

<b>Agenda item:</b>	<b>12</b>
<b>Report title:</b>	<b>Meetings between doctors and patients</b>
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<b>Action:</b>	<b>To note</b>

## Executive summary

The Senior Management Team (SMT) approved proposals for a model for piloting meetings between doctors and patients at a meeting on 7 August 2017. Meetings will be offered in cases where a patient has suffered serious clinical harm and has not already met the doctor or been provided with an explanation at a local level. Doctor-patient meetings are intended to bring to life our guidance on the professional duty of candour and give patients an increased voice in the complaint framework. We will proceed with a meeting only if an individual assessment of the case indicates it would be beneficial.

Meetings will run in parallel, but separate to our fitness to practise procedures. They do not replace our role in taking action to protect patients and maintain confidence in the medical profession.

The pilot phase will allow us to test and evaluate different options before deciding if doctor-patient meetings should be implemented. The option we are proposing is a mixed location model which will test the benefits of both internal and external facilitation. It will also enable us to assess the impact a meeting's location has on take up rates and the overall success of the process.

## Recommendations:

The Executive Board is asked to:

- a** Note the proposed pilot model for meetings between doctors and patients detailed at paragraph 4 which has been approved by the SMT.
- b** Agree that we pilot the option detailed at paragraphs 13 to 16.
- c** Agree that the pilot is internally evaluated [paragraph 17].

## Background

- 1** Facilitated meetings between doctors and patients first arose in our consultation on the Sanctions guidance in late 2014 and was linked to a separate proposal [not subsequently taken forward] to require doctors to apologise as part of our fitness to practise procedures. The idea of doctor-patient meetings also arose from our work on the duty of candour.
- 2** Our belief that doctors have a duty to be open and honest in offering an explanation and/or apology when things go wrong formed the basis of our joint guidance with the NMC on the professional duty of candour published in June 2015. We aim to embed the principles contained in the duty of candour guidance and Good Medical Practice into how doctors handle complaints, encouraging a behavioural change towards a culture of openness with patients. This will improve public confidence and fits in with the third strategic priority to '*Improve the level of engagement and efficiency in the handling of complaints and concerns about patient safety*'.

## Aims

- 3** By introducing facilitation of meetings between doctors and patients, we want to achieve the following:
  - An opportunity for complainants with unresolved questions about what happened to them/their relative to get answers.
  - An increased voice in our investigatory framework for patients by providing an opportunity for them to speak to the doctor involved.
  - Embody the professional duty of candour for doctors.

## Meeting model

- 4** We have developed a pilot meeting model using the following criteria to identify eligible cases:
  - The complaint relates to serious clinical harm suffered by a patient and the doctor(s) named in their complaint played a key role in the events which led to the harm (this does not mean they were liable for what happened).
  - The patient/relative has not already met the doctor at a local level or received a detailed explanation. This could have been in writing or through a meeting.
  - We can provide the doctor with enough information to adequately prepare for the meeting. As a minimum, this is likely to include the patient's medical records and the key documentation from any local investigation such as witness statements.
  - We have obtained any relevant local intelligence from the organisation where the incident of harm took place and have not identified issues that make the case unsuitable for a meeting.

- There is no history of abusive behaviour by the patient or doctor.
- The doctor's health was not a key contributing factor to the harm suffered by the patient and there are no known concerns about the doctor's health.
- The doctor is not in Foundation Year 1 (FY1) or Foundation Year 2 (FY2).
- Both parties have agreed to participate and are available to attend a meeting.
- Where a complaint relates to more than one doctor, we will assess feasibility on a case by case basis. The general principle is that we will seek to facilitate a meeting with the most senior doctor involved in the incident that led to harm (this does not mean the doctor was liable for what happened).

### **Impact on current fitness to practise case**

**5** We are considering the impact of such a meeting on a doctor's fitness to practise case. Our initial view is that:

- The only outcome of the meeting will be a note confirming the meeting took place. Meeting content will not be transcribed.
- It is not intended that meetings will result in additional allegations of fitness to practise. However, like meetings we currently hold with doctors at the end of an investigation, we are not able to have without prejudice discussions. The circumstances in which a meeting could result in additional fitness to practise allegations would be confined to self-incrimination in relation to a serious matter or serious misconduct at the meeting or serious misconduct such as violent or abusive behaviour. As with the meetings we currently hold with doctors in the process, we would undertake preparation with a doctor beforehand so that they understand the risks of self-incrimination.
- The only reference to the meeting in subsequent proceedings would be, where a doctor has refused (without good reason) to meet the patient, if they choose to make submissions relating to insight and reflection, their refusal to meet the patient may be referenced in response.

### **Timing of meeting**

**6** The meeting would be held as early as possible in the fitness to practise process, in the individual circumstances of the case. This reflects our guidance that doctors should provide an explanation/apology as soon as possible. It is also in line with feedback from the RJC and the research undertaken into restorative justice by the Research Team (Annex D).

### **Differences with restorative justice meetings**

**7** We have liaised closely with the Restorative Justice Council in light of their experience of third party facilitation of meetings between persons, where one person

has been involved in harm and the other is a victim of harm. They have provided useful insights into issues such as facilitation, location and preparation of such meetings. However, the proposed meetings between doctors and patients are not restorative justice and also have significant differences to that model.

- 8 To proceed with a meeting, we only need to have established that the patient was harmed and that the doctor played a key role in that event. The doctor does not need to have admitted causing the harm and by agreeing to meet they will not be accepting any personal fault. Our expectation is that the doctor will follow our [guidance](#) on apologising and provide the patient with an explanation of what happened, explore what can be done to address any harm caused and explain what they will do to prevent someone else being harmed.
- 9 As such meetings usually take place locally, facilitated by a healthcare provider, we have also sought to learn from that experience.

