Duties of a doctor: UK doctors and *Good Medical Practice*

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Abstract

***Objective*—To assess the responses of UK doctors to the General Medical Council's (GMC) *Good Medical Practice* and the *Duties of a Doctor*, and to the GMC's performance procedures for which they provide the professional underpinning.**

***Design*—Questionnaire study of a representative sample of UK doctors.**

***Subjects*—794 UK doctors, stratified by year of qualification, sex, place of qualification (UK *v* non-UK), and type of practice (hospital *v* general practice) of whom 591/759 (78%) replied to the questionnaire (35 undelivered).**

***Main outcome measures*—A specially written questionnaire asking about awareness of *Good Medical Practice*, agreement with *Duties of a Doctor*, amount heard about the performance procedures, changes in own practice, awareness of cases perhaps requiring performance procedures, and attitudes to the performance procedures. Background measures of stress (General Health Questionnaire, GHQ-12), burnout, responses to uncertainty, and social desirability.**

***Results*—Most doctors were aware of *Good Medical Practice*, had heard the performance procedures being discussed or had received information about them, and agreed with the stated duties of a doctor, although some items to do with doctor-patient communication and attitudes were more controversial. Nearly half of the doctors had made or were contemplating some change in their practice because of the performance procedures; a third of doctors had come across a case in the previous two years in their own professional practice that they thought might merit the performance procedures. Attitudes towards the performance procedures were variable. On the positive side, 60% or more of doctors saw them as reassuring the general public, making it necessary for doctors to report deficient performance in their colleagues, did not think they would impair morale, were not principally window dressing, and were not only appropriate for problems of technical competence. On the negative side, 60% or more of doctors thought the performance procedures were not well understood by most doctors, were a reason for more defensive practice, and could not be used for problems of attitude. Few differences were found among older and younger doctors, hospital doctors, or general practitioners, or UK and non-UK graduates, although some differences were present.**

***Conclusions*—Most doctors working in the UK are aware of *Good Medical Practice* and the performance procedures, and are in broad sympathy with *Duties of a Doctor*. Many attitudes expressed by doctors are not positive, however, and provide areas where the GMC in particular may wish to encourage further discussion and awareness. The present results provide a good baseline for assessing change as the performance procedures become active and cases come before the GMC over the next few years.**

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In recent years there has been increasing publicity about errors and malpractice of doctors, both hospital physicians and general practitioners (GPs). Although the medical profession in the UK is currently self regulated, there have been fears that unless the General Medical Council (GMC) responds to growing public fears, then self regulation of doctors may not be sustainable for too much longer. Blueprints for the improvement of doctors' self regulation were first put in place several years ago, and this study is concerned both with what doctors themselves think of those changes while they are ongoing, and doctors' proposed alterations in their medical practice in response to those changes.

Good Medical Practice,[1 2] one of a series of booklets published by the UK's GMC in 1995 under the general heading of *Duties of a Doctor*,[3] signalled a revolution in the regulation of British medical practice, being the first indicator of what the president of the GMC has called a "new professionalism".[4] *Good Medical Practice* sets out "the standards of competence, care and conduct set by the GMC"; in effect, a definition of best quality medical care, against which the performance of a doctor can be judged. It makes clear that its role is advising on "the basic principles of good practice. It is guidance. It is not a set of rules, nor is it exhaustive". It emphasises that patients must be able to trust their doctors, and to justify that trust, "we as a profession have a duty to maintain a good standard of practice and care...". The inside cover lists 14 specific "duties of a doctor", which, "in particular, as a doctor you must [observe]" (box 1). The international interest in *Good Medical Practice* is clear from the fact that it has already been translated into six other languages, including Japanese.

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

- Make the care of your patient your first concern
- Treat every patient politely and considerately
- Respect patients' dignity and privacy
- Listen to patients and respect their views
- Give patients information in a way they can understand
- Respect the right of patients to be fully involved in decisions about their care
- Keep your professional knowledge and skills up to date
- Recognise the limits of your professional competence
- Be honest and trustworthy
- Respect and protect confidential information
- Make sure that your personal beliefs do not prejudice your patients' care
- Act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practise
- Avoid abusing your position as a doctor
- Work with colleagues in the ways that best serve patients' interests

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

Box 1 The duties of a doctor registered with the GMC.[11] *This extract appears on the inside front cover of Good Medical Practice*

The GMC's performance procedures,[5] in operation since July 1997 as a result of the Medical Act of 1995, and which went hand-in-hand with *Good Medical Practice*, have been described as the biggest change in the self governance of British doctors since the first Medical Act of 1858. Before that, removal from the medical register was either on the basis of conduct or of health. The performance procedures meant that for the first time it is possible for the registration of a doctor to be restricted or removed not only because of poor conduct or ill health but also because of poor performance. Box 2 describes the mechanism of the performance procedures in a document prepared by the GMC. In December 1998 the first UK doctors had their registration with the GMC removed because of poor performance.

