



## **Reviewing the LRMP: Options for Development**

**Report prepared for the GMC by Trajectory**

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## Executive Summary

### Introduction – about the research

This report contains the findings of a research study which explored how the online List of Registered Medical Practitioners (LRMP) is currently being used and how it can be developed to become more responsive to stakeholders needs in the future. In particular, the research was designed to: understand who currently uses the LRMP; the function and use of online registers in other jurisdictions; how regulatory information is presented in other jurisdictions including identifying examples of good practice; and explore how far the LRMP currently meets the needs of its stakeholders.

Trajectory was commissioned by the GMC to carry out the research which included two rapid evidence reviews, primary quantitative and qualitative research that directly consulted educators and employers in the health sector, doctors, patients and the public and a range of GMC employees.

### Online registers in other jurisdictions and sectors

Compared to some other jurisdictions, the LRMP offers limited information. A number of other medical registers reviewed included information not provided by the LRMP, such as location of practice, contact information, languages spoken, and greater detail on the specialisms of doctors.

A survey of international regulators (the majority of which were medical) found that the LRMP does not provide two categories of information provided by the majority of others – current workplace and current scope of practice/area of specialism. This survey also found that there are a number of information categories that the majority of regulators do not think appropriate for their registers, including patient reviews, performance data and nationality of the doctor. There were mixed views on other categories, such as former names, additional training or qualifications and working procedures.

The majority of registers are not seen as patient-oriented currently, but there are indications that this may change in the future. While for many regulators, the current role of their registers is as a reference tool, more than 50% see it as a tool to help individuals find a suitable professional – with the majority of future ambitions focussing on making this a more prominent aim.

### Current use of the LRMP and other health sites

A survey on the LRMP website itself revealed that the majority (68%) of current users are professional stakeholders, with only a minority (12%) patients or carers. Professional users are very likely to be regular users of the site, professionally knowledgeable about the information it contains, and

generally satisfied with it. Overall, the information most commonly sought is the doctor's status on the register, followed by their reference number.

Patients, however, are much less likely to use the LRMP regularly and, when explored during the primary qualitative research, generally find the site difficult to use and interpret. Specific criticisms include: difficulty identifying doctors, dissatisfaction with the search function and difficulty interpreting some of the information. While patients and the public are increasingly comfortable using the internet to search for health information, very few had used it to search for information about doctors or services (most common uses involved searching for symptoms or conditions).

### **Developing the LRMP**

Overall, the LRMP in its current form meets many of the needs of the majority of its professional stakeholders, and its current primary users. However, it falls far short in meeting the needs of the public. In addition, within the GMC there is a feeling that the LRMP has not kept pace with the expansion of the regulator's functions (for example, postgraduate education and revalidation).

Although many professional users are currently broadly satisfied with the LRMP, many are keen to see it change and offer a greater range of information. Those expressing this view are drawn from a range of professional groups (doctors, educators, employers) and the public, who do not find the LRMP useful in its current form. However, there are some stakeholders (a minority) who would not like the LRMP to develop. For many of those reluctant to see change (most frequently voiced by some primary care doctors and some employers) this is the result of a narrow view of regulation, and their seeing the function of the LRMP as being primarily to provide information on who has met the requirements to practise.

Overall, there is a clear appetite to change and add information, and, while almost no change will be met without some disapproval, there was some consensus for certain additional information categories – notably the doctor's scope of practice, sub-specialisms, their revalidation dates and information on the location of work at a regional level. Additionally, there were some information categories which were met with almost universal disapproval – notably outcome data and public reviews.

Over the course of the research comments regarding the design and functionality of the LRMP were also raised, with a particular emphasis on expanding and improving the search function (such as providing a 'suggested search' option, improving navigation (through better signposting and a 'back' button) and mobile customisation.

Throughout the research, stakeholders of all types emphasised the need for new data on the LRMP to be objective and factual, and that any information category added should be available for all doctors. The stakeholders generally opposed the notion that doctors could themselves add information about their practice or personal circumstances to the register, without it being verified by the GMC (although some suggested that this would help drive up standards in the profession, as doctors would not lie or exaggerate to the regulator). In other jurisdictions, many data are supplied by the individual.

The public also expressed an appetite for one site to provide them with all the health information they may need, including symptoms, health centres and information on doctors and health professionals. Currently, this information is fragmented, creating an opportunity for one service or website to provide them all.

### **Conclusions and implications**

The function of regulators is changing, and accordingly, the content and scope of the registers they maintain is changing. Across the stakeholder environment, there is a clear appetite for change and development from the majority (with some significant opposition). The options for the nature of this development are very broad – from introducing tiers of access (i.e. having some information accessible only to professional stakeholders) to developing a different type of online service aimed more directly at patients.

# 1 Introduction

This report contains findings from a programme of research undertaken in 2014 to understand current users of the online List of Registered Medical Practitioners (LRMP) and how similar regulatory information is presented in other jurisdictions – the ultimate aim being to explore how the LRMP could develop to better meet the needs of its stakeholders, including patients and the public, doctors, employers, educators and other users.

Trajectory, an independent research agency, was commissioned by the General Medical Council (GMC) to carry out this research.