**Variations of meeting model**

- 10 There are four potential variations of the meeting model and the key advantages and disadvantages of each one are summarised below. Detailed costs for each option are at Annex A.

Meetings at GMC offices	Key advantages	Key disadvantages
1. Meetings facilitated by GMC staff held in all GMC offices	<ul style="list-style-type: none"> <li>√ Will be more cost effective than commissioning an external provider to facilitate them throughout the United Kingdom. Per meeting cost is £534.00.</li> <li>√ GMC retains full control over the meeting process and can adapt it as required</li> <li>√ Model aligns with the existing framework offered by the Patient Liaison Service</li> <li>√ Logistically more straightforward and cost effective if venue hire is not needed</li> </ul>	<ul style="list-style-type: none"> <li>× Potential for either party to be uncomfortable with GMC facilitation</li> <li>× Potential blurring of our regulatory role</li> <li>× Inconvenient for patient and doctor to travel to GMC office leading to low uptake. External feedback has been negative about this option</li> <li>× May need to give doctors 6 weeks' notice to enable them to re-arrange their clinical commitments for whole day absence at GMC offices</li> </ul>

<p>2. Externally facilitated meetings held in all GMC offices</p>	<p>√ Meetings will benefit from the facilitator’s specialist experience of facilitation.</p> <p>√ Meetings may be perceived as fairer if they are facilitated by an independent person leading to higher uptake</p> <p>√ Logistically more straightforward and more cost effective if venue hire is not needed</p>	<p>× Costly. Using an independent facilitator is more expensive than using GMC staff. Cost per meeting is approximately £1117 (average of 4 quotations received)</p> <p>× The GMC would have less direct control over the quality of facilitation and meeting process</p> <p>× Inconvenient for patient and doctor to travel to GMC office leading to low uptake.</p>
<p>Local meetings</p>	<p>Key advantages</p>	<p>Key disadvantages</p>
<p>3. Meetings facilitated by GMC staff held locally to where the patient and doctor are based</p>	<p>√ GMC retains a significant amount of control over the meeting process and can adapt it as required</p> <p>√ A more cost effective option than commissioning an external provider to run them throughout the United Kingdom. Per meeting cost is £734.00 (excluding travel expenses) based on the assumption they are facilitated by case examiners.</p> <p>√ Likely higher uptake as more convenient for patient and doctor to attend local meeting. Meetings may also happen more quickly.</p> <p>√ Local meetings were the preference of stakeholders including doctor’s representatives, patient groups, NHS Trusts and the RJC</p>	<p>× May not be practical for key staff such as case examiners to travel around the country. A relatively large number of case examiners may need to be trained to facilitate meetings to avoid diverting resource away from their core decision making role.</p> <p>× More expensive than holding them in GMC offices (at least £200 per meeting more not including travel expenses)</p> <p>× May be difficult to identify suitable local venues and more risk in holding meetings at untested external venues</p>
<p>4. Externally facilitated</p>	<p>√ Meetings will benefit from the facilitator’s specialist experience</p>	<p>× Costly. Using a third party to facilitate meetings at external</p>

meetings held locally to where the patient and doctor are based	<p>of facilitation</p> <p>✓ Meetings may be perceived as fairer if they are facilitated by an independent person leading to higher uptake</p> <p>✓ The chances of a successful outcome may increase if the facilitation process is independent [to be tested in pilot]</p> <p>✓ Likely higher uptake as more convenient for patient and doctor to attend local meeting. Meetings may also happen more quickly.</p> <p>✓ Local meetings were the preference of external stakeholders</p>	<p>venues is the most expensive option. The approximate cost is £1237 per meeting (average of 4 quotations)</p> <p>× May be difficult to identify suitable local venues and more risk in holding meetings at untested external venues</p> <p>× The GMC would have less direct control over the quality of facilitation and the meeting process</p>
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## Potential number of meetings

**11** Our initial sampling of 20% of complaints from members of the public about substandard clinical care between June 2016 and June 2017, concluded that 94 cases would be eligible for a doctor-patient meeting over a 12 month period. However, to more accurately estimate the likely number of meetings, we also asked the Patient Liaison Team (PLT) to assess each new case referred to them against the eligibility criteria at paragraph 4. Their assessments over a five week period showed that only 2 out of 9 (22%) provisional enquiries were eligible for a meeting and only 6 out of 23 stream one cases (26%) met the criteria. Our initial analysis suggests, on average, only 8 cases per month will be eligible for a meeting. Acceptance rates for patient meetings are currently 70% and 60% for end stage doctor meetings. As the purpose of doctor-patient meetings is significantly different, it is difficult to estimate acceptance rates with certainty. The PLT are continuing to assess potential cases and further data will be needed to reach a firm conclusion on the number of meetings a year.

## Proposal for pilot

**12** It is important to test the variations of the meeting models through a pilot so the most suitable one is identified for potential roll out. Previous experience with pilots for separate GMC meetings with doctors and patients showed that around 25-30 cases need to be piloted to yield a meaningful and reliable analysis of whether the model is successful. The pilot will run from June 2018 and its length will depend on the number of cases which are eligible for a meeting and whether both parties agree

to participate.

- 13** We recommend that a single preferred location model is adopted for the pilot that will primarily test the strengths and weaknesses of external and internal facilitation.
- 14** The feedback from external stakeholders has been in favour of meetings being held locally to where the patient, and possibly the doctor, is based but there are significant practical and cost benefits to holding meetings at GMC offices. Under this proposal, all pilot meetings would be held locally except if the complainant lives within 30 miles of one of the five GMC offices. Analysis of provisional enquiries and stream one cases from June 2016 to June 2017 shows that 41% of complainants and 36% of doctors lived within 30 miles of a GMC office. A mixed location pilot will therefore have the benefit of also testing the advantages and disadvantages of holding meetings at GMC offices and at a local level.
- 15** We propose that 60 cases should be piloted using the mixed location model above with half facilitated by specially trained GMC staff and half facilitated by independent external facilitators. Meetings would be allocated on a rota basis to an internal or external facilitator to ensure an even split. We anticipate that around 24 meetings (40%) would take place in GMC offices and 36 meetings (60%) locally to where the patient lives.
- 16** This option will allow us to fully explore the key issues including internal and external facilitation and the location of meetings.