The performance procedures are perceived internationally as a unique experiment of a profession providing specific control of the professional attitudes and behaviour of its members, and making clear statements as to the nature of quality in medical practice.[7] Both their introduction and their impact upon the professional attitudes and behaviour of doctors therefore merit careful evaluation. Evaluation is not entirely straightforward, not least because the performance procedures are novel, there is no experience upon which to base an evaluation, and of necessity there is only one possible occasion on which to carry out an evaluation. The GMC has commissioned several studies evaluating the performance procedures and their introduction, which look at various aspects of a complex problem.

The present study takes as its relatively limited primary remit to assess doctors' awareness of *Good Medical Practice* and the performance procedures, and to determine their attitudes towards them, their perceptions of the need for them, and the acceptability of the duties of a doctor as set out by the GMC. A secondary remit concerns the more ambitious, and hence more difficult, question of evaluating the impact of the performance procedures not only upon the behaviour of the small percentage of doctors who are "seriously and consistently deficient" but also upon the vast majority of adequately performing doctors. Will the performance procedures change the behaviour of *all* doctors (shift the overall mean, as it were), or just affect the small minority of poorly performing doctors (the tail of the distribution)?

The present study describes the first of a repeated series of studies of doctors' perceptions, attitudes, and behaviours during the next few years as the performance procedures become a routine part of professional activity. This article therefore describes the baseline against which further change will be assessed, and in so doing also considers various methodological and background questions which are important for validating the approach in general, as well as for providing insights into the mechanisms of change.

This study aims not only to find out *what* doctors think about *Good Medical Practice* and are doing in response to the performance procedures but also to look at some of the underlying mechanisms for change. In particular, we are aware that doctors in particular types of practice (hospital or general practice), or at a specific stage of their career (newly qualified, mid-career, near retirement) may see themselves as more vulnerable to certain aspects of the performance procedures. Repeated concerns about high levels of stress or burnout,[8 9] meant that we also assessed them, along with measures of the response of doctors to uncertainty, to determine their relationship to our other measures.

The focus of our study was a systematically sampled, representative group of doctors working in the UK.

Methods

Stratified sampling of doctors was based on the *Medical Directory* and the medical register. Doctors were divided into eight groups by year of qualification (1955-9, 1960-4, 1965-9, 1970-4, 1975-9, 1980-4, 1985-9, 1990-4); by place of qualification (UK *v* non-UK); by sex; and by practice type (general practice *v* hospital). Practice type was based on doctors' own description in the *Medical Directory.* Doctors were selected at random from the 1996-7 *Medical Directory*, with the intention of obtaining 20 UK and five non-UK qualified doctors with UK contact addresses in each of the com-

"Detailed procedures have been drawn up for investigating a doctor's performance if it appears to be seriously deficient. This is defined by the GMC as a departure from good professional practice serious enough to call into question the doctor's registration. The procedures:

- Assess a doctor's professional performance if there is evidence that it is seriously deficient
- Require a doctor to take remedial action to address any deficiencies
- Can suspend, or place conditions on, a doctor whose performance is found to be seriously deficient

The GMC can investigate complaints about specific acts of misconduct or cases of doctors practising when too ill to do so. It can also take action against a doctor convicted of a criminal offence. It will now also be able to deal effectively with doctors whose general pattern of performance is unsatisfactory.

A new committee, the committee on professional performance (CPP), will have the power to suspend, or place conditions on, a doctor's registration when his or her performance is found to have been seriously deficient, or if the doctor persistently fails to cooperate with assessment.

The new arrangements also safeguard doctors against malicious or frivolous complaints. They will take account of the doctor's professional circumstances, and will be thorough, fair, and objective.

They will give doctors the opportunity to update their knowledge and skills and improve their performance.

Complaints about problem doctors

Patients, other members of the public, and doctors will be able to make complaints under the new procedures. Cases may also be referred by public bodies, such as NHS trusts or health authorities.

SCREENING

The complaints will then be screened to see if they fall within the GMC's jurisdiction and, if so, to decide whether they are appropriate for performance procedures. The process will be made clear to all parties, and decisions will be explained.

The GMC has a well established system for screening complaints, with screeners who are experienced medical and lay GMC members. Once cases are referred into the performance procedures, they will be managed by other council members appointed as case coordinators.

ASSESSMENT OF PERFORMANCE

Assessors will visit doctors at their place of work to review records, discuss cases, interview colleagues and, where appropriate, observe consultations. Assessments may also include tests of professional knowledge and skills. The arrangements will be comprehensive and based on best practice internationally. They will be pivotal to the success of the performance procedures.

An assessment panel will normally comprise two medical and one lay member. A wide range of assessors will be available to take account of the specialty and circumstances of the doctor. An initial pool of around 150 assessors will be established; the number will he increased when necessary.

The assessors will be appointed for their impartiality and their ability to weigh evidence and make difficult decisions. They will be trained for the work and in each case will follow a detailed protocol related to the specialty of the doctor. The medical assessors will have up-to-date knowledge and experience in their field.

On the basis of the outcome, the GMC will decide if further action is necessary. If it is, the council will decide whether to refer the case to the committee on professional performance or allow the doctor to take remedial action without being referred to the committee on professional performance, depending on the severity of the case.