The project objectives in full are:

1. To better understand who uses the List of Registered Medical Practitioners (LRMP) and for what purpose(s)
2. To review the use, content and function of online registers employed in other relevant jurisdictions
3. To review how related regulatory information is presented in other relevant jurisdictions and to identify learning points for the presentation of information in the LRMP
4. To explore how far the LRMP currently meets the needs of stakeholders and how it should change to become more responsive to these

In meeting these objectives, we used a multifaceted research methodology that incorporated both qualitative and quantitative primary research, as well as rapid reviews of existing evidence.

The first stage involved a rapid evidence review that investigated what information was currently being offered by other online registers (run by regulators) of professionals who have met the requirements to practice in a particular jurisdiction (both medical and non-medical) and the impact that such registers had. This initial stage also included two internal focus groups with GMC staff whose roles either involve them using the LRMP or bring them into contact with stakeholders who use it and a web-based survey on the LRMP to quantify use by stakeholder group.

The next stage saw further investigation into the role of online registers provided by regulators – with a second rapid evidence review exploring best practice in the presentation of health information online. This was supported by a survey of international regulators and the start of a series of in depth interviews with experts around the world.

The final stage involved an extensive programme of primary qualitative research with a range of different stakeholder groups, including focus groups with patients and the public and doctors, as well as workshops and telephone interviews with educators and employers.

In total, the research has comprised the following elements:

**Table 1: Research Overview**

Stage	Research conducted <sup>1</sup>
1	<ul style="list-style-type: none"> <li>• Rapid evidence review into existing registers and their impact</li> <li>• Survey on LRMP website (3,351 responses)</li> <li>• 2 internal focus groups with GMC (16 participants)</li> </ul>
2	<ul style="list-style-type: none"> <li>• Rapid evidence review exploring best practice in displaying health information online</li> <li>• Survey of international regulators (45 responses)</li> <li>• 9 Expert interviews (telephone)</li> </ul>
3	<ul style="list-style-type: none"> <li>• 6 Focus groups with patients and the public (48 participants)</li> <li>• 2 Focus groups with doctors (both primary and secondary care) (18 participants)</li> <li>• 2 workshops with employers and educators (20 participants)</li> <li>• 17 Telephone interviews with employers and educators</li> </ul>

## 1.1 About the LRMP

The LRMP is the only up-to-date, publicly accessible database of all doctors eligible to practise in all four countries of the UK. The GMC has produced a medical register since 1859 and in 2005 an online version ([www.gmc-uk.org/doctors/register/LRMP.asp](http://www.gmc-uk.org/doctors/register/LRMP.asp)) was introduced comprising a subset of the medical register that it is required to publish under the Medical Act 1983.

Currently, the online LRMP offers the following information:

- name (including any former names), reference numbers and gender
- the year and place of doctors' primary medical degrees
- status on the Register (for example, temporary, emergency, full or provisional) including whether doctors hold a licence to practise
- date of registration

<sup>1</sup> Detailed information on research methods and fieldwork dates included in appendix

- entry on the GP and Specialist Registers (any doctor who wishes to take up a post as a substantive, fixed term or honorary consultant in the health service in the UK must also be on the Specialist Register and similarly, anyone who wishes to work in general practice – with the exception of doctors in training – must be on the General Practitioner Register). However, an entry on the GP or Specialist registers does not mean that the doctor currently practises in that field – simply that they were eligible to do so
- any publicly available fitness to practise history since 20 October 2005

## 1.2 The future of regulation – two viewpoints emerging from the research

Over the course of the research, several key themes have emerged that have a significant bearing on the results and the potential implications of changing or developing the LRMP.

One such theme is what the role of the regulator is or should be, particularly for patients and the public who are becoming increasingly confident in using the internet to source information on health and health services. While these discussions were centred on the role of the LRMP and the type of information that it does (or should) contain, they frequently broadened into a discussion about the role of a regulatory body such as the GMC. Other major themes were closely related to this central question, and included whether the register could be a tool used to drive improvement in the profession (or whether it should only exist to provide reassurance).

Broadly, two viewpoints emerged during the research, one (the minority view) being that the register should provide only objective information on whether or not an individual is registered with a license to practise in the UK.

*'All the GMC site is designed to tell you is that the doctor is licensed to practise... and that's all the regulator should be required and invited to provide.'*

-- NHS Employer

The second viewpoint (expressed by a far greater range of stakeholders) was that the register should help to enable individuals to find a suitable professional to meet their needs. In order to do this, the LRMP would need to expand and offer a greater range of information.

*'It would be very useful to have more information on there. I would find a professional address useful, for example.'*

*'We live in a different era now. Patients demand more information.'*

*-- Secondary Care Doctors*

These viewpoints greatly conditioned the tone and nature of more detailed discussions held around the specific content of online health registers, the priorities of the regulators or organisations providing them, and their online registers' primary intended audience. As noted during the main body of the report, these opposing viewpoints have significant bearing on the implications for developing the LRMP.

Until now, the LRMP has existed primarily to inform the public whether or not a doctor is qualified with a license to practise medicine in the UK. As the role of regulation changes, and regulators take a less reactive and more preventative role in maintaining standards, the nature and content of online registers changes.

