.¹

References

- 1 *Good medical practice*. General Medical Council, 3rd edn. May 2001
- 2 *Seeking patients' consent: the ethical considerations*. General Medical Council, November 1998.
- 3 *Confidentiality: protecting and providing information*. General Medical Council, September 2000.
- 4 *Management in health care, the role of doctors*. General Medical Council, 1999.

Part 2.

Standards and evidence to support revalidation

Good medical practice for physicians offers additional guidance to that provided in the GMC's *Good medical practice*.¹ It is of specific relevance to all physicians and supplements the generic guidance by informing physicians of the standards that may be applied to their appraisal and revalidation. Where appropriate, additional specialty-specific standards and evidence have also been prepared (see Appendices 1–20). The Federation and the specialist societies have endorsed these standards and expect physicians to comply with those applicable to their field of practice. We anticipate that the evidence of adherence to the standards could be used to secure revalidation.

Good clinical care

Standard 1

Physicians will be auditing practice against nationally agreed standards of care. This includes guidelines set by the specialist societies and nationally agreed standards; for example those developed by the Joint Speciality Committees of the Royal Colleges.

Evidence: Physicians should be able to demonstrate where their practice lies against the above standards. If it varies significantly from the norm, the physician should be able to demonstrate the reasons, in particular that the variation results from facilities available or casemix, rather than competence.

Standard 2

Clinical notes should always enable a colleague to understand the current needs of the patient.

Evidence: Minutes of the meetings where clinical records have been audited against agreed standards should be retained.

Standard 3

Physicians should be taking part in clinical governance schemes² in all places of clinical work, such as:

- Risk assessment
- Critical incident review
- Adverse drug reporting
- Mortality meetings
- Patient surveys.

Evidence: The minutes of such meetings should be retained, including details and evidence of change of practice as a result of participation in these schemes. Physicians who are not participating in the schemes listed above should demonstrate the reasons for this.

Maintaining good medical practice

The key elements of maintaining good medical practice are participation in CPD and audit. It is also recommended that consultant physicians review all aspects of the running of their unit at least every five years.

Standard 1

By participation in the Federation CPD scheme a physician should be able to keep up to date the knowledge and skills relevant to their practice. This should include regular review of educational objectives.

Evidence: A physician should provide documentary evidence of meeting the national minimum annual requirement of approved CPD (currently 50 hours). This CPD should be in a balance appropriate to their work roles. Thus the CPD should include both specialty and acute care commitments, where appropriate.

A physician should produce documentary evidence of a regular, at least annual, review of their educational goals and how these will be achieved.

Standard 2

Physicians should actively participate in peer review of individual case notes. Each review should follow a predetermined template, taking into account elements of *Good medical practice*.¹

Evidence: The minutes of case note review meetings should be retained, including details and evidence of change of practice as a result of participation.

Teaching and training, appraising and assessing

Standard 1

Physicians responsible for the education and training of junior medical staff should have completed appropriate training. They should evaluate the effectiveness of their teaching.

Evidence: Physicians should have evidence of attendance at an appropriate training course (eg RCP *Physicians as Educators* courses). They should provide details of teaching activities and feedback from trainees about the effectiveness of their teaching.

Standard 2

Physicians responsible for the supervision of junior medical staff should have completed appropriate training (eg College or Deanery course).

Evidence: Physicians should have evidence of attendance at an appropriate training course on Effective Educational Supervision.

Standard 3

Physicians responsible for undertaking the appraisal of clinical colleagues should have completed appropriate training.

Evidence: Physicians should have evidence of attendance at an appropriate training course for appraisers, (eg College or Deanery course).

Standard 4

Physicians responsible for undertaking the assessment of junior medical staff should have completed appropriate training. They should know how to give constructive effective feedback and be honest and objective when assessing performance.

Evidence: Physicians should have evidence of attendance at an appropriate training course.

Standard 5

When providing references for colleagues, physicians must be honest and be able to justify their statements. They must include all relevant information that has a bearing on the colleague's competence, performance, reliability and conduct.

Evidence: Physicians should retain copies of references provided for colleagues, which would be available for submission with all confidential person-specific fields removed.

Relationships with patients

A hospital admission can be a frightening experience for many patients. Medical care, specifically acute care, is delivered to patients who may be unwell, confused or unable to be fully involved in the immediate management decisions. Wherever possible, physicians must ensure that the patient has understood the investigations and/or treatment proposed and given their consent.³ Regular updating on results and response to treatment is essential, as is good communication across the primary and secondary care interface.