REMEDIAL ACTION FOR REASSESSMENT

This will vary from case to case and depend on the nature and extent of the problems identified by the assessment.

The onus will be on the doctor to rectify deficiencies. Doctors will be able to obtain advice from regional postgraduate deans and regional directors of postgraduate general practice education.

CONSIDERATION BY THE COMMITTEE ON PROFESSIONAL PERFORMANCE

The committee will consider cases referred to it by the case coordinators. When deciding whether to refer a case, coordinators will consider:

- The seriousness of the deficiencies identified by an assessment
- The level of the doctor's cooperation with the procedures
- The degree of the doctor's improvements in performance

The committee's task will be to determine if the standard of a doctor's professional performance has been seriously deficient and, if so, whether to put conditions on, or suspend, the doctor's registration.

Committee hearings will be in private for an initial trial period. However, complainants will be able to attend to address the Committee."

Box 2 The mechanism of the GMC's performance procedures, as described in a pamphlet published by the GMC.[6]

binations of grouped year of qualification by sex and by practice type (general practice/hospital). The final number of subjects was 794 because some groups could not be fully achieved. The questionnaires were sent out to the main sample in November 1997, and three further reminders were sent to non-respondents. All subjects were sent a copy of

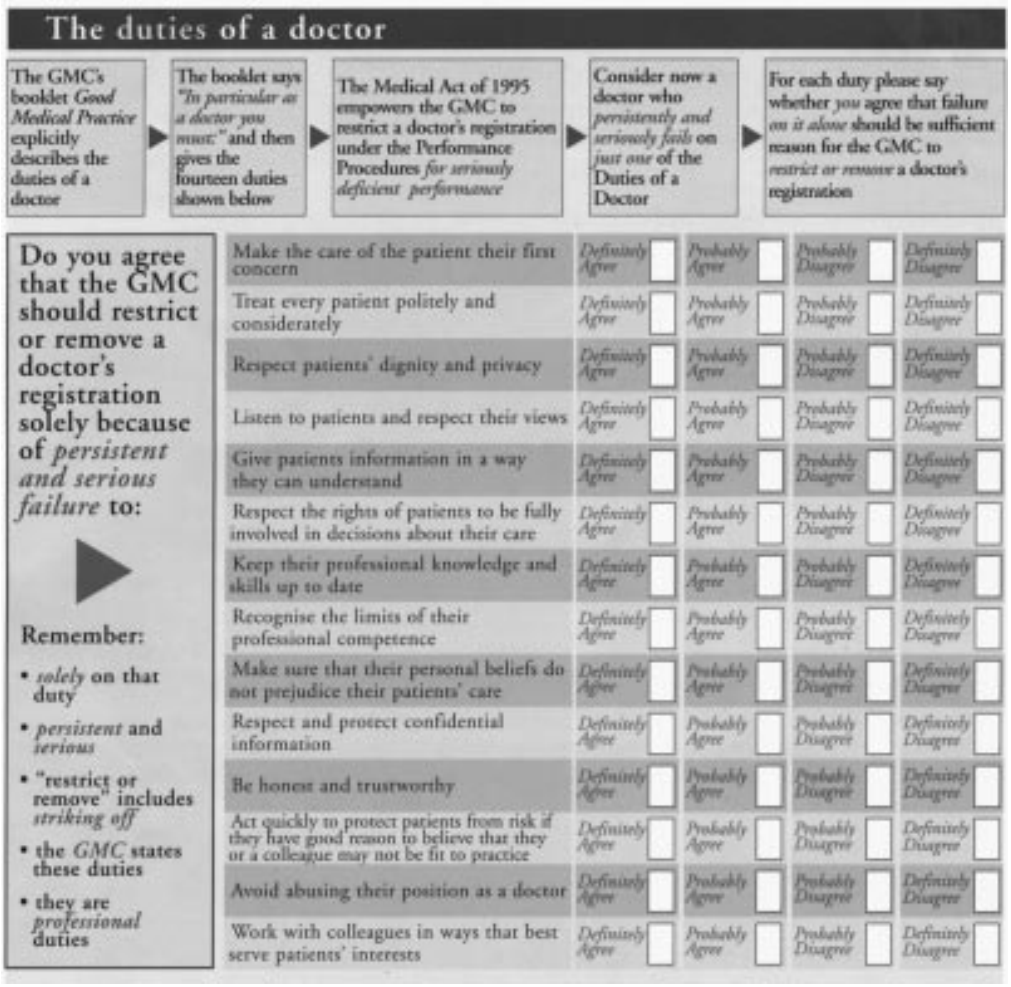

Figure 1 The full text of the question on Duties of a Doctor.

Good Medical Practice a week before the main study. The present analysis considers all questionnaires returned by 25 March 1998.

QUESTIONNAIRE DEVELOPMENT AND PILOTING

Question development followed a traditional approach, starting with 16 extensive interviews with doctors and NHS and trust executives (undertaken by Ms Melanie Williams and Professor Allen Hutchinson) concerning the need for the performance procedures, and possible problems with them. From the resulting transcripts DG and ICM developed about 30 attitude questions. Early versions of the questionnaire were piloted on approximately 20 hospital doctors and GPs. For the final version of the questionnaire, the attitude questions were reduced to 12, with refinement of content to avoid overlap, ambiguity, and asking for multiple information in a single question. The attitude questions were answered on a four point scale.

