Chapter three:

What can we learn from enquiries about doctors and our standards?

The GMC gathers qualitative intelligence from a number of sources – this is more difficult to interrogate and analyse than the quantitative data, but it may be useful in helping to identify current or future risks to patient safety.

In this chapter, we look at this qualitative intelligence and consider where it can help those responsible for planning, managing or regulating healthcare to understand pressure points in the system, and to assess what action they might take to support doctors and the systems in which they work to tackle any deficits and deliver a good standard of care.

We have categorised these sources of intelligence into two forms – proactive and responsive.

It should be noted that the numbers of both proactive and responsive enquiries to the GMC are relatively small when set against the number of patient interactions with doctors every day in the UK's healthcare system. We need to be careful therefore not to overstate or ascribe too much meaning to these data. In some cases though, it may be indicative of an underlying concern, or a trend, or a more fundamental issue that requires further investigation.

Proactive enquiries

Doctors and medical students contact the GMC for advice on a wide range of issues, including how they should apply the GMC's guidance in practice. The GMC also receives queries from patients, relatives and other interested groups about the standards set in the GMC's guidance, the care they should expect, and a host of specific ethical issues.

These enquiries reach the GMC through a number of channels (box 1, page 86): the standards and ethics advice service, the teams in Northern Ireland, Scotland and Wales, the regional liaison service (RLS), the confidential helpline, the contact centre, and the education quality assurance team. In this chapter, we use 2014 data from these sources.

These enquiries can signal that the GMC, employers or others may need to raise the profile of particular issues or to improve the guidance and support available.

Responsive enquiries

Responsive enquiries arise when there are concerns as to whether a doctor or doctors have followed good practice. Again this can come from medical students, doctors, employers or members of the public. Some of these enquiries come through the same channels as proactive enquiries, but most come in the form of a complaint about an individual doctor.

Chapter 2 discusses complaints about doctors that come through fitness to practise channels in greater detail.

Responsive enquiries can signal areas where doctors may need more support to meet the standards expected of them.

BOX 1: Sources of qualitative intelligence

The GMC standards and ethics advice service
This service offers advice on how doctors should address an ethical dilemma or challenging situation in a way that is consistent with the GMC's *Good medical practice* and explanatory guidance.[66] In 2014, the service received 564 enquiries, of which 295 were proactive enquiries and 41 were responsive enquiries raising a concern that doctors had failed to meet the standards expected of them.*

The teams in Northern Ireland, Scotland and Wales
The teams in the devolved offices promote GMC guidance through workshops and other events for doctors, medical students and patient groups as well as others working in this area. As part of this, they gather feedback on what concerns those on the front line, as well as topics on which they want advice.

The Regional Liaison Service in England
On a daily basis, Regional Liaison Advisers meet patients, doctors, medical students and medical educators to explain the GMC's role, including how its guidance and standards should apply in practice. They also gather feedback on what is happening on the ground and this includes asking for feedback from workshop participants.

The confidential helpline
The GMC confidential helpline is one of a number of routes by which doctors and others can raise concerns. It was set up in late 2012 to enable doctors to seek advice and to raise serious concerns about patient safety when they feel unable or unsure how to do this at local level.[67] There were 586 calls to the helpline in 2014, most of which were about doctors' fitness to practise or failure to follow GMC standards. Only 150 enquiries had enough detail recorded to understand the nature of the enquiry.†

The education quality assurance team
The team analyses information from a range of sources. The team visits and takes part in inspections of hospitals and GP surgeries where doctors practise. As part of this they gather feedback from staff, students and doctors in training, as well as carrying out formal surveys of doctors' experiences of these training environments.

The team also works with a range of organisations to improve the quality of medical education and training through a process of enhanced monitoring. This occurs when there is concern about the training of medical students or doctors, which has not improved sufficiently despite attempts to collaborate with those responsible, and the GMC believes this could adversely affect patient safety, doctors' progress in training, or the quality of the training environment. In addition to concerns raised through the enhanced monitoring process,[68] we have also analysed the issues raised by medical royal colleges and faculties through their annual reports to the GMC.‡

* The remaining 228 enquiries did not contain enough information to establish the subject, should have been directed to other regulatory organisations, asked for non-specific advice (ie where to locate the advice section of the GMC website) or for official GMC positions or statements on particular subjects, or were employer-related issues or unrelated to doctors' activities.

