Chapter six: Upholding standards and the remediation of doctors
Sanctions and warnings are designed to uphold standards, protect patients and help doctors remediate

**Why remediation is important**

The GMC’s first responsibility above all others is to protect patients. In some cases it is necessary to suspend or remove a doctor’s licence to fulfil that responsibility. However, in common with other health regulators in the UK and around the world, the GMC will try, wherever it is safe and appropriate to do so, to give the doctors who have not met the required standards the opportunity to remediate. When it is proven that they have remediated they can return fully to their vocation.

Enabling doctors to remediate while protecting patient safety is important for a number of reasons.

- **Duty of care to doctor**
  The GMC’s statutory powers are not designed to punish doctors, although of course their effect may be punitive. The aim is to protect patients and the reputation of the profession. That remains the most important part of the process and is a prerequisite for anything else. However, providing this is done the GMC has a parallel duty of care to the doctors that come under its scrutiny. That includes making sure that any action taken by the GMC, where possible, encourages and enables effective remediation. This is important for the doctors as well as their patients.

- **Retaining trained doctors**
  There are shortages of doctors, particularly in certain specialties and geographical areas. The national systems in England, Northern Ireland, Scotland and Wales are under significant spending pressure. It costs on average £485,390 to train a GP and £726,551 to train a consultant. Retaining expensively acquired skills clearly makes sense.
Chapter 6: Upholding standards and the remediation of doctors

The concerns of this chapter
The full range of outcomes from a GMC fitness to practise process has been discussed earlier (see chapter 2). In this chapter we concentrate on those outcomes that are designed to encourage the doctor to reflect on their practice or which put in place arrangements to allow safe remediation. These outcomes are a warning, undertakings or conditions (see box 1).

This chapter explores whether the arrangements that have been in place are likely in practice to enable the remediation that they are designed to achieve. It identifies what conditions tend to make it more or less likely that remediation is successful. It also raises questions for further discussion about how the system might be improved and who should bear the costs of enabling remediation.

BOX 1: What are the GMC’s sanctions and warnings?

A doctor is given a warning when the GMC needs to register concerns about their behaviour or performance to uphold the standards expected of all doctors working in the UK. It is designed to send a signal to the doctor and the wider medical profession that standards must be maintained. In legal terms it does not signify that the doctor’s fitness to practise is impaired – were that to be the case a more serious sanction would be appropriate. Warnings are published on the online medical register for five years and must be disclosed to employers on request indefinitely.158

When a doctor’s fitness to practise is found to be impaired, the GMC and the Medical Practitioners Tribunal Service (MPTS) will seek to take action to protect the public or to maintain public confidence in doctors by giving the doctor one of four sanctions: undertakings, conditions, suspension or erasure.

If the GMC or an MPTS panel believes that the doctor can work safely under certain restrictions, then undertakings or conditions can restrict their practice or require them to do something, such as retrain.

- An undertaking is agreed between the doctor and the GMC, either at the end of an investigation or at an MPTS panel hearing. Undertakings remain in place until the doctor has remediated the concerns.

- A condition is imposed on a doctor’s registration by an MPTS panel, rather than agreed with the doctor. These remain in place for a term agreed by the panel.

In practice the only difference between undertakings and conditions is that the former is agreed with the doctor and the latter is imposed. Both are published on the medical register and disclosed to employers indefinitely.

In the most serious cases where the doctor is not safe to work and is not able to remediate effectively, an MPTS panel can temporarily suspend or erase the doctor from the medical register, which means they are no longer able to work as a doctor in the UK.
In 2014, 131 complaints about doctors resulted in warnings and 158 complaints resulted in doctors having their practice restricted by agreeing to undertakings or having conditions imposed.

How warnings, undertakings and conditions are designed to work

Restricting a doctor’s practice is appropriate when their practice is impaired but the GMC, or the MPTS panel, is confident that they can remediate and return to unrestricted practice. The doctor is responsible for making arrangements so they can continue to practise under the restrictions and demonstrate successful remediation. The GMC or the MPTS panel will remove the restrictions when there is evidence that the doctor is no longer impaired. When a doctor fails to remediate, an MPTS panel can take further action by increasing the restrictions, suspending their registration or removing (erasing) them from the medical register.

Given that the purpose of warnings, undertakings and conditions is not to punish, any sanction or warning should be the minimum needed to protect the public. However it is clear that aspects of the current system are not working as well as they should, and in particular questions are being raised as to whether doctors whose practice has been restricted can be better supported.\(^{159}\)

We know that a significant number of doctors who are referred to the GMC are already suffering from serious mental health issues, including depression and addiction. In addition, undergoing an investigation is itself stressful and doctors within the process are more likely to suffer depression, anxiety and suicide ideation.\(^{159}\) In considering how to deal with the period when a doctor is under restrictions, it is important to establish whether these negative feelings continue once a case formally ends and the doctor restarts practice with arrangements. As a first step though there is a need to find out more about doctors’ experiences of practising with a warning, undertakings or conditions.