The question on attitudes towards *Duties of a Doctor* was particularly difficult to word properly. The problem is essentially that of "motherhood and apple pie"—if poorly worded then it was perhaps inevitable that everyone would agree with all of the items, which would provide little information for looking at differences between groups. After much piloting and discussion it was felt necessary to emphasise that restriction of registration should depend solely on failure, albeit persistent and serious, *on a single duty*. Figure 1 shows the final version of the questionnaire.

It should be noted that due to a minor ergonomic error in the design of the questionnaire, some respondents initially failed to turn to the last page of the questionnaire. As soon as this problem was recognised, future questionnaires were rubber stamped to rectify the problem.

BACKGROUND MEASURES

The questionnaire included several background measures to help in interpreting the answers given by the respondents. The General Health Questionnaire (GHQ)[10] was used in its 12 item version,[11] scored on a 0-1-2-3 basis for looking for correlations with other items. The Maslach Burnout Inventory was used in a shortened version,[12] with three items on each of the three subscales of emotional exhaustion, depersonalisation, and personal accomplishment; high scores on the first two and low scores on personal accomplishment are associated with professional burnout. An abbreviated version of the Physician's Reactions to Uncertainty scale was used,[13] with two items from the scale assessing "stress of uncertainty", and three items assessing "reluctance to disclose uncertainty to others". Social desirability was

assessed using two items (1 and 5) from a measure designed for use in medical situations,[14] which correlates with the well validated Marlowe-Crowne Social Desirability Scale[15]; the questions are written such that even a paragon of perfection is unlikely to be able to agree fully, so that positive responses can be construed either in a negative sense as simple lying or, in more charitable terms, as "social acquiescence".[14 16]

STATISTICAL ANALYSIS

In the main sample, exploratory regression and logistic regression analyses were done using a forward stepwise entry. Variables entered into regression are described as "design" (sex, year of qualification, place of qualification (UK *v* non-UK), and type of practice (hospital *v* general practice), plus an indicator of whether the doctor had had a locum appointment during the previous three years); "background" (General Health Questionnaire (scored 0-1-2-3), three burnout measures, two responses to medical uncertainty, and the social desirability measure); and "outcome" (described further in the results section; measures of how much doctors have heard about the performance procedures, how much they know about *Good Medical Practice*, their acceptance of the duties of a doctor as a basis for restriction of registration, the changes they have made in their practice, their perception of the need for the performance procedures, and their attitudes to them). The attitude statements were analysed with an unfolding procedure equivalent to Thurstonian scaling[17 18] using the program GUMJML.[19]

Results

Questionnaires were sent to 794 doctors. Thirty five could not be delivered (returned by the post office or overseas). Responses of some sort were received from 591 doctors giving an overall response rate of 78% (591/759). In total, 23 doctors declined to take part because they were now retired, 11 did not wish to take part, and one said they would return the questionnaire later (they did not), giving 556 questionnaires containing useable data. The effective response rate is therefore 73% (556/759). Five questionnaires were returned anonymously and therefore not all background data were available for them. Considering the 586 non-anonymous respondents, there was no significant difference in response rate between men and women, general practice and hospital practice, or year of qualification. The response rate was, however, significantly higher among doctors qualified in the UK (78% (479/613)) compared with those qualified overseas (66% (96/146)); odds ratio = 1.86, 95% CI = 1.26 to 2.75). Seven per cent (40/556) of doctors indicated that they were now retired but were prepared to complete the questionnaire and their responses were included in the study.

DOCTORS' KNOWLEDGE OF GOOD MEDICAL PRACTICE

Doctors were asked how much they knew about *Good Medical Practice* before receiving the questionnaire. Eighty nine per cent of doctors acknowledged that they had received a copy of *Good Medical Practice*; however only 17% of doctors had read it at least fairly carefully. Table 1 indicates the spread of answers to this question.

Table 1 The range of responses to the question of the booklet Good Medical Practice

Response	*Number (%)*
Never seen a copy	58 (10.6)
Received a copy but not looked at it	30 (5.4)
Received a copy and glanced at it	176 (32.3)
Received a copy and looked through it	188 (34.5)
Received a copy and read it fairly carefully	73 (13.2)
Received a copy and know its contents well	20 (3.6)

Regression on the design and background variables found that those knowing the contents better had higher personal accomplishment scores (β=0.121, p=0.0047) and higher social desirability scores (β=0.115, p=0.0073).

HOW MUCH DOCTORS HAD HEARD ABOUT THE PERFORMANCE PROCEDURES IN THE PREVIOUS YEAR

Doctors were asked how often they had heard about the performance procedures in the past year from 10 different sources (table 2). Most doctors (>60%) had received information from the GMC or read about the performance procedures in quality medical journals on at least one occasion, but few (<10%) had heard them mentioned by patients or the general public. An overall score was created by summing across the various sources and regressed on the design and background measures; no variables were significant predictors. Those who had heard more of the performance procedures were also more aware of *Good Medical Practice* (r=0.306, n=509, p<0.001).