† 351 enquiries did not capture enough detail to fully establish the subject, of which 209 were concerns about doctors' fitness to practise that would have been referred to the relevant team and counted there. The remaining 85 enquiries had identifiable topics but were not relevant to this analysis.

‡ Data from the formal surveys of doctors' training environments are used in chapter 4 where we look at a case study of trust performance in England.

Proactive enquiries to the GMC

From the activity of GMC staff and liaison teams across the UK, we can identify issues that doctors and medical students appear to be most interested in (box 2).

In 2014, there were three areas which stood out in terms of doctors seeking further information or advice:

- prescribing*
- confidentiality, including the risks from new technology
- end of life care.

BOX 2: What do our key interest groups in Northern Ireland, Scotland, and Wales want advice on?

In 2014, in Northern Ireland, the most popular sessions asked for were about confidentiality, revalidation, maintaining boundaries with patients, continual professional development and acting as an expert witness. Doctors in training asked for sessions about consent, confidentiality, personal beliefs, maintaining boundaries with patients, and reporting convictions.

In Wales medical students in their first, second and third years asked for sessions about end of life care, advice on delivering care to those aged 0–18 years, protecting children and young people, conflicts of interest and prescribing.

In Scotland medical students expressed interest in similar issues, particularly prescribing and personal beliefs. Other events drew enquiries about informed consent, raising concerns, end of life treatment and care, and good medical practice.

* *Good practice in prescribing and managing medicines and devices*[37] was updated in 2013. It builds on the principles set out in *Good medical practice*, but does not advise on which medicines or devices to prescribe for particular conditions.

There is strong interest in advice and support on prescribing practice

Unsurprisingly, there is continuing interest in acquiring and maintaining the knowledge and skills for safe and appropriate prescribing.

In their enquiries to the GMC, doctors raised a range of questions.

- Who takes responsibility for checking prescriptions to make sure that medicines are safe and appropriate in environments where a patient may be assessed, treated and monitored by multiple doctors or other healthcare professionals?
- When is it appropriate to use new, imported or unlicensed medicines?
- What should I do when a patient asks for a particular drug and disagrees with my view that the drug should not be prescribed?
- What do I need to consider when prescribing for patients in other countries?
- Can I prescribe a cheaper but unlicensed medicine instead of the licensed alternative?

The GMC published updated guidance on prescribing in 2013.[69] The publicity and subsequent promotional work may have led to increased interest in clarifying the expected standards for prescribing. In 2014, 100 doctors fed back to the RLS that they would be interested in attending a workshop on good practice in prescribing and managing medicines – this was their fifth most common request. In 2013, this topic was not in the top five topics raised by doctors, although it was the most requested by medical students.[57]

Research on the prevalence and causes of prescribing errors shows that this is an ongoing concern, and shows that many prescribing errors involve doctors in training who do most of the prescribing in secondary care[70, 71] as well as GPs.[72]

National organisations have made prescribing errors a priority in recent years. For example, the British Pharmacological Society and Medical Schools Council Assessment set up a website to allow medical students to demonstrate their competence at prescribing.[73] Last year, The Medicines and Healthcare products Regulatory Agency (MHRA) and NHS England issued a patient safety alert to improve reporting of and learning from medication errors,[74] and the Health Foundation produced an evidence review of ways to tackle prescribing errors.[75] The Welsh Government,[76] the Scottish Patient Safety Programme[77] and Northern Ireland's Regulation and Quality Improvement Authority are all promoting better prescribing.[78] This may also have prompted doctors to seek advice from us and other sources.

Doctors are concerned about patients' confidentiality

The perennial tension between confidentiality and appropriate sharing of information continues to provoke interest and concern among front-line practitioners. The digital revolution which has brought so many advantages in terms of access and speed of transfer of patient data has also raised a host of ethical questions and added further complexity. Balancing competing interests, especially in sensitive areas, such as child protection and fitness of patients to drive, can present practitioners with difficult decisions, sometimes with no single right answer.

The GMC's standards and ethics advice service will only come across a tiny fraction of the dilemmas faced by doctors in everyday clinical practice, but the issues raised about confidentiality illustrate the range of issues doctors face as they grapple with these challenges.

Enquiries in 2014 to the standards and ethics advice team covered topics such as:

- disclosing medical data to family members and whether to do so in sensitive situations (for example, when the patient has a sexually transmitted disease)
- sharing information with medical colleagues who are not involved in the patient's treatment, with administrative staff or with external organisations (for example, medical insurance companies)
- what information can be shared as part of legal processes (for example, court hearings)
- keeping data secure and controlling access to medical records
- how to deal with accidental disclosure of information through insufficiently secured medical records or correspondence.