## 2 Online registers in other jurisdictions and sectors

### 2.1 What information is provided?

The first rapid evidence review completed as part of this research investigated stakeholders' needs for online medical registers, the type of information typically provided and the value and impact of online registers.

Seven online registers in other countries were reviewed during the research. Compared to these sites, the LRMP offers very little information.<sup>2</sup> In Ontario, Canada, the profession is regulated by the College for Physicians and Surgeons and on this register the information is supplemented by contact details (including address of primary practice and additional practices), languages the doctor speaks, speciality and professional corporation information.<sup>3</sup> In Australia, the register also contains practice location, and allows the user to search with a particular area of specialism (for example, Chiropractor, or Cardiologist).<sup>4</sup> The public register of the Medical and Dental Practitioners Council of Zimbabwe is similar to that of Australia, in that it provides practice information and is searchable by area of specialism.<sup>5</sup>

**Table 2: information provided by other online medical registers:**

	UK	Au	Can	Eir	NZ	US	US (Mass)	ZIM
Registration Number	Y	Y	Y	Y	N	N	Y	Y
Status (i.e. registered etc.)	Y	Y	Y	Y	Y	N	Y	N
Expiry of registration	N	Y	N	N	Y	N	Y	N
Registration type (specialisation, limited, provisional, student etc. etc.)	Y	Y	Y	Y	Y	N	Y	N
Type of specialization	N	Y	Y	N	Y	N	Y	Y
Qualifications	Y	Y	Y	Y	Y	Y	Y	Y
Gender	Y	Y	Y	Y	N	Y	N	N
Geographical area	N	Y	Y	Y	Y	Y	Y	Y
Address of practice	N	N	Y	N	N	Y	Y	Y <sup>6</sup>
Telephone	N	N	Y	N	N	N	Y	N
Additional practice locations	N	N	Y	N	N	N	N	N
Hospital privileges	N	N	Y	N	N	N	Y	N
Languages	N	O	Y	N	N	N	N	N
Endorsements, conditions and notations	N	Y	Y	N	Y	N	Y	N
Undertakings (by practitioner if required e.g. to limit practice)	N	Y	N	N	Y	N	Y	N

<sup>2</sup> Sites consulted: Australia, Canada (Ontario), Eire, UK, New Zealand, US (AMA and Massachusetts), Zimbabwe

<sup>3</sup> <http://www.cpso.on.ca/Public-Register/Public-Register>

<sup>4</sup> <https://www.ahpra.gov.au/>

<sup>5</sup> <http://www.mdpcz.co.zw/>

<sup>6</sup> The Zimbabwe register contains an address, although it is unclear if this is the practice address or another address

Unsatisfactory performance, reprimands, suspension, investigation, unprofessional conduct	Y	Y	Y	N	Y	N	Y	N
Appraisal	N	N	N	N	N	N	N	N
Quality/error reporting (outcomes, care, prescribing & monitoring, customer reporting)	N	N	N	N	N	N	Y	N
Patient rating (e.g. accessibility, treatment, outcomes)	N	N	N	N	N	N	N	N
Complaint management	N	N	N	N	N	N	N	N

In comparison to some of these examples, the LRMP is minimalist in terms of the information it offers – and not user-centric in terms of the design of the site (particularly the search function). The registers mentioned above typically allow the user to search by a wide variety of fields (including geographical area and areas of specialism), although the LRMP does offer multiple search fields, and includes a 'sounds like' function to assist searches where the user is not certain of the spelling of a name. In the primary research, both public and professional stakeholders variously expressed difficulties using the LRMP, or problems they had encountered while doing so.<sup>7</sup>

However, while the extent of the information on the LRMP is of a narrower range than the online registers of Australia or Canada, compared to other regions – particularly Eastern Europe (according to Dr Kovacs, below) – it compares very positively, with even the limited amount of information considered crucial – simply because many areas do not have a publicly available online medical register.

*'The GMC register is very widespread and contains a lot of accessible and available information...many other countries are struggling with their databases.'*

--- Dr Eszter Kovacs, Semmelweis University

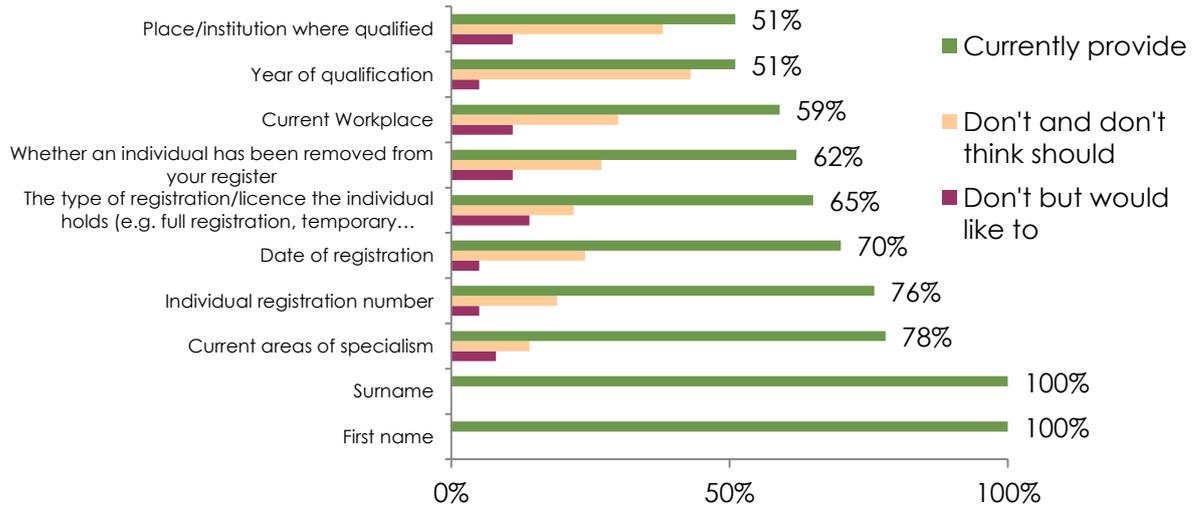
In addition to international registers, the information on the LRMP also differs to that offered by other registers in the UK. For example, both the General Dental Council and the Nursing and Midwifery Council give address information on their registers (although this can be either practice or home address) and allow users to search by speciality – indicating that the LRMP is not only limited in terms of international medical regulators, but national ones as well.