DUTIES OF A DOCTOR

In *Good Medical Practice* there is an explicit list of 14 duties of a doctor, preceded by the statement "In particular ... you must:". Respondents were told that under the Medical Act of 1995 the GMC was empowered to restrict a doctor's registration for seriously deficient performance. They were then asked to consider a doctor who persistently and seriously failed on just one of the duties and to say whether or not they thought that failure on it *and it alone* should be sufficient reason to restrict or remove registration. Table 3 shows the percentages of doctors who agreed that each of the duties was sufficient reason for restricting registration. Few doctors (<10%) disagreed with restriction of registration on the grounds of avoiding abuse of position, being trustworthy, respecting confidentiality, recognising limits of competence, and keeping skills up to date. A moderate number (>25%), however, disagreed on the basis of keeping patients fully informed, giving patients information in ways they understood, and treating all patients politely and considerately. To assess whether doctors who agreed with any one item were also more likely to agree with other items, a factor analysis was calculated of the 14 scores, using a principle component analysis. Factor analysis suggested one major factor with a possible hint of a

Table 2 The number of times doctors had heard about the performance procedures during the previous year. Items are ranked in approximate order from most heard to least heard, with the order in the original questionnaire being indicated in parentheses alongside each question

	Never (%)	*Once (%)*	*2–3 times (%)*	*4–6 times (%)*	*7–10 times (%)*	*≥11 times (%)*
Information from the GMC (1)	61 (11)	259 (48)	198 (36)	16 (3)	6 (1)	4 (1)
Read about them in the quality medical journals (*BMJ*, etc) (4)	145 (28)	158 (30)	176 (34)	28 (5)	7 (1)	5 (1)
Read about them in (free) medical newspapers/magazines (5)	209 (41)	85 (17)	156 (31)	44 (9)	12 (2)	5 (1)
Information from the BMA or other professional organisation (2)	184 (36)	168 (33)	140 (27)	16 (3)	5 (1)	1 (<%)
Mentioned by colleagues in your own hospital or practice (8)	281 (55)	67 (13)	126 (25)	28 (6)	7 (1)	2 (<1)
Heard about them at conferences or meetings (7)	345 (67)	82 (16)	73 (14)	11 (2)	2 (<1)	3 (1)
Information from the health authority, trust, or local medical committee (3)	353 (70)	81 (16)	60 (12)	8 (2)	4 (1)	1 (<1)
Read about them in the popular press (6)	366 (73)	81 (16)	53 (11)	2 (<1)	2 (<1)	1 (<1)
Mentioned by members of the general public (10)	486 (95)	13 (3)	9 (2)	2 (<1)	0	0
Mentioned by patients (9)	502 (98)	6 (1)	1 (<1)	1 (<1)	0	0

second factor. Varimax rotation suggested that if two factors were present then the first six items loaded on one factor, the next seven on a second factor, and the last item on both factors (table 3); the first factor seems mainly to concern the rights of the patient and the second the skills and attitudes of the doctor. Separate scores were calculated on the items relating to duties towards patients and duties about the skills and attitudes of doctors and regressed on the design and background variables, knowledge of *Good Medical Practice*, and how much doctors had heard about the performance procedures. Those agreeing more on each of the scales were more likely to have heard more about *Good Medical Practice* (approach to patients: β=0.133, p=0.0016; attitudes and skills of doctor, β=0.148, p=0.0005) and to have higher social desirability scores (approach to patients: β=0.209, p<0.0001; attitudes and skills of doctor, β=0.163, p=0.0001).

EFFECTS ON PRACTICE

Doctors were asked about the effects of the performance procedures on their practice. Twenty five per cent had already made changes in their everyday practice during the previous year, and 24% were considering changes during the next year. Thirty per cent had already made changes during the previous year in their continuing medical education, and 30% were considering it for during the next year. Overall, 47.1% had made or were considering some change in their practice. Logistic regression on the design and background measures, knowledge of *Good Medical Practice*, and how much doctors had heard about the performance procedures found those considering or making a change in their practice had heard more about the performance procedures (r=0.186, p=0.0003), and were more likely to be women (odds ratio = 1.95; 95% CI 1.38 to 2.75), 39% of male doctors and 56% of female doctors considering or making changes.

NEED FOR PERFORMANCE PROCEDURES

Doctors were asked how often they had been aware of doctors in their own professional experience in the previous two years who should, or could now, have been considered under the performance procedures. Sixty three per cent said never, 21% once, 13% two to three times, 1% four to six times, less than 1% seven to 10 times, and 1% more than 11 times. On average therefore each doctor in the survey was aware of 0.77 doctors in the previous two years who might be vulnerable to the performance procedures. Regression of the number of cases encountered upon the design and background measures, knowledge of *Good Medical Practice*, and how much doctors had heard about the performance procedures found that significant predictors were higher depersonalisation scores (β=0.111, p=0.0089), higher personal accomplishment scores (β=0.123, p=0.0040) and hearing more about the performance procedures (β=0.129, p=0.0023).