In 2014, the Regional Liaison team in England received 86 requests for sessions on confidentiality and ran 34 workshops on this issue. The Northern Ireland office asked doctors to suggest workshop topics they felt would be useful – this was the second most-requested workshop from doctors in training. The GMC's web pages which offer guidance on confidentiality issues received 64,572 hits in 2014. This was the second most-popular guidance section on the GMC's website for that year.

The wide variety of confidentiality issues raised through different channels suggests that there may be significant demand for advice, training and other practical support.

Developments such as new technology, or laws such as the new duty for all health and social care professionals to report cases of female genital mutilation in England and Wales, changing public expectations about privacy, and widespread media coverage about patient confidentiality are all likely to lead to doctors facing questions from patients and having questions of their own.

Recent high-profile media events[79, 80] have highlighted the delicate balance between maintaining confidentiality and ensuring public safety. This is likely to be of some concern to doctors, and it is clear that there are difficult decisions to be made around the sharing of patient data where the public is at risk. GMC guidance currently offers specific advice on when it is appropriate to disclose medical information to the DVLA or DVA, where a doctor has concerns about a patient's fitness to drive and the safety of the public.[81]

Next year the GMC will update and reissue its guidance on confidentiality and will develop further resources and training materials.

Doctors are concerned about risks arising from the spread of new technology

There is evidence that doctors are concerned about the implications of developments in the use of new technology. Most of the enquiries to the GMC concern the impact of telehealth, and the risk of sharing information inappropriately through the personal use of social media platforms.

The impact of telehealth

Telehealth (delivering medical care at a distance using communication technologies) is quickly becoming an established feature of modern healthcare delivery.[82] There have been numerous studies on the benefits, including one trial that found that telehealth can reduce both hospital admissions and patient mortality.[83] There are now initiatives across the UK looking at how to expand and extend the use of telehealth.[84, 85, 86, 87]

The Medicines and Healthcare Products Regulatory Agency is concerned about online prescribing, and from July 2015 anyone in the UK selling medicines online to the general public has to be registered with them and display the approved logo.[88]

Providing good end of life care

This continues to be an important issue politically, socially and in the media.[89, 90, 91, 92, 93, 94] The GMC published updated guidance on end of life care in 2010,[95] along with a range of resources with other organisations to support doctors and multidisciplinary teams.[96] In last year's report we looked at the issues around the abolition of the Liverpool Care Pathway,[57] which was used to plan care for people in the last few days and hours of life. In the summer of 2014, the Leadership Alliance for the Care of Dying People released its report on how to approach end of life care[91] but there have also been concerns voiced that end of life care is not seeing enough investment to be fully effective[96] with the Health Service Ombudsman criticising end of life care in many areas in the recent *Dying without dignity* report.[97]

Some doctors have warned that existing care homes are not set up to cope with modern palliative care, at a time when the need for it is increasing.[98] Professionals and campaign groups working in this area believe it is important to give people the choice of where to die, and that this can be achieved with better planning, more support for carers, and health and social care professionals cooperating in a coordinated way.[99] Healthcare organisations are aware that the ageing population means there will be increasing numbers of people with long-term conditions that require medical treatment over the next two decades.[100] This will be combined with a rising death rate (projected by the Department of Health to increase 17% between 2012 and 2030[100]) to increase pressures on end of life services. It is not certain what impact this will have on end of life care at this time.

Doctors are expected to respect patients' decisions, which can include their wish to die at home rather than in a hospital – but relatively few people have made their preferences clear to their doctors or their family. A recent UK-wide study of 1,972 members of the public found that only 4% of people had recorded a written preference for their end of life care, but only 7% wanted a doctor to decide their treatment if they became unable to communicate or make a decision for themselves. 52% of people stated they preferred to make their own decisions in advance, and 30% preferred a partner or family member to make the decisions.[101]

Again, the number of direct enquiries received by the GMC on this topic is small, but it is clearly an area of continuing interest and concern for many doctors. Last year, 105 doctors asked the RLS for workshops on delivering good quality end of life care while the standards and ethics advice service received enquiries about a range of end of life topics, including queries about deciding whether to resuscitate a patient, and how doctors should respond to patients who want to end their own lives. The GMC's web pages which offer guidance on end of life care received 24,834 hits in 2014.