There are many organisations involved in investigating a doctor and with the process of returning to practice. Doctors investigated by the GMC are also likely to have been investigated by their own employer before, or at the same time, increasing the pressure and the stress they experience. For many doctors, once they have received a sanction or warning, it is these employers to whom they turn first to resume their practice as a doctor. In reality, we know that doctors can find it difficult to obtain the support they need to comply with restrictions but as restrictions are imposed only where they are needed to protect the public it can be difficult to devise alternative arrangements.

If warnings, conditions and undertakings do not work in the way intended, there may be missed opportunities to improve poor standards and for doctors to remediate. In the GMC’s 2014 consultation on changes to sanctions guidance, most respondents felt the GMC should take more serious action where a doctor repeats conduct that led to a warning. In this context, it would be even more important that opportunities to help doctors improve their practice are not missed.\(^{160}\)

This examination of how warnings and restrictions work for medical practice in the UK may give useful insights to other health regulators in the UK and around the world. It is also helpful for the UK medical profession to consider whether there are lessons to be drawn from the research on this issue. The different approaches to giving sanctions and warnings around the world and in the UK are briefly described in box 2 (page 144).
**BOX 2: The framework of sanctions and warnings around the world**

The approach to giving sanctions and warnings varies across countries operating in different jurisdictions. Figure 50 shows this variation across ten countries.

**Figure 55: Which countries give warnings and different types of sanctions?**

<table>
<thead>
<tr>
<th></th>
<th>Removal of right to practise medicine</th>
<th>Suspension</th>
<th>Admonition or warning</th>
<th>Fined</th>
<th>Public statement of blame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egypt</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Germany</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Greece</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Italy</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nigeria</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pakistan</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poland</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Africa</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* In the cases of Spain, South Africa and India no evidence could be found on whether other types of sanctions than those marked in the table are used in fitness to practise cases. For those countries reliable evidence could only be found for the use of the sanctions indicated with a ✔ above.

† Data are reproduced from De Vries and colleagues’ study.161
Use of sanctions and warnings by different healthcare regulators

In the UK there are nine statutory regulators covering healthcare professionals. Each operates a broadly similar model, but the outcomes of their fitness to practise processes vary. In particular, the proportion of complaints that result in a sanction or a warning, and the use of conditions and undertakings, varies (figure 56 below). 162

The warnings, undertakings and conditions are similar to those used by the GMC. For example, the Nursing and Midwifery Council can impose a cautions order for one to five years, which is broadly similar to the warnings issued by the GMC, and an order placing conditions on a nurse’s or midwife’s practice for up to three years. 163 The General Dental Council can give a warning to a dentist without a public hearing, or dentists can have restrictions placed on their practice at a hearing. 164 If pharmacists in Great Britain are found to be impaired at a hearing, they can be given a warning or have restrictions put on their practice for up to three years, or they can agree to undertakings before a hearing. 165

Outside the healthcare profession, in England and Wales the Bar Standards Board can consider taking action if barristers breach its guidance. 166 After fitness to practise hearings, social workers in England can be given cautions and have restrictions placed on their practice. 167

**Figure 56: Sanctions and warnings given by UK healthcare regulators in 2014**

<table>
<thead>
<tr>
<th>Healthcare Regulator</th>
<th>Sanctions or warnings per 1,000 investigated complaints</th>
<th>Sanctions which restricted practice (conditions or undertakings) per 1,000 investigated complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medical Council</td>
<td>185</td>
<td>15</td>
</tr>
<tr>
<td>General Medical Council</td>
<td>163</td>
<td>60</td>
</tr>
<tr>
<td>Nursing and Midwifery Council</td>
<td>229</td>
<td>114</td>
</tr>
<tr>
<td>Nursing and Midwifery Council</td>
<td>475</td>
<td>38</td>
</tr>
<tr>
<td>General Pharmaceutical Council</td>
<td>208</td>
<td>42</td>
</tr>
<tr>
<td>General Pharmaceutical Council</td>
<td>112</td>
<td>22</td>
</tr>
<tr>
<td>General Pharmaceutical Council</td>
<td>259</td>
<td>11</td>
</tr>
</tbody>
</table>

* Includes restricting the individual’s registration through undertakings or conditions, or suspending or erasing them from the register.
What issues help or hinder remediation and improving standards?

The GMC commissioned independent researchers to investigate what is needed for successful remediation and to identify obstacles doctors face in obtaining the support they need.

This small study approached doctors who had been given a warning, undertaking or condition between 2006 and 2013, and a range of employers.