### **Pilot evaluation**

- 17** The pilot will be evaluated by GMC business transformation staff.

### **Other costs of pilot**

- 18** Additional costs will include required training for GMC staff in facilitation skills. Potential costs for this are included in annex A. If the contract for providing training and facilitating meetings for the pilot exceeds £30,000 then a tendering process will be required.
- 19** It is intended that support for patients and doctors participating in meetings will be provided through our existing arrangements for Witness Support and the Doctor Support Service. This is likely to be covered by our existing contracts with Victim Support and the BMA. However, there may be an additional cost if the number of meetings and requests for assistance is higher than expected and this will need to be kept under review.
- 20** The estimated total cost of the pilot including travel expenses for facilitators and training costs is £63,130.

## Equality and diversity

- 21** We have given careful consideration to the aims of the equality duty in developing our proposals.
- 22** The offer of a meeting will be triggered by a fitness to practise case and some groups of doctors are over-represented in those procedures. As we will only offer meetings where certain criteria are met, the numbers are likely to be quite low so that identifying trends for individual groups is challenging. However, as a general principle, groups over-represented in fitness to practise may also be over-represented in the cohort who may be offered a meeting.
- 23** As such meetings relate to the delivery of the Duty of Candour which is a requirement of our guidance and should already have taken place prior to our receiving a fitness to practise case, we do not consider that facilitation of such meetings will disadvantage groups unfairly. Disadvantage would only arise from self-incrimination, serious misconduct during a meeting, or an unreasonable failure to comply with the Duty of Candour with a subsequent submission of insight. In those circumstances any disadvantage would be outweighed by the public interest. The same risks apply to the current model for meetings between case examiners and doctors at the end of the investigation stage and to date have been effectively managed. We will ensure that doctors in the pilot are prepared for the meetings and fully understand these risks.
- 24** Doctors will be able to opt out of the meetings and we accept that there are circumstances where there are good reasons why a meeting may not be appropriate or desirable. Details of the additional measures we are taking to mitigate the risks of equality and diversity issues are included in Annex C.

## Engagement

- 25** We are working closely with the RJC who provided advice on the meeting model and provisional costs for external facilitation and training. We met with ROs and staff at NHS Trusts who offer patient-doctor meetings to obtain key local learning to shape the meeting model. We also liaised closely with teams across Fitness to Practise.
- 26** Briefing meetings have been held with the BMA, the Medical Defence Union, the Medical Protection Society and the Medical and Dental Defence Union of Scotland and their initial feedback obtained. There was general agreement that doctors should meet patients if harm has occurred and that these meetings should have already taken place prior to our being notified of concerns. Reassurances were sought that doctors will be provided with sufficient information to adequately prepare for the meeting.
- 27** A telephone meeting was recently held with AVMA and the RLS have obtained feedback from patient organisations including Healthwatch at a local level. A summary of the feedback is at Annex B. While most respondents thought meetings will be beneficial, it was felt that there are several key issues that need to be resolved. These include adequate support for patients throughout the process

(including before and after the meeting), the importance of being clear about the purpose of meetings and their benefits from the outset and how the meetings will be facilitated. Some concerns were raised about meetings potentially being intimidating for patients, lack of engagement by doctors and whether they could affect a patient's future care.

**28** We will continue to engage with these key stakeholders as the project develops.

### **Next steps**

**29** The following additional actions were agreed by the SMT at their discussion on 7 August 2017 and will be incorporated into the project plan:

- a** If we decide to close a provisional enquiry (PE) where a meeting has not yet happened, we should reference our expectation that the meeting will go ahead in the decision sent to the doctor and patient.
- b** We will talk to Responsible Officers (ROs) about the pilot and this will hopefully encourage a greater focus on meetings happening earlier before cases get to us.
- c** We will use the pilot as an opportunity to gather best practice in this area that we can share with ROs in order to support the upstream 'local first' model.
- d** We will share our plans with the NMC in advance of the pilot, given we produced shared Duty of Candour guidance.

## **12 – Meetings between doctors and patients**

## **12 – Annex A**

### **Estimated costs for facilitated meetings**

**\*\*PLEASE NOTE THAT THE FOLLOWING COSTS ARE A REFLECTION OF THE RJC FEEDBACK: COSTS BASED ON 10 HOURS PER MEETING REQUIRED\*\***

Annex A - part one - Meetings between doctors and patients

		ESTIMATED COST PER MWDP						Total cost to pilot 30
		Facilitation of meeting		Expenses Travel Expenses for patient only	Internal Resource PLO Coordinator	Room hire Use of external meeting room	Total Cost Per Meeting	
		External Facilitator Cost Estimate	CE Facilitation					
Option 1: Internally facilitated meetings held in GMC offices	Internal Facilitation (CEs)	N/A	£400	£80	£54	N/A	£534.00	£16,020
Option 2: Externally facilitated meetings held in GMC offices	RJCs recommendation of 1st independent practitioner	£800	N/A	£80	£54	N/A	£934.00	£28,020
	W P [familiar with GMC processes as previously trained staff for doctor and patient meeting pilots]	£880	N/A	£80	£54	N/A	£1,014.00	£30,420
	RJCs recommendation of 2nd independent practitioner	£1,000	N/A	£80	£54	N/A	£1,134.00	£34,020
	Restorative Solutions (nationwide organisation)	£1,250	N/A	£80	£54	N/A	£1,384.00	£41,520
Option 3: Externally facilitated meetings held locally to where the patient and doctor are based  *Please note this does not include travel expenses incurred by internal or external facilitators to travel nationwide	Use of internal Facilitation (CEs)	N/A	£480	£0	£54	£200	£734.00	£22,020
	W P [familiar with GMC processes as previously trained staff for doctor and patient meeting pilots]	£880	N/A	£0	£54	£200	£1,134.00	£34,020
	RJCs recommendation of 1st independent practitioner	£800	N/A	£0	£54	£200	£1,054.00	£31,620
	RJCs recommendation of 2nd independent practitioner	£1,000	N/A	£0	£54	£200	£1,254.00	£37,620
	Restorative Solutions (nationwide organisation)	£1,250	N/A	£0	£54	£200	£1,504.00	£45,120