Responsive enquiries: concerns raised about failure to meet standards

The most common topics raised by calls to the GMC's confidential helpline (box 3) and contact centre, where doctors appear to have fallen short of the standards expected of them, are:

- doctors bullying and undermining other doctors and healthcare professionals or being bullied and undermined by them
- mental and physical health problems in doctors.

The GMC offers advice and guidance on both of these topics, though there are many other places that doctors can get advice or guidance, and raise concerns – including with their employer, the British Medical Association (BMA), medical defence organisations and medical royal colleges. It is important to stress therefore that the GMC's qualitative data are a small part of this wider picture. Nevertheless, the GMC's web pages on raising concerns received 15,202 hits in 2014, suggesting an interest from doctors in how and where to raise concerns about their working environment. The types of issues raised are likely to be within the power of employers and others to intervene and prevent, as has been reported in the GMC's national training survey bullying and undermining report.[102]

BOX 3: What enquiries do we receive through the confidential helpline?

The confidential helpline received 586 calls in 2014. Of these 150 had sufficient detail recorded about the topic and these are the basis of analysis in this chapter.

135 enquiries were reporting doctors for failing to meet professional standards, often because of poor clinical performance, bullying and undermining behaviour, or failure to act honestly. Many of these enquiries were from doctors or employers, although some were from other healthcare professionals or the public.

15 enquiries were from doctors who wanted advice on how to provide good quality care.

Bullying and undermining continue to be a problem

Over the past two years, there has been heightened awareness about bullying in the NHS.[103] The 2014 NHS England staff survey found that almost one in four staff said that they experienced harassment, bullying or abuse from their manager or other colleagues.[104]

This has coincided with growing interest in allegations that staff who do raise concerns can find themselves pilloried and victimised by both colleagues and managers.[103, 105, 106, 107]

It is possible that this raised profile, exacerbated by the debates following the Mid Staffordshire inquiry[30] is encouraging more doctors to draw attention to undermining behaviour and to be less tolerant when they see it. The GMC's 2014 national training survey found that 8% of doctors in training had experienced bullying and 14% had witnessed it.

Nearly one in five of the 150 confidential helpline calls analysed were about serious problems in working relationships between doctors. About three-quarters of these were linked to bullying or undermining in various forms. The education quality assurance team also found problems with bullying and undermining at six of the 23 sites that required enhanced monitoring in 2014. In many cases, the education team found that consultants were not aware that doctors in training regarded their actions as undermining. When made aware of this, they were prepared to change their behaviour.[44]

This difference of perception, where one side sees firm management and another sees bullying, was also raised when the GMC consulted on proposed changes to the sanctions guidance.*, [108] Respondents to the consultation also highlighted the importance of tackling and properly investigating bullying, especially when it involves doctors who are whistleblowers. These issues suggest that healthcare organisations – such as employers, regulators and doctors' representatives – need to work together and with doctors to handle bullying carefully.

Action to tackle bullying and undermining

The GMC's 2015 review – *Building a supportive environment: a review to tackle undermining and bullying in medical education and training* – found that many medical students and doctors who have experienced bullying find it hard to speak up.[44]

The GMC's experience is that even when doctors try to resolve problems with working relationships or instances of bullying by working with their employers or local bodies, this can cause a further deterioration in relationships. Moreover, data from the national training survey show that doctors in training are often reluctant to speak out about bullying, fearing reprisals and with no confidence that their concerns will be addressed.[102]

* The Medical Practitioners Tribunal Service (MPTS) fitness to practise panels use the sanctions guidance[109] to decide what action to take against doctors whose fitness to practise is impaired.

Doctors and other healthcare professionals at all levels and in all environments have a right to work free from bullying and undermining. Regulators have a role to play in tackling this behaviour, particularly when healthcare professionals feel that their concerns have not been addressed locally or that they cannot raise concerns locally. Doctors may raise concerns with the GMC because they see it as a safer option.

In June 2015, the GMC and the Nursing and Midwifery Council issued joint guidance for doctors, nurses and midwives on their duty of candour – a professional responsibility to be honest with patients when things go wrong.[38] This guidance was developed following the inquiry into events at Mid Staffordshire NHS Foundation Trust, which showed that healthcare professionals did not feel supported by their employers to meet their duty of candour. In England, the Care Quality Commission will regulate organisations' compliance with a statutory duty of candour, and the governments in Northern Ireland, Scotland and Wales are developing their own plans for implementation. It is intended that encouraging a culture of openness, where doctors feel able to raise concerns about others and speak with candour about their own practice, will make it easier for doctors to report any bullying and undermining that they have experienced or witnessed.[45]

Helping doctors with mental and physical health problems

Many doctors may suffer ill health during their careers, but in most cases this will not affect their fitness to practise. They are able to manage their conditions effectively, and the quality of care they deliver is not impaired.