Standard 1

If a patient complains about the service they have received, the treating physician should respond to the complaint in line with the complaints policy of their place of work.

Evidence: Where applicable, documentation should be supplied to demonstrate compliance with the complaints policy and evidence of change of practice as appropriate.

Standard 2

Physicians should actively participate in validated patient surveys relevant to their practice.

Evidence: A physician should be able to demonstrate how the results of validated patient surveys have been used to monitor and, where appropriate, improve relationships with patients. The results of validated patient surveys should therefore be retained.

Standard 3

Physicians should give patients sufficient information in a way they can understand and enable them to consent to or decline treatment.³

Evidence: Physicians should provide details of the methods and examples of patient information used to achieve this for clinical care and research.

Standard 4

Physicians should ensure that all treatment decisions and discussions with the patient and their families are appropriately documented in the notes.

Evidence: Audit of the notes should provide such evidence.

Working with colleagues

Standard 1

In order to deliver optimal care to patients, physicians often work in multidisciplinary and multiprofessional teams. An effective team requires strong clinical leadership and respect for the skills and contributions of all members. Physicians must ensure effective communication within and outside the multidisciplinary teams.

Evidence: Physicians should be able to demonstrate how the results of professional colleague surveys have been used to monitor and, where appropriate, improve relationships with colleagues.

Probity

Standard 1

Physicians must comply with relevant guidance issued by the Royal Medical colleges for example, *Physicians and the biomedical industry*.⁴

Evidence: As part of the revalidation process, physicians should submit a completed Probity Statutory Declaration, currently being developed by the GMC (refer to revalidation section of the GMC website). To ensure that opinions or decisions can be seen to be free of bias, physicians must declare any interest they may have in a biomedical manufacturing company or contract research organisation. Examples of declarations of interests submitted to committees or government agencies should be retained, (eg local or national committees for the purchase of drugs or medical products, or declarations of interests submitted to NICE as part of a Health Technology Appraisal).

Standard 2

Research activities must have appropriate Research Ethics Committee approval.

Evidence: To demonstrate compliance with this standard, copies of Research Ethics Committee applications and outcomes should be retained.

Health

Standard 1

Physicians must ensure that their own health does not put patients at risk.

- Physicians must comply with the requirements of their employer's infection control and risk management protocols.
- Disabled physicians should comply with the standards outlined in the RCPL guidance *Doctors with disabilities: meeting the needs of patients and practitioners – A practical guide*⁵ in order to protect the safety and well-being of their patients and colleagues.

Evidence: Physicians should demonstrate where changes have been made to clinical practice as a result of illness or deterioration of a medical condition. As part of the revalidation process, physicians should submit a completed Health Statutory Declaration, currently being developed by the GMC (refer to revalidation section of the GMC website).

Standard 2

Physicians undertaking exposure prone procedures must declare their hepatitis B status to the appropriate body at each hospital in which they operate, including private and NHS facilities.

Evidence: Physicians undertaking exposure prone procedures must confirm that they have notified the appropriate body at their places of work of their hepatitis B status.

References

- 1 *Good medical practice*. General Medical Council, 3rd edn, May 2001.
- 2 *Governance in acute general medicine. Recommendations from the Committee on General (Internal) Medicine of the Royal College of Physicians*. RCP, November 2000.
- 3 *Seeking patients' consent: the ethical considerations*. General Medical Council, November 1998.
- 4 *The relationship between physicians and biomedical industry*. Royal College of Physicians London, August 2002.
- 5 *Doctors with disabilities: meeting the needs of patients and practitioners – A practical guide*. Royal College Physicians London (in preparation).

Appendices

The online appendices to this document provide physicians with the supplementary specialty-specific standards and evidence that may be applied to their appraisal and revalidation. This supplementary advice should be read in conjunction with this document and the GMC's generic guidance.¹

Many physicians will also have an acute on-take commitment in addition to their specialty commitments. The supplementary standards and evidence for physicians delivering acute care has therefore also been provided in addition to the speciality-specific standards (see Appendix 1) and further advice has been produced by the RCP.²

The specialty-specific standards listed below have been provided on the websites of the three Colleges:

Edinburgh www.rcpe.ac.uk

Glasgow www.rcpsglasg.ac.uk

London www.rcplondon.ac.uk

Specialty-specific standards

- | | |
|----------------------------------|-----------------------------|
| 1. Acute medicine | 11. Infectious disease |
| 2. Allergy | 12. Intensive care medicine |
| 3. Cardiology | 13. Medical oncology |
| 4. Clinical genetics | 14. Neurology |
| 5. Clinical pharmacology | 15. Nuclear medicine |
| 6. Dermatology | 16. Palliative medicine |
| 7. Diabetology and endocrinology | 17. Rehabilitation medicine |
| 8. Gastroenterology | 18. Renal medicine |
| 9. Genitourinary medicine | 19. Respiratory medicine |
| 10. Geriatric medicine | 20. Rheumatology |

References

- 1 *Good medical practice*. General Medical Council, 3rd edn, May 2001.
- 2 *Governance in acute general medicine. Recommendations from the Committee on General (Internal) Medicine of the Royal College of Physicians*. RCP, November 2000.

Appendix 1. Acute care

Supplementary standards and evidence for physicians delivering acute care

Good clinical care

Many physicians have a commitment to the care of patients admitted as acute medical emergencies. The RCPL committee on general (internal) medicine has published recommendations for governance in acute general medicine;¹ these include the infrastructure required within a Trust to meet the standards with regard to the provision of emergency medical practice. Acute care is provided by consultant physicians on call, supported by a team of resident junior medical staff. When care is delegated to other members of the multidisciplinary team, including junior doctors, it is essential that they are appropriately trained and supervised and that the consultant on duty is readily accessible. Clear, legible, contemporaneous records, including 'do not attempt resuscitation' statements are essential, as is the careful handover of patients out of hours. The need to consult or refer to other colleagues is very important in acute medicine.

Standard 1

Physicians on the acute medical take must view it as a priority. Where the intensity of work requires it, the team on take for acute medical emergencies must have their other fixed duties cancelled to allow proper assessment of acutely ill admissions during the on-take period and to permit a post-take ward round to be conducted.

Evidence: A nominated lead consultant (often the clinical director) is responsible for organisation of the service. Details of how proper supervision of the on-take period is achieved, including cancellation of non-emergency fixed sessions as appropriate, must be available.

Standard 2

A consultant physician must carry out a ward round with the on-call team at least once every 24 hours. At least 90% of patients admitted as an acute general medical emergency should be reviewed by a consultant physician within 24 hours. Patient records should record the frequency and outcomes of take and post-take ward rounds.

Evidence: Minutes of the meetings where clinical records have been audited should be retained.

Standard 3

Emergency readmission of patients to hospital within 28 days of discharge from care should be the subject of regular audit by physicians.

Evidence: Review of the clinical records should demonstrate whether readmission was due to inappropriate early discharge, community or social factors.

Standard 4

All deaths within 24 hours of admission and other unexpected deaths should be promptly reviewed in a multidisciplinary forum. Records of these reviews should inform the clinical governance process.

Evidence: The outcome of the review should be formally documented and action noted through the local clinical governance or morbidity/mortality meeting.

Maintaining good medical practice

All physicians participating in the acute medical take must ensure that part of their regular CPD activities focuses on acute emergency medicine.

Standard 1

There are a limited number of common acute medical emergencies which cover the majority of emergency admissions. Suitable guidelines for the management of common emergency conditions should be adopted.

Evidence: Physicians should demonstrate audit of their practice against these guidelines and evidence of change of practice as appropriate. The results of these audits should be retained, including evidence of change of practice as appropriate.

Standard 2

Physicians responsible for acute medical emergencies should keep their knowledge and necessary skills of acute medicine up to date throughout their professional life.

Evidence: A physician should provide documentary evidence of achieving at least an annual average of 50 hours of nationally approved CPD in a balance appropriate to the distribution of their acute medicine and specialty.

Working with colleagues

Standard 1

Physicians must ensure that during their absence appropriately trained colleagues cover their on-take commitments and maintain the care of their acute patients.

Evidence: Formal documentation of arrangements to cover should be retained.

Probity

When emergency patients are recruited into clinical trials it is important to ensure that patients have given informed consent and that at all times their care and safety is of paramount importance. Acutely ill patients are particularly vulnerable and adequate time for explanations and questions must be given.

Reference

- 1 *Governance in acute general medicine: recommendations from the Committee on General (Internal) Medicine of the Royal College of Physicians*. London: RCP, 2000.