Key	
	Cheapest option
	Expensive option - RJC options

## Annex A – Part two: Meetings between doctors and patients - Estimates received for training costs

External provider	Basic three day training package in facilitation skills for 12 members of staff	Bespoke training package specially designed for meetings between doctors and patients
Workplace Communication Ltd [familiar with GMC processes as previously trained staff for doctor and patient meeting pilots]	£2700.00 [£225.00 per delegate]	£3350.00 including £650.00 to design training content
Generic facilitation skills course - Quotation one obtained on our behalf by the Restorative Justice Council (RJC)	£3960.00 [£330.00 per delegate]	
Generic facilitation skills course - Quotation two obtained on our behalf by the RJC	£4200.00 [£350.00 per delegate]	
Generic facilitation skills course - Quotation three obtained on our behalf by the RJC	£5400.00 [£450.00 per delegate]	
Bespoke training package - Quotation one obtained on our behalf by the RJC		£1000.00
Bespoke training package - Quotation two obtained on our behalf by the RJC		£2500.00
Bespoke training package - Quotation three obtained on our behalf by the RJC		£4000.00
Bespoke training package - Quotation four obtained on our behalf by the RJC		£3000.00

## 12 – Meetings between doctors and patients

### 12 – Annex B

#### Doctor patient meetings - Feedback from patient organisations

We have shared the following brief with patient representative organisations across the four countries to ask for their initial views on the pilot. We did this through face to face meetings, email and at events.

The GMC wants to pilot facilitated meetings between patients and doctors in cases where a patient has suffered serious clinical harm and a meeting has not already taken place locally. It is not intended that meetings will be held as an alternative way to resolve complaints and they will not have an impact on our investigation process. The purpose of meetings is to give patients an opportunity to explain how they feel about the harm they suffered and obtain answers to their unresolved questions.

We want to gather initial views on the project from patient organisations before the Executive Board at the GMC considers it in July. We shall then seek wider engagement with patients and their representatives as we develop and conduct the pilot.

We asked three questions to prompt for feedback.

- Do you think that doctor patient meetings will be beneficial to patients?
- Do you think there could be any downside to offering these meetings to patients?
- Do you think there is anything we should consider to conduct the pilot?

#### Health and Social Care Alliance – Scotland – Ian Somerville

“The pilot sounds interesting – my first thought is that facilitated meetings should also encourage and support the use of independent advocacy as a broker for supporting people to have their say. We recently ran a pilot during which independent advocates

were used to support people through social security assessment processes, which showed the huge benefits this had for people's ability to speak up and to the end outcome. More than happy to discuss this when we meet."

### **Chief Executive of the Patient and Client Council NI – Alan Walker**

This is something that the PCCNI have done in the past. She said that this is a beneficial process for those who do not want to go down a formal complaints route and that it can stop the complaint moving to the formal procedure. She also said that patients find it cathartic to be able to air their concerns. She identified that doctors, however, can be reluctant to engage in such meetings but that the PCCNI's experience of these meetings demonstrates that it is effective. She provided an example of a lady who had expressed concerns to doctors that there was something wrong with her unborn baby but they did not listen and it turned out that there was something wrong with the baby. One of these meetings then took place and as a result it led to practice being changed for the better.

She outlined that there needs to be capacity building on both sides. She identified that patients need to be well prepared in advance of the meeting in order to understand that they may not get all the answers that they want but also that doctors may not like what they hear. She also said that these meetings would need to be held locally.

NB: The CEO's secretary is also putting this matter before the PCCNI SMT meeting this week in order to seek wider feedback on it.

### **Healthwatch England**

#### **Healthwatch chairs (19) – Louise Robinson**

- We need more information to give more specific feedback
- Not to be a hurdle or add time to process
- Staff attitudes are the issues in most complaints - it is communications so should be a good way to resolve early if done well
- People are confused by routes to complaint frameworks, lack of transparency and availability of advocacy so there may be other bits of the jigsaw to address and ensure the patients are aware of or accessing

- Concerns about how the meetings will be held and support generally around the patient before, after and during – how will it be funded? Their travel?

### **NAPP conference England: 24 June 2017**

- Feedback from 12 Patient Participation Group Chairs
- I wonder what it's trying to achieve?
- Is it a form of arbitration?
- You need a good facilitator for the groups as it could go badly wrong
- Could result in a terrible shouting match – which would be terrible for the doctors.
- It sounds like restorative justice
- No – I'd rather sue the doctor if they have caused me harm. I don't want to meet them.
- This would be better done during a doctor's professional development
- It could affect the doctor quite badly
- Doctors often only focus on the bad things and not any positives, so it could reinforce this
- Could be a good idea
- Depends on the circumstances
- Would be good as some patients want doctors to say sorry and then they won't make a complaint.
- Decreases anxiety – better face to face
- Must be sensitively handled
- I don't agree with this – it could be damaging
- The principle is good
- Where does it overlap with NHS Resolution?
- Some people will welcome it