The online regulator survey, which ran from October-December 2014 collected information from 45 different regulators in the UK and globally, the

<sup>7</sup> For more detail on these concerns, please see section 5.3

majority of them (41) health or health related. Of those that do provide an online register of individuals who have met the requirements to practice (37 in total), the majority (both medical and non-medical) provide certain types of information, including current areas of specialism, registration number and date of registration. Within this, however, there are two categories of information that are not provided by the LRMP – current workplace and area of specialism – that are provided by the majority of other regulators.

**Chart 1: Information currently provided by the majority of regulators<sup>8</sup>**

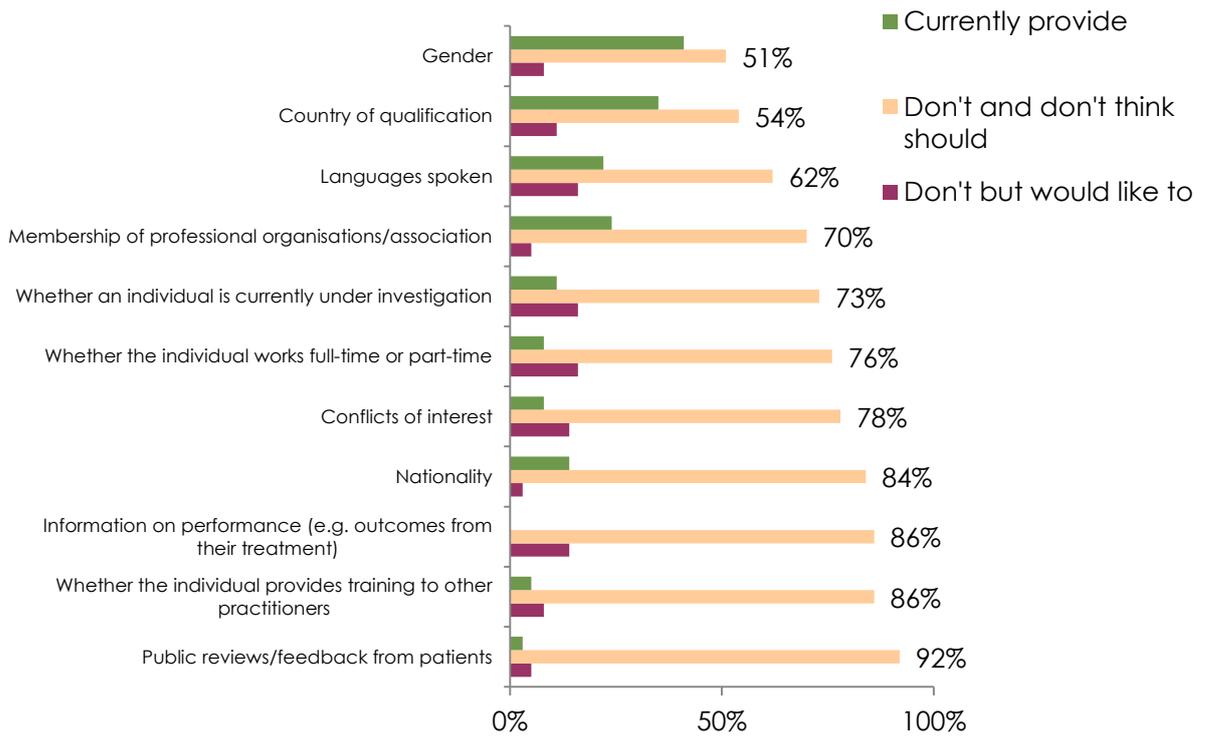


Source: Survey of International regulators, 2014 (Base: 37)

There are several categories of information that the majority of regulators do not publish, and do not believe should be published, including nationality and patient reviews or feedback. Conflicts of interest were also not supported, although over a fifth of the regulators either currently provide this information or would like to. For some, this was purely the result of favouring other types of information (for example, one regulator suggested that language spoken is more relevant and useful than nationality). For the majority, information categories were not included because they were not considered important or relevant for patients. Of these categories, only one is currently provided by the LRMP – gender – although another, country of qualification, is inferred through the LRMP's data on university of qualification.