152 doctors agreed to take part and were invited to complete a questionnaire; 99 doctors responded, of whom 42 had been given warnings and 57 had had conditions or undertakings imposed on them. 40 doctors and 21 employers took part in in-depth interviews. This is a small sample and doctors may be more likely to take part if they have had an experience that they are particularly motivated to share. The research therefore does not claim to give a representative picture of doctors who have been given a warning, undertaking or condition, but it does provide an insight into how these outcomes impact on the practice of some.

This chapter looks at the results of the research and we have included excerpts from some of the interviews. Broadly the research showed that:

- Sometimes constraints imposed by the GMC sanction can obstruct doctors’ attempts to remediate – there is a need for a discussion about whether some obstructions could be removed or alleviated and how this might be resourced

- Remediation tends to be effective where both the doctor and their employer are willing and able to make it happen – in those cases, the doctor was proactive and had the insight and willingness to change, and their employer gave them adequate support to do so

- Doctors tend to fail to uphold standards or successfully remediate where they feel the process or the outcome (warning, undertaking or condition) is unjust, or where employers don’t want or don’t have the resources to continue to support the doctor.

What did doctors say had changed following a warning or a restriction?

The doctors surveyed by the researchers had a wide range of views about whether their experience had improved their practice (figure 57, page 147).

Many reported risk aversion and excessive caution in their work. While most disagreed that a warning had led to them being more likely to reflect on their practice, most with a condition or undertakings thought that it did make them more likely to reflect on their practice. Strikingly, there were large majorities of doctors disagreeing that their practice was safer (see discussion in box 3, page 148), and that their skill as a practitioner has improved.

It is difficult to understand purely from the responses of this sample whether warnings and restrictions on practice work to make doctors more careful, and to what extent this involves encouraging defensive practice. Perceptions of careful practice (where a patient is better cared for) as opposed to risk-averse or defensive practice (where a doctor’s decisions do not better care for the patient) are often contested (see box 3, page 148).
Figure 57: Level of agreement with a list of statements about how having a warning or a restriction changed a respondent’s approach to practising as a doctor

### WARNINGS

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>My skill as a practitioner has improved as a result of the outcome of my case</td>
<td>1</td>
<td>5</td>
<td>11</td>
<td>20</td>
<td>1</td>
</tr>
<tr>
<td>My practice is safer for patients now, as a result of the GMC outcome</td>
<td>2</td>
<td>2</td>
<td>13</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>I am more likely to seek the advice or opinions of other clinicians as a result of the outcome of my case</td>
<td>3</td>
<td>5</td>
<td>20</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>The outcome of my case has made me less confident in my own practice</td>
<td>7</td>
<td>13</td>
<td>12</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>I am more likely to reflect on my own performance and practice</td>
<td>7</td>
<td>8</td>
<td>15</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>I am sometimes excessively cautious in my practice now</td>
<td>8</td>
<td>10</td>
<td>13</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>I practise in a more risk-averse way now</td>
<td>11</td>
<td>8</td>
<td>12</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

### RESTRICTIONS ON PRACTICE

<table>
<thead>
<tr>
<th>Statements</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>My practice is safer for patients now, as a result of the GMC outcome</td>
<td>3</td>
<td>10</td>
<td>11</td>
<td>18</td>
<td>3</td>
</tr>
<tr>
<td>My skill as a practitioner has improved as a result of the outcome of my case</td>
<td>3</td>
<td>7</td>
<td>17</td>
<td>17</td>
<td>1</td>
</tr>
<tr>
<td>I am more likely to seek the advice or opinions of other clinicians as a result of the outcome of my case</td>
<td>7</td>
<td>15</td>
<td>14</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>The outcome of my case has made me less confident in my own practice</td>
<td>8</td>
<td>11</td>
<td>15</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>I am more likely to reflect on my own performance and practice</td>
<td>9</td>
<td>23</td>
<td>7</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>I am sometimes excessively cautious in my practice now</td>
<td>12</td>
<td>15</td>
<td>11</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>I practise in a more risk-averse way now</td>
<td>13</td>
<td>17</td>
<td>10</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>
Chapter 6: Upholding standards and the remediation of doctors

A senior partner in a GP practice received a warning because she did not arrange for a patient with breast cancer to see a specialist or have a further review appointment, in accordance with the National Institute for Health and Care Excellence (NICE) guidelines.

The doctor has reflected greatly, writing a reflective essay, reviewing all previous referrals and the NICE guidelines, and arranging further training. The doctor believes that the warning has made them a more careful doctor.

‘If I see somebody with any breast problem or something I’m not sure about, I do all I can to be doubly safe and leave less up to the patient. It’s probably safer practice.’

However, another doctor, who was subject to a health case, warned about the risk that undertakings could lead to more defensive practice.

‘I think everybody’s getting more risk averse but I think that with undertakings over your head certainly would make me more cautious.’