However, in some cases, illness can negatively affect the care a doctor delivers, which can put patients at risk.

Doctors may be more vulnerable to mental health problems than the general population,[110] particularly female doctors.[111] A higher proportion of doctors experience social dysfunction, fatigue, depression and substance abuse than the general population.[112, 113] 10–20% of doctors become depressed at some point in their careers and they have a higher risk of suicide than the general population.[114]

About one in seven of the 150 confidential helpline calls analysed were about other doctors' substance abuse or mental health or physical health problems potentially impinging on their practice. However, the proportion of all fitness to practise complaints made to the GMC that relate to a doctor's health is much lower – just 6% of cases.

Research suggests that doctors in general tend to minimise their own health problems, do not take time off work, have a poor understanding and distrust of occupational health services and tend to self-diagnose and self-prescribe.[111] They are aware of how to hide illness and may want to do so because of the stigmas attached.[115]

Data on the frequency of enquiries about doctors' health can help the GMC and employers show doctors with health conditions that they are not isolated. The GMC and employers understand that health issues are common and must be addressed appropriately before doctors' practice becomes impaired. If doctors do so, they will usually be able to continue practising. In 2014, 22 doctors were given a sanction by a fitness to practise panel because they had not addressed their health problem and it affected their fitness to practise.

Issues raised by medical educators

Concerns raised by medical royal colleges and faculties

The medical royal colleges and faculties submit annual specialty reports to the GMC. These provide an oversight of the quality of training, highlight areas of good practice, and comment on developments in the specialty.

Feedback from the 2015 reports reveal that service pressures are having an impact on education and training in a range of ways. The themes raised have remained consistent in recent years and it is fair to say that the 2014 reports covered the same concerns. The reports do not provide enough evidence to gauge the depth or consequence of concerns, but the situation as described is certainly not improving. More research is needed to establish how far service pressures are damaging postgraduate education and, if so, what action needs to be taken to deal with it.

One measure which echoes what the medical educators are saying and which may reflect some of this pressure is the increasing number of organisations that are subject to enhanced monitoring (see box 1 on page 86). Enhanced monitoring was introduced at the start of 2012 with a handful of organisations under surveillance. In June 2012 the number of sites under enhanced monitoring was 23, and by September 2015 it had risen to 89. To some extent this may be the result of extra vigilance by the GMC and local bodies but the GMC's resulting quality assurance work certainly suggests that more often than not the educational challenges are linked to service pressures.

In particular the reports highlight the following challenges in the current system.

Job planning: there is a lack of dedicated time in many educational supervisors' job plans to support doctors in training. The colleges argue that if doctors in training do not receive appropriate support, the quality of their education and patient safety could be at risk. This is a view that the GMC would endorse.

Organising assessment: recruiting senior doctors to act as examiners is proving increasingly difficult. As a result examinations are having to be reorganised. There are also problems filling roles essential to training and a lack of locations in trusts to hold examinations.

Staffing levels: some specialties have trouble filling all their training posts. This results in rotas having to be filled by other doctors. This may impact on the quality of education, with doctors in training having to focus on routine work, at the expense of acquiring new skills and knowledge.

The independent sector is restricting training in some key skills: some medical royal colleges have expressed concerns that the transfer of some service contracts to the independent sector has reduced opportunities for doctors in training. This is an emerging issue, and the colleges have suggested it will become more acute unless contracts with independent providers include provision for training. The GMC does not have any firm evidence to support this, but it is a matter that will need to be kept under review.

Issues in training environments that require enhanced monitoring

In 2014, the GMC identified new training and education issues in 32 trusts and GP surgeries to the extent that they were subject to enhanced monitoring (see box 1, on page 86, for more information about the enhanced monitoring process). The most commonly reported themes in these sites concerned:

- poor access to education
- clinical supervision on weekdays or out of hours.

The difficulties were mostly focused on the quality of clinical supervision and access to high-quality training opportunities. This was combined with the detrimental effects on patients arising from doctors not receiving appropriate training. There were also three sites where bullying or undermining was serious enough to require intervention. The vast majority of sites had more than one theme. Only seven training environments had one theme, indicating that problems are often interconnected and require coordinated intervention to unpick.