<sup>8</sup> Although the sample of 37 is small, we have chosen to display data from this survey as percentages rather than figures for more clarity – for example, seeing that 78% of regulators currently provide areas of specialism helps to convey the proportion of respondents in a way that 29/37 would not. This applies to all charts in the report from this survey.

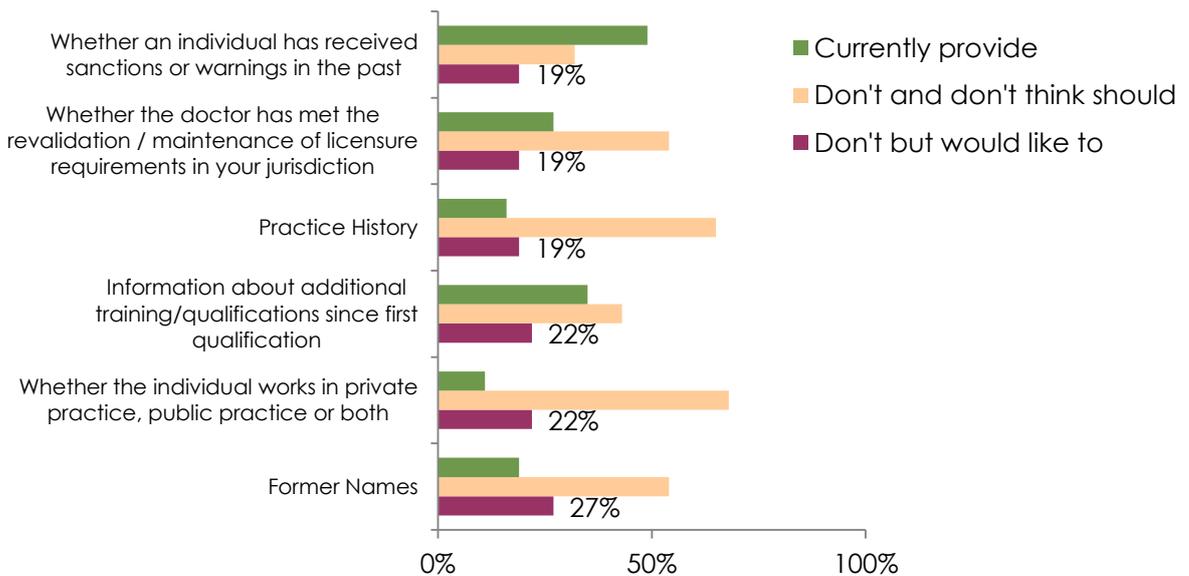
**Chart 2: Information not currently provided by the majority of regulators**



Source: Survey of International regulators, 2014 (Base: 37)

In addition to information that is currently unpublished by the majority of regulators, there are also some categories of data (as demonstrated in the chart below) that a sizeable minority of regulators would like to publish.

**Chart 3: Mixed views on certain categories**



Source: Survey of International regulators, 2014 (Base: 37)

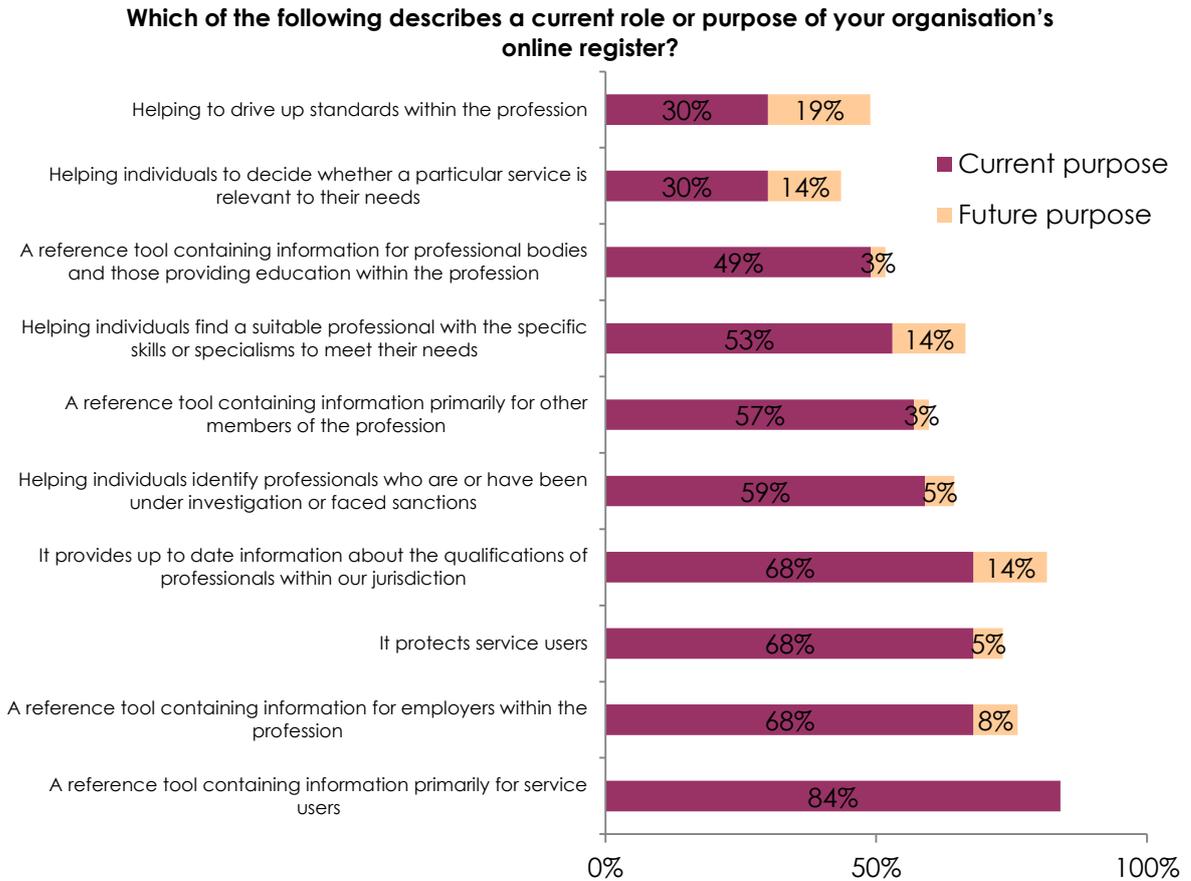
The categories of information in this final chart could each allow the user of the register to understand in greater detail about the professional they may come into contact with. This may be in the form of making it easier to identify them – through including former or other names – or through providing more in depth information about their career and practice. As explored in the next section, for many regulators surveyed, providing more information is a stated ambition.