- Accessibility has to be considered.
- Could you use the voluntary sector organisations that are skilled in mediation – they are struggling with funding and may be able to help
- Absolutely, most doctors who have not trained recently will not find this easy at all.
- Patients might be nervous to meet the doctor – I am a well-informed PPG member and don't find talking to doctors difficult or intimidating, but other patients may do.
- Patients may feel that future care that the doctors give them will be affected.
- Some doctors are too presumptive and think they are right.
- If they caused me harm is it right for me and doctor to speak, I don't think so.
- We need to first change the doctor / patient relationship before we do this

### **Manchester CCGs and LGBT Foundation - Tista Chakravarty-Gannon**

LGBTQ patient reps and CCG colleagues. Whilst all welcomed the principle of the model, there were a number of comments/concerns:

- Both patients and CCG colleagues initially found it difficult to envisage a situation where a patient has not been offered an explanation for serious clinical harm, especially since the duty of candour (both professional and reg 20)
- There was acknowledgement however that there are "system" cover-ups, where explanations provided to patients and family are defensive or seek to obfuscate. In these situations, both groups wondered if the initiative is relevant given the professional, FtP focus rather than system focus. A GP noted that senior doctors, such as MDs who lead the "system" could be involved in this and those harmed would benefit from meeting them. The patient reps agreed.
- Patient reps commented that there is often serious harm that isn't clinical. Speaking of LGBTQ experiences, some examples of pretty egregious discrimination were provided. All (including GPs) agreed that the model could be transformative in these situations where a face to face meeting may demonstrate the impact of behaviours much better than the usual process. This was perhaps where there was strongest feedback. They were emphatic it shouldn't be limited to clinical.

- There was some concern from both groups that the aims would need to be framed very clearly. The patient reps thought that the GMC can be perceived as a doctors' org and of course the GPs worried about the fear of "a GMC summons". Both agreed that an independent venue would be preferable.

## **Healthwatch conference – Darren Mercia**

### **Do you think these will be beneficial to patients?**

- 1** Yes – there is often levels of misunderstanding that can be improved upon or resolved. It is important to try to retain positive doctor patient relationships.
- 2** Patients participation groups being co-led between patients and practice being given strategic information enable issues to be raised.
- 3** Yes - it could help people to understand the nature of the concern. Also being face to face with the person can help to see what matters to them. But only if the patient wants it.
- 4** Yes – opportunity to talk things through and get more information.
- 5** Yes very good idea – could massively reduce the excessive time period that patients can currently wait for a response/outcome. Could also tell you something about the doctors attitude if they refuse.
- 6** Possibly – it depends to some degree on the depths of divergence between the doctor's view and that of the patients.
- 7** Yes unless patient feels intimidated by the power of the GP.
- 8** Yes – giving the patient the opportunity to discuss situation directly with the GP and get straight answers.
- 9** In general, the more direct conversation can be about a complaint/concern the quicker it can be aired and hopefully resolved the better for all parties. Patients are often frightened of complaining when they know they will have an ongoing relationship with the doctor and do not want to get into a highly formalised process. Many want to voice their concern, be listened to, if not to 'happen again' to them or others. It should reduce the stress for them and the doctor, facilitate reflective learning and cost less in the long run.
- 10** I have worked in mediation and think the way forward is sound preparation prior to the actual meeting, what is the problem, what does each party need and want to

resolve the questions and what the scope of the meeting would be. Plus a 'code of conduct' and assessment of the likelihood of successful mediation setting.

- 11** Possibly – they are really 'emotionally' dependent on circumstances – grieving parents may take longer for example to come to terms with an incident.
- 12** What if doctors refuse to participate?

### **Any downsides or considerations?**

- 1** There may be some situations where this is inappropriate i.e. where the relationship has completely broken down or where the nature of the complaint makes this inappropriate. An independent facilitator may be helpful in some circumstances.
- 2** GPs and practices are being willing to listen and undertake change
- 3** Time and availability of GPs/doctors setting the boundaries/context would need careful prep and handling
- 4** Emotions will be high – people focus on wanting an admission of guilt/blame. If not managed effectively then the meeting may escalate/exacerbate an issue/complaint
- 5** Not really, but who would facilitate the meeting? It would need to be someone well trained and stilled to do this – so you would need to gear up for that...
- 6** Patient may be reluctant to have a face-to-face meeting, even with a third party in attendance. They may feel 'threatened' as to their future healthcare.
- 7** Patient could feel inferior and susceptible to persuasion/ pressure.
- 8** Potential for aggression due to heightened emotions - needs careful mediation
- 9** Time – unless handled sensitively, could escalate the problem, might need to be facilitated in some cases, what is the 'status' of the meeting/needs to be clear and recorded - Could introduce another bureaucracy and delay if not streamlined – cost
- 10** That it could increase distrust, open up old wounds if not properly managed. If no effective follow up then there may be no impact – it's not quite clear what the purpose is, if a complaint has been made?
- 11** How would this factor in situations where there were also issues with other members of the team? For example a nurse who may have had a bearing on the outcome of a situation – complaints to their regulator too? How does this affect compensation claims – would it constitute evidence for the case to be resolved in other processes?

**12** How does the meeting influence outcome of investigation? How much 'prep' is required by the patient and will they need to have legal representation at the meeting?

Patient and Client Council Northern Ireland – Carolyn Ekin

They considered that these meetings would be very important and helpful and were broadly positive about the project but did have some questions or reservations about certain aspects. They felt it was a good idea in principle but the boundaries and parameters must be clearly defined. The emotional impact on the patient must always be assessed and it must be clearly stressed why this is something that would be worthwhile for patients to be involved in. The precise purpose and benefits must be clearly defined.

They wanted to know if these meetings take place once liability has clearly been established? I said that I thought this was the case?