**BOX 3: How can we tell when a doctor has become safer?**
Upholding standards and successful remediation may depend on whether doctors feel they were treated fairly

Insight is more likely if doctors feel they have been treated fairly

Doctors and employers both need to engage positively in the fitness to practise process for standards to be upheld and remediation to work. For doctors, insight and personal reflection are key and the research identified examples where this was happening. One Responsible Officer* in secondary care reported that a surgeon, who had received a performance-related warning from the GMC linked to a medico-legal report, had improved his standard of practice because he was willing to reflect and learn.

‘He’d been slow in producing a report and the patient got disadvantaged. It didn’t stop him being a really good surgeon. It was viewed quite severely but he took it in the context of what had happened, talked to us and said “I shouldn’t have treated this person this way”, and he’s better for it. We were happy to keep him on.’

It could be that doctors who feel they have been fairly treated are more likely to show insight, but it could also be that insight into their circumstances may lead to doctors to view the fitness to practise process as being more fair.

Many doctors view the fitness to practise process as unfair and outcomes as disproportionate

Some doctors are better able to reflect on and understand where they can improve their practice and behaviour. But, as you might expect, the research showed that this is less likely where a doctor believes the outcome is wrong, especially if they question its fairness or see it as disproportionate. Many doctors who received a warning, undertaking or condition felt a strong sense of injustice because they felt:

- it should not have been given at all
- it was not a proportionate response to what had happened.

The fitness to practise process aims to give the minimum outcome consistent with patient safety and maintaining the reputation of the profession. However, a doctor’s perception is what can determine whether reflection and remediation are likely.

* Responsible Officers are licensed doctors, and in most cases will be the medical director within a healthcare organisation. They have a key role in revalidation: they are responsible for making a recommendation to the GMC, usually every five years, about whether each doctor in their organisation should be revalidated. Responsible Officers also ensure that systems of clinical governance and appraisal in their organisation are working and are appropriate for revalidation.
The research suggested this may be affected by four elements:

- **Whether the doctor felt the process recognised the facts and information appropriately**
  A feeling of injustice may depend on whether the doctor felt that the fitness to practise process recognised the facts and information appropriately. This may be the result of a reaction to the formal style of deliberation, or – in cases resulting in conditions – the doctor may have disagreed that their conduct amounted to impaired fitness to practise.

- **Whether the doctor felt the bringing of the case was just**
  Some doctors thought the bringing of the case was unjustified, arguing that it had come about as the result of:
  - professional rivalries
  - a one-off incident that had failed to take into account an unblemished track record
  - an unavoidable fade in skills after a period of suspension or sickness.

- **Whether the doctor resented the impact of a warning**
  Many doctors felt a sense of injustice that, irrespective of the nature of the concerns, a warning remained on the online medical register for five years, and they must declare the warning for the rest of their career. One doctor described this as ‘public corporal punishment’ and an employer said it did nothing except to embarrass doctors. A doctor who received a warning in a misconduct case said:

  ‘If you’re warned you’re warned, so why do you have to be continuously warned for five years. Why not just a year? Five years is a massive amount of time.’

- **Whether doctors feel their voices are heard in the fitness to practise process**
  Doctors with a legal representative will be given advice on how to respond to the GMC’s case against them. Nevertheless, whether represented or not, feelings of unfairness may arise in particular cases because a doctor has been persuaded by their legal representative to accept a warning or undertaking that they were not happy with.

  A number of doctors interviewed said they had been advised to accept a warning or undertaking, making them feel that they had not been heard in the process and leaving a lasting psychological impact. Although undertakings must be agreed by a doctor, some of the doctors interviewed clearly felt that their choices had been limited, leaving them with a feeling of injustice. A doctor who agreed undertakings said:

  ‘You agree the undertakings or you don’t agree the undertakings. If you don’t agree the undertakings you go to Manchester, to the panel. So while they call them voluntary, they’re not. The solicitor’s advice was if you go to panel, that they will put undertakings or conditions on. They’ll put conditions on and to get the conditions lifted you have to go back to panel, so it’s a much more difficult procedure so I agreed the undertakings.’
Whether the outcome is felt to be appropriate
Many of the doctors interviewed complained that the immediate and long-term effect of the warning, undertakings or conditions was not proportionate to the concerns. For these doctors, the stigma and shame lasted after the notice their warning or restriction was removed. A doctor who received a warning in a misconduct case said: ‘I will never accept it, it’s like breaking my dignity and honourability.’

If doctors felt that their career had been severely curtailed or ended because their employer or other factors meant they could not demonstrate remediation, they had a strong sense of unfairness. They felt that the ultimate outcome for them was disproportionate.

The research suggested that employers may be more sympathetic and supportive in cases about a doctor’s health, which in turn supported successful remediation. Employers could make supervision arrangements more easily for doctors seeking clinical and psychological help for health-related issues than for those with performance issues. There was some praise for the medical supervisors in the GMC processes, but there were calls for a more pastoral and understanding approach.