While the consensus is behind not providing the information categories listed in Chart 3, there is a significant minority which would like to publish it. This fits with the divergent perspectives on the role of regulation – some regulators see it as part of their function to be providing users with more information – and reflects the direction of travel within many medical regulators, who increasingly see the purpose of their registers to be more than simply providing a list of people who have met the requirements to practise.

## **2.2 The role and purpose of online registers**

Understanding the role and purpose of online registers in general is particularly relevant as options for the development of the LRMP are considered. Gaining knowledge not only of the current content and scope of other relevant online registers but also their ambition and envisioned purpose will allow the LRMP to develop with both current and future needs in mind.

**Chart 4: Current and future views on the purpose of registers**



Source: Survey of International regulators, 2014 (Base 37)

The data above demonstrates that while registers are currently viewed as reference tools for either service users or employers, the most common future ambitions centre around providing information that enables patients and the public to make a choice. This is particularly the case with 'helping individuals find a professional with the specific skills or specialisms to meet their needs' - currently a purpose of around half of the regulators surveyed, and an ambition of a further 14%. The same proportion will prioritise the provision up to date information on training and qualifications.

Perhaps the most significant finding here is that while fewer than a third of regulators see their online register currently as being a tool that can drive up standards in the profession, a further 19% would like it to be so in the future. In 2014 an article in the Harvard Business Review praised the University of Utah for overhauling its fee based approach to service and replacing it with a team based, patient-centric service – including allowing patient reviews and

feedback.<sup>9</sup> This is a clear indication of the direction of travel of medical regulation around the world. This view is reflected by the Chief Executive of the GMC:

*"The LRMP is one of the most open registers in the world, but it is pretty much the same as it was in 1858. In that time we've moved into, in terms of content and technology, a completely different world of openness about data... The LRMP is unique - why are we not using it more effectively, and why is it not more useful to those who use it?"*

--- Niall Dickson, Chief Executive, General Medical Council

Despite this evidence, the rapid review of evidence completed as part of this research found little evidence of the impact of online registers on driving up standards, primarily because it is an under-researched area. One academic consulted in the course of the research noted that what evidence does exist points to registers' positive impact on standards overall:

*"Some studies make reference to the positive consequences that regulatory information has on professional conduct...[in addition] a number of reviews have noted a positive correlation between the specialist certification and the quality of care."<sup>10</sup>*

--- Dr Oliver Quick, Bristol University

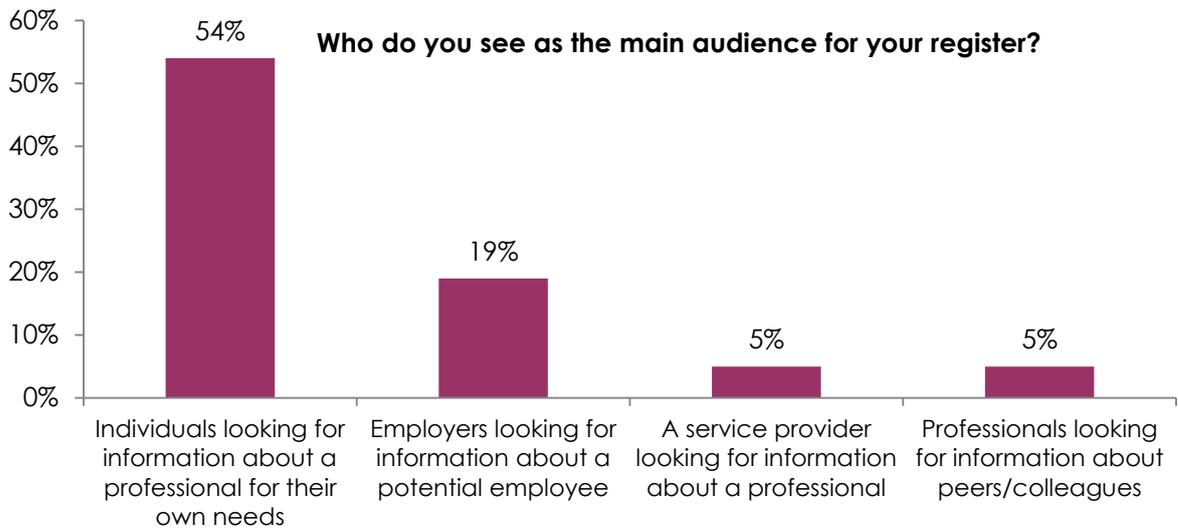
The role of online registers is naturally related to their intended audience, and this in turn affects the information they contain. International regulators are most likely to see patients or individuals as the primary users of their register.