They said in these meetings should the patient be supported by a solicitor or a patient organisation? Who goes into these meetings with the patient? Supporting the patients in this process is crucial. They wondered who is qualified to guide them in this meeting or who is best placed? They said the GMC must be prepared to acknowledge the role of advocates and this role would have to be fully supported by the GMC. They asked if this process would be likely to compromise any further legal action from taking place? They felt that if this wasn't already being done you should seek some views on this pilot project from the legal profession.

They said that this process must not seek to influence a patient in any way and that their rights should never be compromised. The rights of the patient must be looked after at all stages and they must not be put in jeopardy. The GMC must be very clear of the benefits these early stage meetings would have for patients. The GMC must be clear about what purpose these meetings would serve and the outcome. They feel these meetings need to be very closely managed and clearly explained.

They also asked whether or not this process would be obligatory for doctors? They said it obviously could never be mandatory for patients. They felt that doctors would perhaps be more likely to be open and transparent if it was something they'd come to voluntarily. They said that if a doctor is going to participate they must be willing to help the person and come with a compassionate approach as it can be painful for patients to relive the experience. Doctors must be open and honest if this is going to work, as if not, this could do more harm than good. They acknowledged that what doctors often say in meetings such as these with patients where they act more compassionately can often differ drastically from any subsequent written response given by the doctor.

They also felt that doctors could be reluctant to engage in such a process as they could be concerned with the damage it would have to their reputation if others found out they'd engaged in this process.

Ultimately they felt it was a positive idea but that it would need extensive evaluation to ensure that the patient is protected at all stages.

Richard Dixon from the PCCNI has said he would like to be kept in the loop about this project as it develops and he and Louise are both very willing to provide further commentary. He stressed that this pilot project would have to involve the PCCNI.

**Shaben Begum, Director of the Scottish Independent Advocacy Alliance – Ian Somerville**

- In essence a really good idea, but it needs to be done in the right way.
- Question about whether this would be too late in the process – i.e. need to be clear about reason for these meetings. Patients feeling they have been listened to is often a huge aspect of a complaint, this stage could be too late, but also could be very important.
- Danger that if it got to this stage, both sides could be quite entrenched in their positions.
- Any criticism would be about potential power-imbalance. Therefore there would be a huge responsibility for patient support before, during and after. This would be even more challenging in terms of psychiatry, where the potential for power imbalance would be greater.



## 12 – Meetings between doctors and patients

### 12 – Annex C

#### Equality and diversity (E&D) considerations in the pilot

- 1** The pilot will incorporate the principles below. When evaluating the pilot we will be consider if the model has raised any E&D issues and review the meeting model accordingly.

#### E&D considerations for patients

- 2** We do not systematically collect diversity data on the patients and complainants who are involved in our procedures. However, it is likely that a number of patients who are eligible for a meeting have vulnerabilities which could make it harder to attend and participate in a successful meeting. This may include people who have mental capacity and learning difficulties, a disability, cognitive impairment (i.e. brain injuries or dementia), or who are older and frail. Some patients may be vulnerable as a result of harm that occurred during their treatment.
- 3** Part of the rationale behind holding meetings is to provide a process for patients to obtain an explanation. Consequently, the benefits of meetings are geared mainly towards patients, or their relatives making the complaint. We want all complainants whose case is eligible for a meeting to have the opportunity to take part, and we will ensure that the meetings are fair and accessible by taking the following steps:
  - a** The complainant may bring someone with them to a meeting to support them.
  - b** We will make reasonable adjustments.
  - c** The preferences of the complainant will be taken into account when setting up a meeting, on a case by case basis.

- d** Where external venues are used for meetings, they will be held in fully accessible buildings. The option of telephone meetings may be explored where complainants are unable to travel.
- e** Trained facilitators will be used to enable effective communication between both parties.
- f** The terms of the meeting will be clarified in advance to help manage expectations.

## Issues for doctors

Certain groups of doctors are overrepresented in our FTP procedures compared with their proportion on the register. Statistics from previous years show that complaints are more likely to be made about doctors from certain groups. In terms of the protected characteristics, this includes older doctors, doctors from a black and minority ethnic (BME) background, doctors who qualify outside of the UK and the European Economic area, and male doctors. Numbers of cases that would be invited to a meeting are too low to assess trends but such groups may be more likely to be invited to a doctor-patient meeting.

## E&D considerations for doctors

- 1** The meetings relate to the delivery of the Duty of Candour which is a requirement of our guidance and should already have taken place prior to our receiving a fitness to practise case. Disadvantage would only arise from a serious admission or serious misconduct during a meeting, or an unreasonable failure to comply with the Duty of Candour with a subsequent submission of insight. In those circumstances any disadvantage would be outweighed by the public interest.
- 2** Doctors will be able to opt out of the meetings and we accept that there are circumstances where there are good reasons why a meeting may not be appropriate or desirable.
- 3** That said, doctors may feel such meetings are challenging and require sensitive communication:
  - a** The doctor has the option not to attend and we understand there are good reasons why a meeting may not be appropriate. Meetings are only offered where enough information is available to the doctor to adequately prepare for the meeting.
  - b** Meetings will not be offered where a doctor's health was a factor in the case.
  - c** The doctor is invited to bring a supporter to a meeting (a personal supporter, it is not envisaged that legal representatives will accompany either party).
  - d** Unrepresented doctors will be signposted to support facilities such as the Doctor Support Service, as well as guided clearly through the process by the facilitator

- e Clear communication in advance of the meeting will clarify the terms of meeting so doctors and complainants know that by taking part, the doctor is not accepting fault for what happened. The facilitator will do their best to moderate a complainant's expectations.
  
- 4 Such meetings typically benefit both parties, and we propose that participating in a meeting has the potential to benefit rather than disadvantage doctors taking part. They may value the chance for: a candid face to face discussion with the patient; a valuable learning opportunity; restoring dignity; closure.