Verified enhanced monitoring data are available on the GMC website.[116]

Enhanced monitoring theme	Occurrences
Clinical supervision (weekdays)	11
Poor access to education	11
Clinical supervision (out of hours)	10
Workload or work intensity	9
Staff behaviour	8
Educational governance	6
Handover	3
Rota issues	3
Trainee safety	2
Induction	1
Total	**64**

What types of cases ended in suspension or erasure in 2014?

The number of doctors erased or suspended every year is very small – less than two hundred out of a register with more than a quarter of a million practitioners. As the cases discussed in this section illustrate, those who are subject to the most serious sanctions have either placed patients at serious risk or undermined the fundamental trust in the profession or in some cases both.

In 2014, only 2% of concerns raised about a doctor's professional standards led to the doctor being suspended or erased from the medical register (157 suspensions or erasures were issued in 2014, there were 8,884 complaints closed that year).

We commissioned an independent review* of 119 MPTS hearings that ended in suspension or erasure in 2014 to understand the types of issues that led to these serious sanctions (figure 40). The review excluded cases in which the doctor's health was an issue.

The 119 cases were referred from a range of sources:

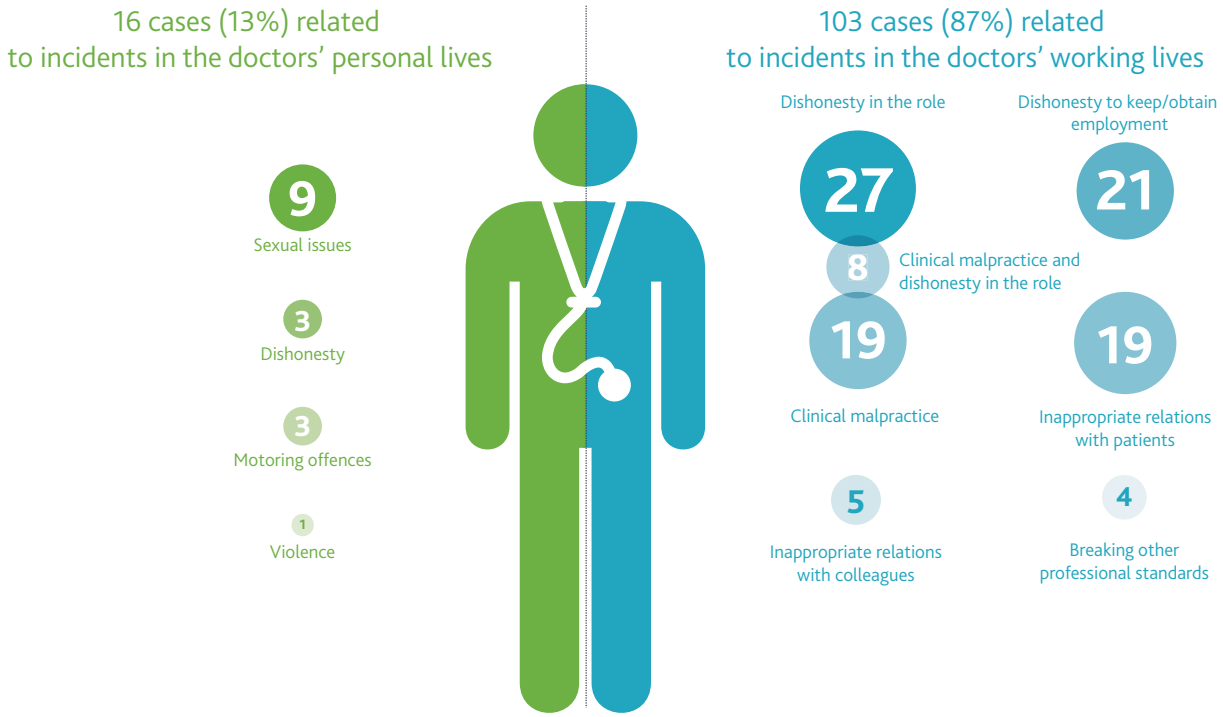
- 36% from the doctors' employers
- 13% from another doctor
- 11% from the police
- 8% from members of the public
- 8% from the GMC, for example after a media story
- 24% from other groups.

These cases fell into a number of broad categories: dishonesty to obtain or retain a job as a doctor; dishonesty in their role as a doctor, clinical incompetence, poor relationships in the workplace and inappropriate behaviour in their personal lives.