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<sup>9</sup> [http://healthcare.utah.edu/publicaffairs/news/current/060214\\_hbr\\_patientengagement.php](http://healthcare.utah.edu/publicaffairs/news/current/060214_hbr_patientengagement.php)

<sup>10</sup> A scoping study on the effects of health professional regulation on those regulated, Council for Healthcare Regulatory Excellence, 2011 (p3).

**Chart 5: Primary Audience**



Source: Survey of International regulators, 2014 (Base 37)

### 2.3 Good practice and case studies

The second rapid evidence review explored the guidelines and best practices for displaying regulatory or comparative information online, in order to provide the GMC with an indication of how best to enhance the LRMP's effectiveness in contributing to patient choice.

While this review initially found very little evidence in this regard, a wider search found that previous research into presenting information has highlighted the risks of information overload. Individual users can use many different sources to gather information, making it harder to make an informed choice. This complexity can be alleviated by presenting complex information in a mixture of text and visuals – making it easier for the individual to make an informed decision. These issues are highly relevant to the GMC, as the number of health information websites grows.

Related to this issue, the primary research found that for some patients this complexity would be alleviated by the presence of a single online health resource that contained all potential information they would need from health services – including information on doctors.

#### **Case Study: College of Physicians and Surgeons in Ontario (CPSO)**

This college is required by law in Ontario to provide a public register allowing individuals to access information about doctors. The register includes the following information categories:

Information fields a user can search by:

- Name (first and last name)
- Gender
- Languages spoken
- Physician type (including over 80 specialisms)
- Location of practice (by both town and postcode)
- Hospitals the physician has a practice
- Fitness to practise information

Information fields contained on physician profiles:

- Former names
- Contact details (including phone numbers)
- Practice locations
- Registration details – including class of registration, when first registered and chronological registration history
- Professional information – such as corporations owned or run by individual
- Qualification place and date
- Postgraduate training.

As a result, the CPSO provides a good example of a regulator helping to provide its audience with the information they need to find a health professional with the right skills, rather than focusing on providing a list of professionals who have met the requirements to practise. However, despite the commitment to providing greater transparency, some information categories are absent – including procedures performed or specific areas of expertise.

The depth of information on the register (and available on the public site) is enshrined in law, and new information types are being added after public consultations. These consultations determine what information is added to the register:

*'In the past year or two we have pushed the transparency initiative and passed new bylaws adding new information and are consulting still further on additional items to be included'*

--- James Stratford, Manager, Membership, Corporations and Physician Register Department

For example, a recent consultation, which closed in December 2014, concerned adding criminal conviction information to the public register,

specifically findings of guilt and bail conditions<sup>11</sup>. These consultations are open to various stakeholders, with the press in particular keen to see greater transparency and detail on the register. This has not been without opposition – there has been some tension between those requesting extra information (such as the media and the public) and some doctors.

*'Overall, there is a general view and a will that transparency is a good thing.'*

--- James Stratford, Manager, Membership, Corporations and Physician Register Department

The information on the register comes from a number of sources, including data collected by the college as part of its standard processes, and also self reporting from physicians themselves. Many of the newer items (such as criminal convictions) are reliant on doctors self-reporting. This of course contains the risk of failure to report – although this in itself is professional misconduct.

During the course of this research, the CPSO register was shown to patients and the public, and was received very positively – not simply for the greater volume of information it contained but also for the authoritative look of the website. By this, the respondents referred to the look and feel of the site – such as the colour scheme and volume of information – which made it look like official, regulatory information rather than commercial.

The public register can be accessed on the College's site here:  
<http://www.cpso.on.ca/Public-Register/Public-Register>