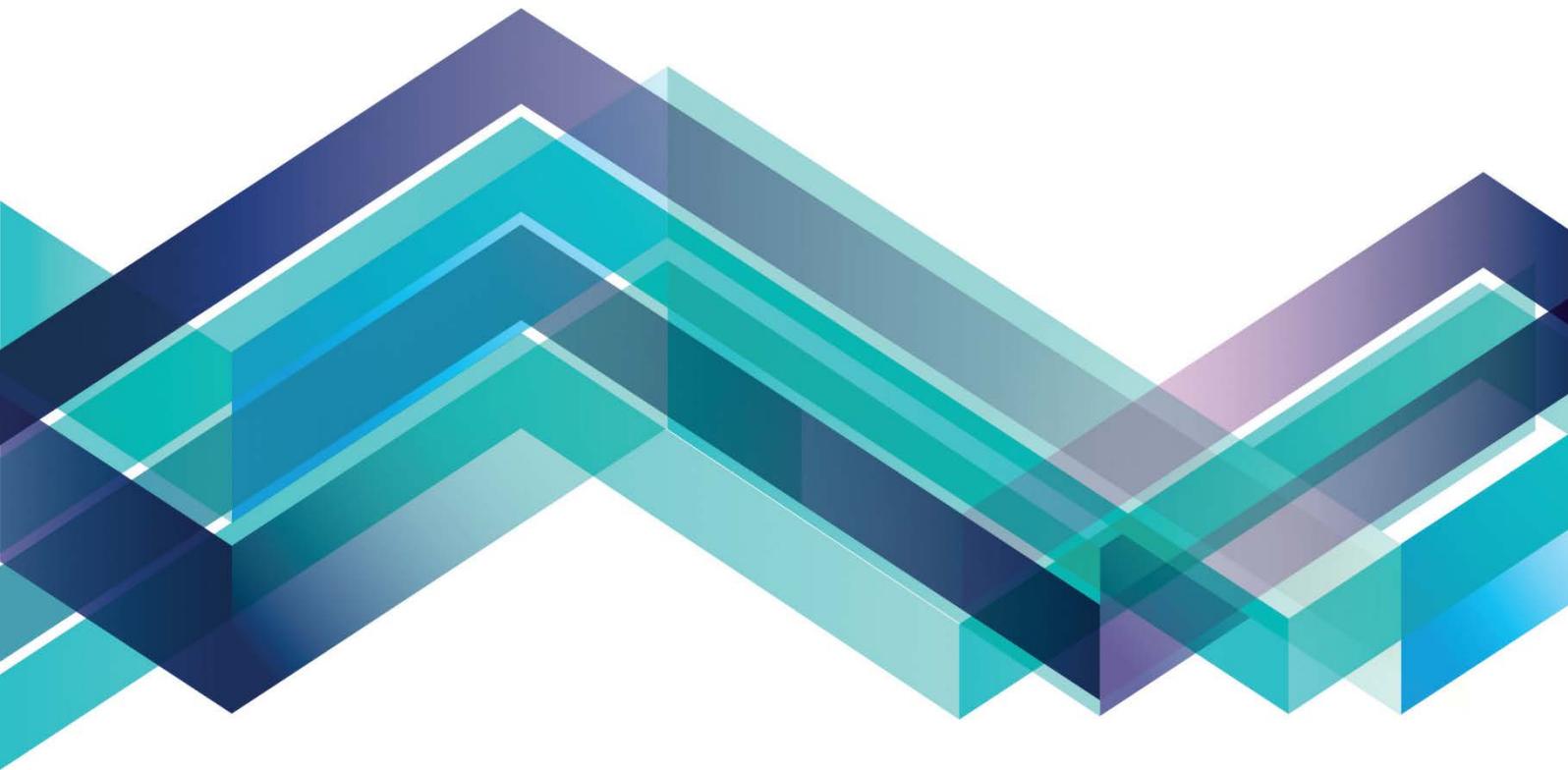
## **12 – Meetings between doctors and patients**

## **12 – Annex D**

### **Restorative justice in doctor patient meetings**

# Restorative justice in doctor patient meetings

Summary research report - June 2017



## **Background**

Restorative justice is a name given to a principles-driven process for addressing harm between two parties. It brings together the person who has been harmed with the person who caused the harm for a facilitated dialogue which is concerned primarily with restoration, repair and healing.

The GMC are considering introducing meetings based on the principles of restorative justice between doctors and patients in cases where the patient has suffered harm.

## **Objectives and methodology**

The aim of the research was to find out whether there are any examples of the use of restorative justice meetings between doctors and patients in cases where the patient has suffered harm in other parts of the world, and if so, to identify the key features of those models, their advantages and disadvantages, and any good practice.

The research involved desk research, contacting regulators in other countries and telephone interviews with four academics and experts and four regulators.

The research findings will be used to inform internal policy development in this area.

## **Restorative justice**

Restorative justice includes a set of principles which can be used to address harm between two people. Its aims are to repair the harm caused, to rebuild trust and to promote healing between the two parties through a managed or facilitated dialogue.

The Restorative Justice Council defines six key principles of restorative justice:\*

1. Restoration – the primary aim of restorative practice is to address and repair harm.
2. Voluntarism – participation in restorative processes is voluntary and based on informed choice.
3. Neutrality – restorative processes are fair and unbiased towards participants.
4. Safety – processes and practice aim to ensure the safety of all participants and create a safe space for the expression of feelings and views about harm that has been caused.

\*

<https://www.restorativejustice.org.uk/sites/default/files/resources/files/Principles%20of%20restorative%20practice%20-%20FINAL%2012.11.15.pdf>

5. Accessibility – restorative processes are non-discriminatory and available to all those affected by conflict and harm.
6. Respect – restorative processes are respectful to the dignity of all participants and those affected by the harm caused

Other principles identified through the research included:

7. Inclusion – seeking to include all stakeholders, rather than representative of the parties. It needs to involve the person who has been harmed and the harmer, not people by proxy or representatives.
8. Participation – people are not there to be spectators but there is participation of the primary parties in the process.
9. Accountability – in restorative theory active accountability is when the person holds themselves accountable to the harmed person and seeks to do what is necessary in order to promote repair.