At the beginning of 2013, the GMC set up a dedicated confidential emotional support service to assist any doctor involved in a fitness to practise case, provided on the GMC’s behalf by the British Medical Association’s Doctors for Doctors service. It provides emotional support throughout the case, pre-hearing visits to the MPTS so doctors can orientate themselves, and an independent supporter to accompany the doctor to any meeting with the GMC and for up to two days of their hearing. An independent evaluation of a two-year pilot involving 140 doctors* found:

- most doctors felt they got the right amount of support time
- doctors liked to talk to peers outside the case who were able to give feedback
- some doctors would have liked the option for support via Skype or face to face rather than just by telephone.

Separately, in 2014, the GMC commissioned an independent report into doctors who had taken their own lives while being investigated by the GMC. The report made a number of recommendations, including a review of the GMC’s fitness to practise process from the viewpoint of vulnerable doctors. The GMC accepted all of the report’s recommendations and, in addition to the fitness to practise review, planned actions include reviewing the tone of correspondence with doctors under investigation to reduce unnecessary stress, reducing the number of health assessor reports where possible, introducing emotional resilience training for medical students, and increased understanding and mental health training for GMC investigators.

* The 140 doctors who accessed the service were asked to provide anonymous feedback and 10% responded.
Several factors affect how well employers support remediation

Employers’ support, and their willingness and ability to make supervision and other arrangements for doctors to fulfil undertakings and conditions, is necessary for doctors to remediate. This section sets out why some doctors and employers think that doctors with warnings, undertakings or conditions are not given support and supervision.

The research showed that employers’ support varied with:

- the issue that led to the doctor’s warning, undertaking or condition
- the value of the doctor to them, both in terms of their position and attitude and in terms of their specialist clinical skills
- the potential reputational risk involved
- the practicalities of supporting the working restrictions, including the resources needed.

Figure 58 (page 153) shows the range of responses from employers for warnings, undertakings and conditions, taken directly from the research. One employer said undertakings and conditions are perceived as ‘much more serious by everybody, much more of a damn nuisance’.
Figure S8: Doctors’ views of the range of employers’ responses to a warning or to an undertaking or condition

WARNING

So it’s become a joke in the practice. One of the supervisors and her red flag, but isn’t that I have that? I could see if you were not so established, you perhaps didn’t have such good home support, you didn’t work with such a good crowd of funny colleagues who take the mickey. You could find it a very lonely experience.

They said to me don’t worry about the warning allegation. We still want you at the moment, you’re number one selected in the recruitment, and ignore that thing and we still want you to come back.

The guy is in charge of the training rotation, they were very supportive of the whole thing.

The Trust had already had a lot of scandals with the previous chief executive, so they were very keen to wash their hands of anything that whispered scandal. So I was pretty much thrown to the dogs.

So the employers, ranging from my supervisor through the human resources department, literally left me hanging out to dry.

To be 100% honest, my department treated me as a criminal.

I think the perception was that I was ill, as opposed to bad. Mad rather than bad, and, you know, we needed a different approach, and was very supportive straightaway.

UNDERTAKING OR CONDITION

They wrote to the GMC a few times whilst I worked there, highlighting little incidences of things that had happened, that were really just trivial things in training which they wouldn’t have done had I not been with the GMC.

Just to give you a perspective, I haven’t had a formal meeting since March 2014 with any official in my Health Board. Everything is said on the phone or by very offensive emails.

Well, I just became unemployed because they wouldn’t employ me because of the undertaking.

I think the perception was that I was ill, as opposed to bad. Mad rather than bad, and, you know, we needed a different approach, and was very supportive straightaway.

To be 100% honest, my department treated me as a criminal.

Fully supportive Nervously supportive Unsupportive Obstructive Terminating the relationship

Supportive Laughing it off Ignoring it Unsupportive Terminating the relationship

I haven’t had a formal meeting since March 2014 with any official in my Health Board. Everything is said on the phone or by very offensive emails.

Well, I just became unemployed because they wouldn’t employ me because of the undertaking.
The issue that led to the warning, undertaking or condition

Where employers felt the issue was minor, did not relate to clinical performance, or was something the doctor could easily have fallen foul of, the employer’s reaction tended to be more sympathetic and supportive.

Doctors in the study reported that employers were less sympathetic and supportive in cases involving poor behaviour, such as touching colleagues inappropriately, or in cases related to clinical skills where a patient died or had a late diagnosis. In some of these cases, doctors believed they were engineered out of their jobs, making it impossible for them to remediate.

The value of the doctor to the employer

Generally doctors were more likely to be treated supportively where they:

- had better, longstanding relationships with colleagues
- had a more established reputation in senior positions
- were totally open about their undertakings or conditions and how they came about (these doctors were more likely to report a positive reaction from both current and future employers)
- were more willing to reflect on their problems and to seek support from their employer
- had clinical skills that made them hard to replace.
This has implications for locums whose relationships with existing employers are naturally more tenuous and less well established.