In the case studies that follow, the doctors are referred to as male, but while 98 of the cases involved male doctors, 21 were about female doctors.

* The GMC commissioned independent consultants DJS Research to determine the various factors involved, the different types of cases and whether there were any patterns in these cases when examined in detail and qualitatively.[117]

Figure 40: Types of issues involved in 119 cases that led to suspension or erasure in 2014



Being dishonest to get or maintain a job as a doctor

Outside the medical profession, lying or exaggerating to obtain a job is apparently acceptable to a minority,[118] and there have been suggestions that it is not treated particularly seriously by the media.[119]

However, there is an important distinction between changing dates of employment or lying about possessing a skill or qualification in many other occupations, and doing so on an application to take up a medical role. The doctor who misleads about possessing an essential skill could place patients' lives at risk, and damage trust in the profession, as in the case study in box 4.

BOX 4: Case study: falsifying a reference

A specialist in training was referred to the GMC after he was convicted in a criminal court of giving a false reference for himself. He was caught because a colleague was concerned about his clinical performance during a locum shift, and so took steps to verify the doctor's references.

The doctor admitted he had created the reference himself as well as the email address that it was sent from.

The MPTS panel took into account distressing family issues and the doctor's evidence of remorse but pointed out that it is difficult for a doctor to demonstrate that they have remediated in cases involving dishonesty. In particular, there was little evidence of insight in this case, other than the doctor's remorse, which gave limited assurance that the behaviour would not be repeated.

Outcome: the doctor was suspended for 12 months
The MPTS panel concluded that the doctor's fitness to practise was impaired due to his conviction, and that falsifying documents relating directly to clinical practice put patients at risk and brought the reputation of the medical profession into disrepute.

Failing to maintain standards through dishonest prescribing

Ten cases involved dishonesty in prescribing. In the case study in box 5, the doctor had been falsifying prescriptions over a long period, showing dishonesty and an ongoing failure to meet expected standards. Dishonesty involving prescriptions can also result in a criminal conviction, as in this case where the doctor was found guilty of both theft and forgery.

BOX 5: Case study: obtaining prescriptions dishonestly

A doctor working at a hospital was referred to the GMC after being convicted of fraudulently obtaining prescription-only medicines.

Over a period of eight months, he stole nine prescriptions, some of which he forged in the names of non-existent patients and non-existent prescribing doctors. He presented some of them at various community pharmacies to obtain medicines fraudulently.

The doctor said he had stolen the prescriptions to treat his own medical condition. He described his actions as a 'stupid mistake' and a 'one-off'. The panel concluded that despite some evidence of insight, his premeditated and prolonged behaviour indicated an underlying attitude problem that was fundamentally incompatible with being a doctor.

Outcome: the doctor was erased from the medical register
The MPTS panel concluded that his fitness to practise was impaired due to his conviction.

Failing to maintain standards through poor clinical competence

Doctors need to keep their skills up-to-date and make sure they are practising to the standards needed to deliver safe, effective care to patients. As well as maintaining high standards in their own practice, the GMC expects doctors to be prepared to protect patients from poor care by tackling concerns about the skills and competence of the doctors and other healthcare professionals they work with.

The public expects high standards from the medical profession and increasingly they also expect their doctors to take responsibility for the wider service and to tackle problems when and where they see them. This has probably been exacerbated by high-profile failures to provide adequate care, such as those exposed by the Bristol and Mid Staffordshire inquiries.[31, 32]

In the case study in box 6 the doctor failed to perform the basic requirements and the problem arose because of poor clinical performance.

In addition, the doctor showed a lack of insight and failed to take responsibility. The doctor's refusal to acknowledge fault placed a serious question mark over his ability to reflect on his performance.

BOX 6: Case study: failure to provide good quality care

A doctor was investigated by the GMC for failing to provide good clinical care to a patient following routine knee surgery. During the transfer from the operating theatre to the recovery area, the patient's condition rapidly deteriorated. The doctor in the operating department found she did not have a pulse, called for assistance from the crash team and started CPR.

The panel said the anaesthetist did not observe the patient appropriately and failed to establish that she was physiologically stable before attempting a handover. After the doctor in the operating department intervened, he did not exert the professional command expected of his position.

He denied his treatment was below standard, stating that he would not have done anything differently. The panel found that the doctor lacked insight and a willingness to reflect on and learn from the event. There was no evidence of concern or regret about the serious extent to which he had compromised the patient's life, and the panel concluded that he had deeply ingrained attitude problems.