ATTITUDES TOWARDS THE PERFORAMANCE PROCEDURES

Twelve questions were asked about attitudes towards the performance procedures (table 4). A majority of doctors (≥60%) agreed that the performance procedures are reassuring to the general public, are a reason for more defensive practice, cannot be used fairly for problems of attitude or communication, and make it neces-

Table 3 Duties of a Doctor. The numbers of doctors who agreed that failure on each of the duties of a doctor on its own would be sufficient justification for restricting the registration of a doctor. The duties are approximately ordered from greatest to least agreement, with the original order in the questionnaire being indicated in parentheses

	Definitely agree (%)	*Probably agree (%)*	*Probably disagree (%)*	*Definitely disagree (%)*	*Factor*
Avoid abusing their position as a doctor (13)	404 (74)	123 (23)	14 (3)	3 (1)	II
Be honest and trustworthy (11)	397 (72)	128 (23)	19 (4)	4 (1)	II
Respect and protect confidential information (10)	371 (68)	156 (29)	17 (3)	3 (1)	II
Recognise the limits of their professional competence (8)	353 (64)	170 (31)	21 (4)	5 (1)	II
Keep their professional knowledge and skills up to date (7)	304 (56)	218 (40)	22 (4)	4 (1)	II
Make the care of the patient their first concern (1)	284 (52)	205 (38)	49 (9)	8 (2)	I
Respect patients' dignity and privacy (3)	285 (52)	200 (36)	58 (11)	6 (1)	I
Make sure that their personal beliefs do not prejudice their patients' care (9)	269 (49)	202 (37)	62 (11)	11 (2)	II
Act quickly to protect patients from risk if they have good reason to believe that they or a colleague may not be fit to practise (12)	198 (36)	256 (47)	77 (14)	15 (3)	II
Work with colleagues in ways that best serve patients' interests (14)	204 (38)	217 (40)	108 (20)	15 (3)	I & II
Listen to patients and respect their views (4)	186 (34)	247 (45)	96 (18)	18 (3)	I
Respect the rights of patients to be fully involved in decisions about their care (6)	164 (30)	244 (45)	125 (23)	13 (2)	I
Give patients information in a way they can understand (5)	166 (30)	182 (33)	163 (30)	36 (7)	I
Treat every patient politely and considerately (2)	137 (25)	208 (38)	148 (27)	53 (10)	I

Table 4 Attitudes towards the performance procedures. The number of doctors who agreed with each of the attitudinal statements about the performance procedures. Statements are ordered from greatest agreement to least agreement with the performance procedures, ordered on the basis of the Thurstonian scale value. The order of items in the original questionnaire is indicated in parentheses

Do you think that the Performance Procedures:	*Definitely disagree (%)*	*Probably disagree (%)*	*Probably agree (%)*	*Definitely agree (%)*	*Characteristics of those agreeing:*	*Scale*
Are well understood by most doctors? (1)	84 (16)	240 (44)	185 (34)	31 (6)	Qualified earlier; ↑social desirability; ↑knowledge *Good Medical Practice*	2.25
Are a desirable step towards the regular recertification of doctors? (11)	82 (16)	169 (32)	228 (44)	45 (9)	Women	1.99
Are reassuring the general public that the medical profession can put its own house in order? (2)	25 (5)	179 (33)	289 (54)	46 (9)	Qualified earlier; ↑social desirability;	1.63
Make it necessary for doctors to report deficient performance in their colleagues? (12)	26 (5)	138 (26)	292 (55)	72 (14)	—	1.47
Are a reason for doctors to be more defensive in their practice? (3)	45 (8)	163 (30)	215 (40)	114 (21)	Men; non-UK qualification; ↑emotional exhaustion	−0.04
Cannot be used fairly for problems of attitude, interpersonal behaviour, or communication? (10)	38 (7)	167 (32)	239 (45)	82 (16)	General practice; non-UK qualified	−0.36
Make all doctors vulnerable, since everyone does something everyday which might seem deficient? (6)	50 (9)	213 (40)	200 (37)	76 (14)	↑Stress from uncertainty; general practice	−0.47
Are unfair to some types of doctor (for example locums, single handed practitioners, overseas graduates)? (7)	93 (18)	266 (51)	128 (24)	40 (8)	Non-UK qualification; ↑stress from uncertainty	−1.11
Will affect GPs the most because hospital doctors find it easier to cover each others' deficiencies? (9)	113 (21)	236 (45)	132 (25)	46 (9)	General practice; non-UK qualified; ↑stress from uncertainty	−1.17
Will impair medical morale and disrupt doctors' teamwork? (5)	86 (16)	285 (53)	135 (25)	30 (6)	↓Knowledge *Good Medical Practice*; ↑stress (general health questionnaire); heard more about performance procedures	−1.18
Are principally window dressing to stop criticism from politicians and the media? (4)	94 (17)	261 (48)	148 (27)	37 (7)	↓Knowledge *Good Medical Practice;* ↑Emotional exhaustion	−1.18
Are only appropriate for problems of technical competence? (8)	158 (30)	274 (52)	86 (16)	12 (2)	General practice; non-UK qualified	−1.83

sary for doctors to report deficient performance in colleagues. A majority of doctors (≥60%) also disagreed with statements that the performance procedures are appropriate only for problems of technical competence, will impair morale and disrupt teamwork, will affect GPs more, are unfair to some types of doctors, are principally window dressing, and are well understood by most doctors.