Doctors with specialist clinical skills that are hard to replace were more likely to be supported, since employers have a stronger drive to preserve their relationship with the doctor. Specialties with shortages, such as emergency medicine, may be more likely to take on doctors with restrictions than those that are well staffed, although this is not the case in primary care where, despite some staffing concerns, it may be that the logistical problems involved in arranging supervision can make the supporting of undertakings or conditions inviable. Warnings had a less noticeable impact on these doctors’ career than on those whose skills and experience are more common.

Doctors in training may not yet have acquired specialised skills that are hard to replace, so there may be a disproportionate impact on younger doctors. As such they may experience a greater impact than specialists or GPs. However, the research also showed that junior doctors were easier to arrange supervision for, and that support for remediation may be easier for them.

**The potential reputational risk**

Employers who thought there was a high reputational risk to their organisation, perhaps because of a high level of media or other interest, appeared less likely to support the doctor.

One Responsible Officer explained ‘*I think the reason people overreact is [when] it’s reputational; they’re worried about the reputation of the organisation understandably, and that’s quite right.*’

In some cases the doctor may be managed out, particularly in large secondary care organisations. Box 5 (page 156) sets out the concerns raised by doctors who believed their employers abused the fitness to practise process.
Around a quarter of doctors interviewed believed that the employer had used the fitness to practise process against them for inappropriate reasons. Several believed they had been reported to the GMC by malicious colleagues or employers who were manipulating the process for their own agendas. These included:

- avoiding costly contractual implications from ousting a GP partner from a practice
- seeking revenge on doctors for raising concerns
- ongoing bullying or victimisation in the workplace.

These doctors felt that, regardless of the outcome of the case, a doctor’s reputation is sufficiently damaged by the process to have a negative impact on their career and ability to practise. The doctors also felt that the person making false allegations had nothing to lose.

In fact the GMC does already consider the context in which a complaint is made as part of considering all aspects of the individual circumstances of a case when deciding whether there are serious concerns that require action.

However, this assessment takes place as part of a full investigation which will almost always have an impact on the doctor involved, irrespective of the outcome of the case.

In 2014, the GMC commissioned Sir Anthony Hooper to undertake an independent review of how it deals with complaints about doctors who are whistleblowers. The review recommended that organisations referring concerns to the GMC should declare whether the doctor has raised concerns about patient safety. Sir Anthony suggested that those who raise concerns may suffer, or believe that they suffer, reprisals from their employer or from colleagues. He said:

‘The key to minimising the risk that the GMC unwittingly becomes the instrument of the employer in a campaign against a doctor is an understanding of the background to the allegation.’

The GMC has committed to change aspects of its fitness to practise process in light of the review, in particular to highlight whether a doctor has raised concerns about patient safety at an early stage.
The resources needed to allow doctors to practise with undertakings or conditions

Employers are confused about what arrangements they are responsible for making and paying for

The research suggested that doctors and employers understood that the doctor is responsible for remediating, but were not clear how far employers should go in organising and paying for arrangements to support this. *

Some employers admitted to being confused over where the duty of care lies for individual doctors working with undertakings or conditions. One Responsible Officer in secondary care saw taking on responsibility for a doctor with restrictions as part of their responsibilities within the NHS. Whereas others were frank that they would assess whether the doctor would be worth the effort and resources needed to support them to fulfil undertakings or conditions.

Arrangements can be expensive and practically difficult to make

Educational and clinical supervision arrangements, as well as practical arrangements to support practice, such as providing chaperones or monitoring prescribing, can be expensive and difficult for employers to put in place.

It can also be difficult for employers to find suitable supervisors; the individuals who are the best qualified to do it may not want to or may be too busy to take part. This is challenging as the affected doctors need this supervision to make sure they are safe to practise. An employer said:

‘Unfortunately, it’s always busy people who attract […] jobs that they don’t need, but you’ve got to do it right.’

* Undertakings and conditions involve one of three types of supervision: medical supervision for doctors with health-related restrictions (appointed by the GMC); educational supervision for doctors who need training as part of their conditions; and clinical supervision for doctors with performance-related conditions.
People can be unwilling to act as supervisors because of concerns about responsibility, risk, time commitment and lack of remuneration. They may also lack experience or understanding of the supervision process. Two different employers said:

‘When you allocate somebody to be the clinical supervisor, they’ve probably never done it before. It’s quite difficult for them to know what they should be doing and how they should be doing it... some clearer guidance on what’s expected of people would be quite helpful.’

‘The main problem is, you find that doctors will say “oh yes, I’ll take that on” and when they find out what’s required they basically say “oh no, I can’t do that”’.

Certain roles are more difficult to supervise – for example, consultants would not usually be accompanied by another senior doctor, making it harder to maintain confidentiality. GPs reported difficulties in meeting requirements: one had to move location to find a position in a training practice, and another had to move into a secondary care setting to have their work supervised.