Restorative justice belongs to the broader Alternative Dispute Resolution (ADR) movement and shares some similarities with mediation. They are distinguished by the goals of each process; where mediation is concerned with seeking settlement restorative justice is concerned with repairing the harm caused.

### **Use of restorative justice between doctors and patients and in the wider healthcare professions**

The research found no examples of restorative justice being used by a medical regulator in cases where a patient has suffered harm by their doctor. However we are aware that it may be being used at a local level or in significant failures such as the Mid-Staffs case.

The research did however identify a healthcare regulator who has recently developed a restorative justice policy which they are planning to launch shortly and three regulators who have used mediation, one of whom is a medical regulator. As mentioned above, mediation is different to restorative justice, but there are some similarities with restorative justice and we therefore explored these models further.

### **Model features, good practice and lessons learnt**

The research identified the following model features, good practice and lessons learnt:

- Types of cases – there were mixed views on the types of cases that would be considered suitable for restorative justice processes. Some felt that restorative justice would be appropriate for less serious cases where there was no issue of fitness to practice, patient safety or public protection issues. However, the question was raised as to whether this was the role of the regulator. Very serious cases were not thought to be suitable; however one expert said that these types of cases

tended to have the most profound impact. There are some cases that are unsuitable for a restorative justice process, for example where there is no acceptance of responsibility.

- Stage in the process – there were different perspectives on the stage in the process where restorative justice should be offered however there was a strong view that the earlier in the process the most beneficial, otherwise parties can become entrenched in their positions which can be difficult to change.
- Facilitation - in the example models we looked at meetings are delivered by an external, independent facilitator. Independence was felt to be important for the individuals concerned.
- Preparation – is very important and the facilitator should be fully aware of the details of the case and be clear on the expectations of each party (and whether they are realistic) and what they want to say and get out of the process.
- Format and content of the meetings – most restorative justice meetings will be face to face and should be delivered locally. In terms of content the restorative conversation tends to have the following phases: storytelling of what actually happened; exploring the impact and how it has affected the parties; looking at repair and what can be done to restore a greater sense of wellbeing. A written agreement may be made at the end of the process, although this may not be something the regulator sees due to confidentiality.
- Language – the terminology used relates to the criminal justice system, e.g. ‘restorative *justice*’, ‘offender’, ‘victim’, and may not be appropriate to use in a regulatory context.

## **Advantages and benefits**

The main advantage and benefits identified through the research included:

- Satisfaction - for those who have taken part in restorative justice processes, generally both parties report that they are satisfied with the process.
- Opportunity to have their say and ask questions – it enables the complainant to have a voice and get answers to questions they may not receive in formal processes.
- Restore ongoing relationships – where there is an ongoing relationship, restorative justice can help to improve that relationship for the future.
- Quicker to resolve cases – tends to be faster than formal processes which can result in less stress for those involved.

- Improved practice and reduced reoccurrence – it is hoped the person causing the harm will learn from the experience and improve their practice, preventing further issues reoccurring in the future.
- Wider learning for the profession – the learning for a regulator was identified as a potential benefit.
- Cultural change in the wider health system – one interviewee felt it may help bring about a cultural change leading to a more compassionate system overall.
- Cost savings – tends to be cheaper and quicker than a formal hearing so has an impact on resourcing.

## Challenges and risks

The two biggest issues identified in the research relate to whether restorative justice should be the role of the regulator and very low uptake in the mediation models:

- Role of the regulator – there was a strong view from two regulators that mediation should not be the role of the regulator and they had difficulty offering this option. They were concerned that the regulatory need might not be met in mediation and felt they were not in the business of resolving disputes but of enforcing standards. Another regulator also had questions around this. They found from a pilot they ran that the earlier mediation is offered the better, but at this point in the fitness to practise process it is not clear whether a case is a complaint that will or will not result in a fitness to practise issue and therefore raised questions about whether it was within their jurisdiction and use of resources to offer mediation. It should also be borne in mind however that mediation is different to restorative justice, particularly in its goals, and these regulators already had mediation within their legislative framework. It is unclear whether restorative justice would be considered a more suitable approach; with some feeling it would be more appropriate but others questioning whether it is the role of a regulator. Overall, the academic and experts interviewed tended to be more positive about whether restorative justice was appropriate and could be useful in a medical regulation context, while at the same time acknowledging the tension between the private need of an individual for restorative justice and the need of a regulator to protect patient safety and the public interest.
- Low uptake – the second biggest challenge was that there was very low uptake in the three mediation examples. There are a number of reasons. There were low numbers of cases found to be suitable for mediation. Both parties needed to be willing and to consent to participate; often one or the other does not. There was also low awareness and understanding of what mediation is. A similar issue with uptake is found in the criminal justice system, where the reluctance to participate tends to be more from the victims than the offender side. Mediation continues to be part of

the legislative framework in the examples we looked at although it is used very, very rarely.

Other challenges or risks identified included:

- Expectations not being met - it may be that through the process it is not possible to reach a resolution that everyone is happy with, and it is important that people are aware that this is a limitation. Good preparation beforehand should help to mitigate this risk.
- It is not a substitute for other support or a magic wand and should be considered as part of a suite of tools, e.g. counselling, practical help.
- Safety risk – harder safety risks were considered to be rare and can usually be managed with a trained facilitator.
- Understanding of restorative justice and engagement – gaining buy-in from relevant parties, Council, Royal Colleges, employers, defence unions, and other stakeholders will be an important part of establishing such a model.
- Privacy – the private and confidential nature of mediation and restorative justice can mean that the regulator has limited control over the process and there are fewer opportunities for lessons to be learnt.