Each of the individual attitudes was regressed on the design and background variables, as well as knowledge of *Good Medical Practice* and how much doctors had heard about the performance procedures. Table 4 summarises those predictors which are significant. GPs, those qualifying earlier, women, and non-UK graduates differed on several items, as did those with high stress scores, responses to uncertainty, emotional exhaustion and personal accomplishment, and those who had heard more about the performance procedures or knew more about *Good Medical Practice* or who had higher scores on the social desirability scale.

The attitude statements were analysed with an unfolding procedure for Thurstonian scaling. Unlike the more usual but less satisfactory Likert scaling,[20] Thurstonian scaling allows for the possibility that a person with middling attitudes may disagree with extreme attitudes from both ends of an attitude scale; the unfolding method allows calculation of the position of items along the scale with no need for arbitrary assumptions about "reversed scoring", and a better resolution of attitudes in the middle of the range.[21] A scale was apparent between those at one extreme who were in favour of the performance procedures and thought them well understood by doctors, a desirable step towards recertification, and a reassurance to the public, through to the other extreme where doctors thought the performance procedures were principally window dressing, would impair morale, and were only appropriate for problems of technical competence (table 4). Regression of the overall attitude score on the design and background measures, and knowledge of *Good Medical Practice* and how much doctors had heard about the performance procedures found those more in favour tended to be women (β=0.159, p=0.0002), to have a greater sense of personal accomplishment (β=0.128, p=0.0035), and to have qualified in the UK (β=0.128, p=0.0023).

BACKGROUND MEASURES

The general health questionnaire was the only measure used in a completely standardised form which allowed direct comparison with population norms. Of the 448 doctors who completed the questionnaire, 15% reported scores ≥4 when scored using the 0-0-1-1 method (mean=1.25, SD 2.26), and taken to be indicative of what has been called "psychiatric caseness".[11] Analysis of the general health questionnaire scored on the basis of 0-1-2-3, which is more sensitive to small differences among groups, showed that doctors who had qualified more recently had higher General Health Questionnaire scores (β=0.124, p=0.0038). On the burnout questionnaires, doctors reporting more depersonalisation tended to be men (β=0.157, p=0.0002), and to have qualified more recently (β=0.125, p=0.0033), doctors reporting emotional exhaustion tended to be in general practice (β=0.120, p=0.0049), and no variables predicted personal accomplishment. Doctors describing more stress from the uncertainty of medical practice tended to practise in hospital (β=0.134, p=0.0016), and not to have qualified in the UK (β=0.121, p=0.0045), whereas no variables predicted reluctance to disclose uncertainty. Higher social desirability scores were found in women doctors (β=0.169, p<0.0001) (found also in the original scale development[14]), who were not qualified in the UK (β=0.153, p=0.0002), and who had qualified longer ago (β=0.188, p<0.0001).

Discussion

This questionnaire has provided both a detailed description of the attitudes and response of doctors to *Good Medical Practice* and the performance procedures, which are part of a broader set of changes in medicine, which, like other professions, are the result of the need to justify professional autonomy and self regulation.[22] The correlations found between attitudes and a range of background measures have provided insight into the processes underlying doctors' responses to the performance procedures. The high response rate is reassuring for the validity of the study and also an indication of the importance with which *Good Medical Practice* and the performance procedures are seen by doctors in Britain.

GOOD MEDICAL PRACTICE, PERFORMANCE PROCEDURES, AND THE DUTIES OF A DOCTOR

Doctors overall had a moderately good awareness of *Good Medical Practice*, were hearing the performance procedures discussed professionally, and agreed with most of the duties of a doctor. Few of the background or design variables showed correlations with these measures, suggesting that the GMC's message is penetrating evenly throughout the profession. The occasional tendency for doctors with higher social desirability scores to know more or to agree more may suggest that to some extent doctors are saying what they think should be said rather than what they believe is necessarily true.

EFFECTS ON PRACTICE, AND THE NEED FOR PERFORMANCE PROCEDURES

Nearly half of the doctors contacted had made or were contemplating making changes in response to the performance procedures. This is strong evidence that the impact is not only upon the seriously underperforming tail of the distribution but also is taking place across the entire distribution of professional performance. That more change is occurring in those who have heard most about the performance procedures suggests that change will continue to occur as more doctors hear more about them. An unanticipated finding of some interest is that women doctors were particularly likely to say they were making changes in their practice. If this finding is repeated in further studies it will be of some importance.