Some of the doctors in the study said that locum agencies also found it particularly difficult to accommodate doctors with undertakings or conditions, given the nature of locum work and the high number of posts many locums undertake. Locum doctors said they needed to get reports on their performance in all posts, which would be time consuming for the agency to organise, supervisors to write and the GMC to review. A doctor who agreed to undertakings in a health case said:

‘My case examiner was being constantly inundated with reports. She said she would get about 20 different workplace reports a month about me.’
Chapter 6: Upholding standards and the remediation of doctors

Warnings and restrictions on practice felt to curtail a doctor’s career

Almost a quarter of doctors with undertakings or conditions who were interviewed as part of the research were no longer practising. A number of doctors interviewed felt that the responses of their employers to the conditions or undertakings had contributed to their failure to demonstrate remediation and improvement.

One doctor said they did not want the humiliation of looking for a job with restrictions on their practice, and others had not been able to secure appropriate posts or even interviews. Many saw getting a new job as very challenging.

Some doctors believed that employers did not want to have to fulfil the supervisory requirements of undertakings or conditions, and they did not want to be tainted by taking on a doctor who had been investigated and given a sanction or a warning by the GMC. A doctor who agreed to undertakings in a case with multiple allegation types said:

‘I lost my post as a consultant and I’m finding it difficult to get a new one. My impression is that as long as there’s anybody else interested they’ll take that one rather than a woman who’s got this history with the GMC.’

And a doctor who agreed to undertakings in a health case said:

‘I have absolutely no hope of finding another job with the undertakings current because you tell them at the point of application. I think they’d find an excuse not to interview me. It would be a lot harder at post-interview. Again, that’s going to follow me no matter where I go.’

Some of the doctors believed that where an employer has a choice between two equally qualified doctors, one with a warning and one without, the employer will always choose the one without, having little or no understanding or recognition that a warning does not mean the doctor’s fitness to practise is impaired. Others felt confident that they would work again, but no longer had all the career choices that were once open to them. Both views were shared by employers.

Most doctors with undertakings or conditions who had secured a job said they’d had to pursue a number of avenues. Success appeared to be dependent on the individual’s tenacity and contacts who were willing to give them a chance.

Some doctors felt that they should not be obliged to share details of a warning when filling out a job application. They said they would still be transparent at interview, but they felt that being able to explain the nature of the warning and the reasons why it occurred might make it less likely that they’d be dismissed as a potential candidate.
How to work with others to make sure warnings, undertakings and conditions are successful

The aim of the system of sanctions and warnings must be to help doctors maintain high standards and to remediate where possible. The research has indicated that there are barriers which make effective remediation difficult which include:

- the doctor’s perceptions of the fitness to practise process and the outcome
- the way that employers respond to warnings, undertakings and conditions
- the confusion about who is responsible for making and paying for arrangements to allow doctors to work with undertakings and conditions.

A number of suggestions were made during the research on ways to overcome or reduce the impact of these barriers.

Tailoring the restriction to the doctor’s situation and care setting

Both employers and doctors called for an improved system that takes better account of each doctor’s individual case, their needs, and the circumstances in which they will have to work with the undertakings or conditions in place. A doctor who received conditions in a case with multiple allegation types said:

'It’s difficult when conditions are imposed on people and they are unfeasibly restrictive and it basically puts doctors in a situation where the conditions render them unemployable, so they can never demonstrate to a review panel that they’ve progressed. Then basically it’s an erasure in everything but name. As long as they are workable conditions and they are tailored to the doctor’s situation to make them feasibly imposed, I think they’re a good thing.'
Several employers suggested that they would like more opportunities to discuss the undertakings or conditions with the GMC before they are put in place. This would allow them to set out the realities of the working environment and any existing requirements in place as a result of local action, so that the restrictions can be tailored appropriately. However, it is important that whatever suspension is put in place ensures that the public is protected.

**Tailoring warnings to the nature of the concern**

Doctors and employers were concerned about what they saw as a one-size-fits-all approach to warnings. They suggested that the wording of the warning and the length of time it stays on a doctor’s record should differ depending on the severity of the issue, whether the issue is clinical or non-clinical, and whether the doctor has accepted the issue and improved standards or has refuted or denied it.

One employer suggested a suspended system, in which appraisals would be used to monitor progress and the doctor could be referred back to the GMC if they have not made changes. Another suggested that the warning could be removed from the online medical register early if the doctor has improved effectively.