Outcome: the doctor was erased from the medical register
The MPTS panel said that the acts and omissions of the doctor led to a situation in which a patient's life might have been at risk and that the outcome would have been very different had it not been for the attention she received from other healthcare professionals. The panel concluded that the care the doctor provided fell seriously below the standard expected of a reasonably competent doctor.

Failing to maintain standards through relationships in the workplace

The GMC's *Good medical practice* states that doctors must not use their professional position to pursue a sexual or improper emotional relationship with a patient or someone close to the patient.

Relationships with patients must be professional and appropriate, even if the patient wants the doctor to act beyond boundaries.

In the case study in box, it did not matter that the doctor did not have any bad intentions: the actions were inappropriate with a negative impact on the patient, and put the reputation of the medical profession at risk.

BOX 7: Case study: inappropriate sexual relations with a patient

A doctor who had worked as a GP for many years, was referred to the GMC after visiting a patient's home and engaging in sexual activity with her.

The doctor claimed that he had visited the patient to deliver a letter, and that the sexual activity was sudden and unanticipated. When he realised that what he was doing was wrong, he immediately stopped. In addition, he insisted he had not previously made any inappropriate advances to any patient.

The doctor immediately admitted and accepted responsibility for his actions when interviewed by the police. The doctor made it clear throughout the hearing that he did not seek to minimise the gravity of what he had done by attaching any blame to the patient, and agreed that his actions had brought the medical profession into disrepute.

The panel considered the doctor's insight and acceptance of what he had done wrong, and his honesty throughout the process. They also considered evidence from the doctor's two adult children that he was under various personal stresses at the time of the incident. Although this evidence was not independent, the panel accepted the credibility of the witnesses and was satisfied with the measures the doctor had since put in place to alleviate his stress.

Outcome: the doctor was suspended for 12 months

The GMC submitted that the doctor should be erased from the medical register due to the severity of his misconduct. However, the MPTS panel accepted that his sexually motivated misconduct, although extremely serious, was out of character. The panel was satisfied that he had full insight into the wrongness of his misconduct and there was little likelihood of repetition. The doctor was suspended for 12 months, which the panel argued would send a message to the public about the seriousness of the misconduct.

Inappropriate behaviour in doctors' personal lives

To sustain and build trust in the profession, doctors need to make sure that their conduct reflects the standards of professional behaviour expected of them,[120] even when they are not acting in a professional role.

Trust is critical to every aspect of the doctor-patient relationship and there is strong evidence that it is critical in delivering effective medical care. As part of this patients expect their doctor to be an honest and trustworthy individual.

Doctors who break the law, even when the crime does not directly affect their practice as a doctor, will be subject to an investigation. If doctors commit inappropriate acts, it is not relevant whether those affected are aware at the time that the person committing the act was a doctor. In the case study in box 8, the victim did not know the person assaulting them was a doctor, but this serious breach of the law had clearly brought the profession into disrepute.

BOX 8: Case study: inappropriate touching of a stranger

A doctor was referred to the GMC after an alleged sexual assault where he exposed himself to a female passenger sitting next to him on public transport and moved his pelvis against her on three occasions during the journey. He also obstructed her from moving seats and stopped her reporting him to the driver.

The doctor denied that there was any sexual intention and rejected the suggestion that he had acted improperly. He claimed that he had been trying to get comfortable.

The panel thought it was unlikely that the doctor would move in this way accidentally or while asleep three times, and concluded that his behaviour was sexually motivated.

The panel concluded the doctor had not demonstrated any insight, and there was no evidence that he had remediated, so there was a risk of repetition.

Outcome: the doctor was erased from the medical register
The MPTS panel stated this was unacceptable behaviour from anyone, and especially so from a doctor. It was noted that the doctor had not shown insight, and had a high risk of repetition. It concluded that his conduct had brought the profession into disrepute and that such behaviour might cause anxiety to female patients in particular.

Conclusions

Qualitative data gathered by the GMC during the course of its work have obvious limitations and should be seen alongside other evidence. It is possible though to identify issues of concern to doctors and others from this intelligence, and in some cases to discern trends which may require further study.

It is in everyone's interest to understand where professional standards may not be being met and it is important not just that the GMC listens to and acts upon emerging evidence, but that employers, the profession and policymakers develop a better understanding of the areas of risk.

It is equally important that doctors, employers and others consider ways in which they can act to mitigate risk, including whether they need to access or provide more guidance and support.