Overall, 37% of doctors were aware of at least one case in the previous two years which might be regarded as requiring the performance procedures. Although it is difficult to make any precise prediction from this, if each doctor is aware of the professional behaviour of about 100 doctors, then this might, all other things being equal, mean about 0.4% of doctors being involved with the performance procedures each year. There are about 180 000 doctors on the medical register, of whom perhaps 100 000 are professionally active, meaning about 400 cases each year for the GMC, at least in the first instance. Of course the judgment of doctors and the judgment of the GMC are not necessarily the same in these matters, and there are several uncertainties in the calculation, so such estimates should be treated with extreme caution. In particular, all other things are not necessarily equal; for instance, doctors' willingness to bring cases to notice is uncertain, with 69% of responding doctors disagreeing that the performance procedures put an obligation on doctors to report deficient performance in their colleagues.

ATTITUDES TOWARDS THE PERFORMANCE PROCEDURES

Attitudes clearly varied, along a spectrum from those who thought that the performance procedures were well understood by most doctors and were a desirable step towards recertification, to those thinking the procedures are principally window dressing and only appropriate for problems of technical competence. It was interesting that women doctors were more positive towards the performance procedures (and had also implemented more changes in response to them). Again, this needs following up in further studies.

INDIVIDUAL DIFFERENCES BETWEEN DOCTORS

Stress and burnout

Doctors who were stressed, at least as measured by the General Health Questionnaire, did not seem different in their knowledge, attitudes, or responses to the performance procedures. However, measures of burnout did correlate with some of the measures, although interestingly it was typically not those with more depersonalisation or emotional exhaustion who were more negative, but rather those with a higher sense of personal accomplishment who had a greater knowledge of *Good Medical Practice*, were most positive towards the performance procedures, and saw a greater need for them. Getting fewer positive rewards from everyday medical practice is therefore the best predictor of being negative towards the performance procedures.

Uncertainty in medicine

Although there may seem cogent reasons why those who feel most uncertain about medical practice, or are least able to communicate their uncertainty, should feel more negative towards the performance procedures, in fact we found no correlation between our measure of uncertainty and attitudes towards the procedures.

Doctors not qualified in the UK

Doctors who had qualified abroad were somewhat less likely to respond to our questionnaire, reported more stress from the uncertainty of medicine, and had somewhat higher social desirability scores. There were, however, no other differences in response to the performance procedures, with the sole exception that their attitudes were less positive; however, they knew as much about *Good Medical Practice*, had heard as much about the performance procedures, had similar attitudes towards the *Duties of a Doctor*, had made similar changes in their own practice, and saw an equal need for the performance procedures.

GOOD MEDICAL PRACTICE AND THE GOOD

An interesting omission thus far in the discussion is the nature of the good that is *Good Medical Practice*. Alasdair MacIntyre argues that virtues find their origins in the social basis of excellent practice (p 190).[23] He postulates that all practice (and practice is more than mere technical skills) involves:

"standards of excellence and obedience to rules … [T]o enter into a practice is to accept the authority of these standards, … [and] to subject [one's] attitudes, choices, preferences and tastes to the standards which currently … define the practice. We cannot be initiated into a practice without accepting the authority of the best standards realised so far."

Following Aristotle, MacIntyre emphasises how practice as a *virtue*, as a good, involves "the enjoyment of the activity and the enjoyment of achievement" (p 197), so enjoyment and achievement become coterminous (and achievement without enjoyment is not virtuous (p 274)). Here then is a clear link to the present data, with knowledge of *Good Medical Practice*, perceiving a greater need for the performance procedures, and having positive attitudes towards the performance procedures being associated in a precisely Aristotelian fashion with positive aspects of professional achievement assessed by the personal accomplishment scale of the Maslach inventory. Because MacIntyre argues for the necessity of historical continuities it is therefore perhaps not mere hyperbole to find a direct genealogy from the Hippocratic corpus to *Good Medical Practice*.

Conclusions

Surveys such as this inevitably have limitations, not least when they are undertaken at only one time point. Our primary intention is to look for change, and therefore in future reports we hope to see the extent to which there are differences from this study. At present we can only provide a single picture of the response of doctors working in the UK to *Good Medical Practice* and the performance procedures. In general, the picture is positive and reassuring, and the GMC should feel encouraged. Many doctors are aware of the performance procedures, have come across *Good Medical Practice*, are broadly in agreement with the *Duties of a Doctor*, see the need for the performance procedures from their own experience, are making changes in their practice as a result of the performance procedures, and have broadly positive attitudes. To that extent the GMC has got its message across, and there are no obvious lacunae in the profession's knowledge or awareness (young or old, hospital or GP, male or female, UK or non-UK graduates). That does not of course mean that all is perfect. The attitudes in particular suggest that a sizeable group of doctors exist who see the performance procedures as potentially unfair to certain groups of doctors, who feel they will impair morale, are political window dressing, and are limited in the areas to which they can be applied. Many doctors also anticipate problems with applying the performance procedures in cases to do with communication skills or working with professional colleagues. These are perhaps areas in which the GMC may wish to concentrate its campaigns to inform and advise doctors, and enlist their further cooperation, in creating a new climate of broader accountability in medical practice which is seen as desirable by many in the profession,[24] as well as by informed lay opinion.

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