Creating a more sophisticated range of warnings could improve the perceived fairness of the fitness to practise process, and prevent some of the disproportionate consequences reported by doctors. In 2014, the GMC consulted on proposed changes to guidance about imposing and agreeing sanctions and on the approach to take when doctors have apologised or shown insight into what happened.
Most respondents thought that the GMC should take more serious action where a doctor repeats conduct that led to a warning, and that publishing warnings for five years, as well as the approach to disclosing warnings to employers, was often disproportional and should be considered on a case-by-case basis. Following the consultation on indicative sanctions last year and this latest research, the GMC has recognised the need to reform the warnings regime and are developing a new model of warnings, including changes to the length of time a warning is published for. Another concern was the use of the word ‘warning’ itself, which might carry more negative connotations than are intended. However, to change this term would require a change in the Medical Act, as the term ‘warning’ is enshrined in the Act.

Taking a different approach to health cases as opposed to other types of cases

In the study, some doctors felt it was unfair and insensitive to handle health cases under the same fitness to practise process used for doctors with performance or misconduct issues. They felt that the GMC should take an entirely different and separate approach in health cases. A doctor who agreed to undertakings in a health case said:

‘I would have found it far more devastating to have felt that this was about conduct or integrity or medical capability, diagnostic capability, those kind of things. The one thing that kept me going was that actually it was about health and I’m going to get better.’

The GMC did operate an entirely separate system for health cases before 2004 but following significant criticism the current approach was introduced in November 2004. Some steps have already been taken to safeguard doctors with health concerns – for example, by making arrangements to protect the confidentiality of a doctor’s information about their health. Undertakings and conditions are published on the online medical register and disclosed to employers on request, but any information related solely to a doctor’s health is not published or shared unless requested by the doctors concerned.

This chimes with the finding from the consultation on sanctions guidance, where some respondents felt that the current GMC approach to disclosing warnings to employers was often disproportional and should be considered on a case-by-case basis.

However, one doctor felt that the GMC should have been more transparent about their health case, since confidentiality about these issues can sometimes lead employers to assume the worst and avoid employing the doctor. Similarly employers can be frustrated by the emphasis on confidentiality about doctors’ health. Two different employers said:

‘The GMC keeps it utterly and absolutely top secret from everybody, keeps us out of the loop. They just discuss it with the doctor and redact everything. So we usually learn more from the doctor who tells us things like “the GMC said I can’t go back to work until I’m not taking this medication”. We’re worrying what’s happening but we can’t be told. Issues around health and lack of communication is a problem.’

‘This is a really tricky area that causes us deep frustration…and it’s a nightmare for the doctors.’
Improving dialogue with the doctor during our fitness to practise process

Doctors said they would like to see a softening of the GMC’s language and communications, making it less legalistic in tone, and to have more opportunities for discussion during a fitness to practise investigation. The GMC has begun to introduce a range of changes to address this and other concerns. The major pilot project to hold meetings with doctors towards the end of an investigation has proved successful and the next stage involves exploring whether there is scope to talk to doctors at the start of an investigation.

Preventing employers misinterpreting warnings and restrictions

Many of the unintended consequences of warnings and restrictions appear to be caused by employers and the rest of the medical profession having an incomplete understanding of what warnings and restrictions are intended to mean.

Doctors felt strongly that employers do not differentiate sufficiently between warnings, which are given in cases where the doctor’s fitness to practise is not impaired, and undertakings and conditions, which indicate that the doctor’s fitness to practise is impaired. They felt that the GMC could do more to educate employers about this.

Employers acknowledged that doctors, HR departments and other colleagues are confused, particularly about undertakings. Some suggested that the consequences of warnings, undertakings and conditions could be reframed by changing the language to terms that are less judgemental and punitive. Two different employers said:

‘I do think one of the biggest problems we often face is doctors understanding the GMC process, GMC conditions, GMC undertakings, what they actually mean, what the words actually mean.’

‘There’s something about the language of it all, what does warning really mean, what’s the consequence of that? And even phrases like undertakings, what does that mean?’

Several employers suggested that the GMC should give them more guidance on how to deal with doctors with undertakings and conditions, particularly those who do not deal with many cases, and called for more, and clearer, guidance for doctors.
Clarifying who is responsible for, and who pays for, the costs of remediation

Employers called for guidance on their responsibilities to doctors with warnings, undertakings and conditions, and who should pay for the costs of remediation. The difficult issue of resources would benefit from further discussion with government, commissioners, medical royal colleges, and education providers.

Employers also suggested that the GMC should take a strong interest in whether they are providing the necessary support to doctors, and challenge trusts to demonstrate how they are dealing with cases appropriately. One doctor suggested that the GMC should write to the employer and the doctor every month to check the doctor is adhering to the undertakings or conditions. The GMC could then become involved if an employer is in some way blocking implementation.

Employers also suggested that the GMC could provide further practical support for those less experienced in dealing with sanctions. One employer suggested that the GMC might facilitate meetings between the doctor and their colleagues or manager, with a specialist team to help remediation and reintegration:

‘Having that third party, who hasn’t got a local bias on what’s been going on, can be useful to bring some balance to the discussion…having a team that can facilitate that reconciliation is useful.’