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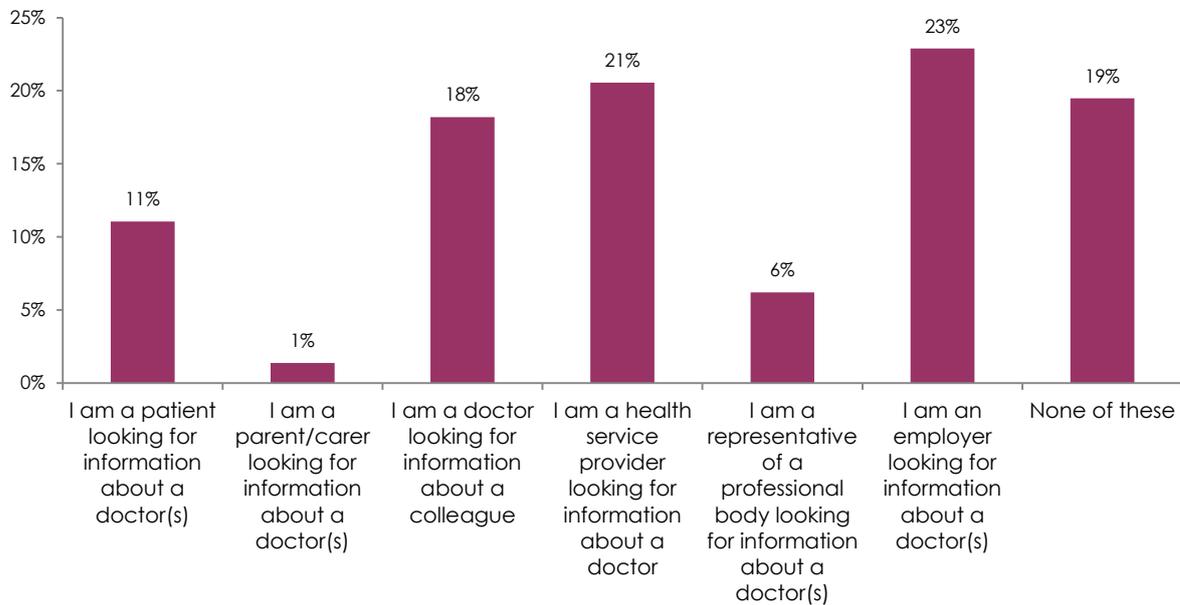
<sup>11</sup> At the time of writing, the College has not yet concluded on this issue

### 3 Current use of the LRMP and other health sites

#### 3.1 Who is using the LRMP?

The first objective of this research project was to understand the LRMP's current users. This was achieved by developing and hosting a 'pop-up' online survey on the LRMP website, which invited any visitor to the website to complete the short survey. As a result, we were able to learn a great deal about the spread of different users and the reasons for their visit. The survey ran for two weeks in October 2014 and was completed by 3,351 respondents.

**Chart 6: In what capacity are you using the register today?**



Source: LRMP Pop-up survey, 2014 (Base 3,351)

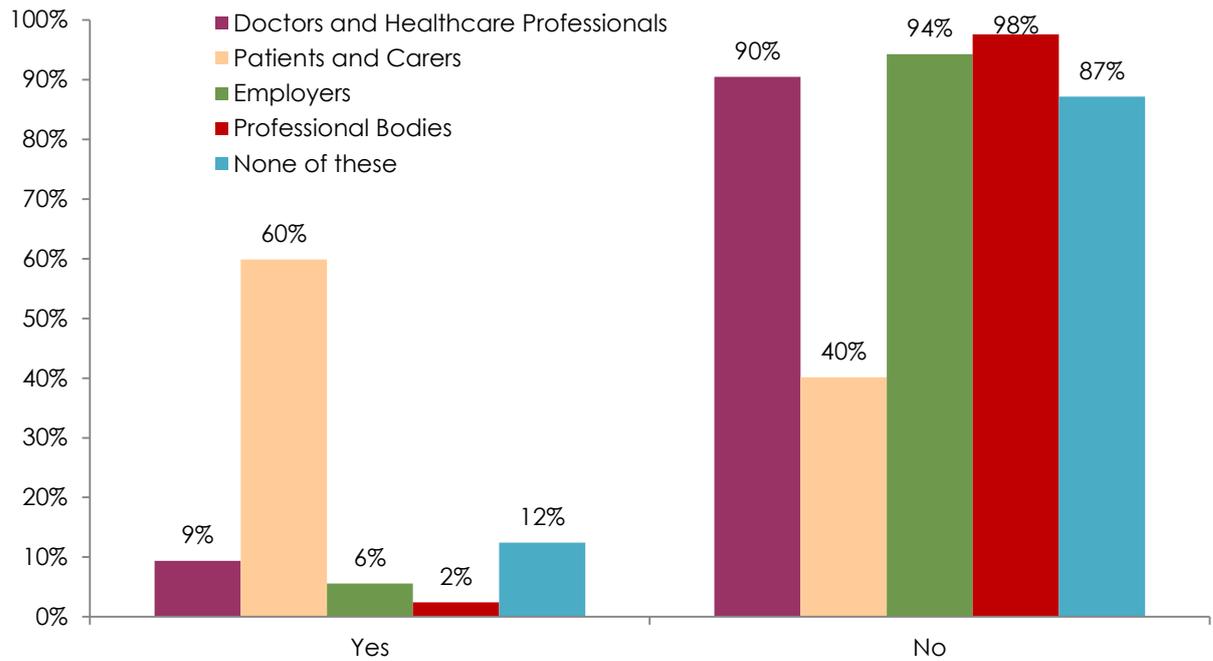
68% of users are from various professional groups – either doctors themselves, or employers or educators working in the health sector. The 19% that fell into no existing category were predominantly either doctors checking their own details (many use it to confirm their GMC registration number) and registrars checking official forms. One of the smallest user groups – just 12% combined – are patients and carers.

The original aims of the medical register were to provide users with information about who was qualified with a license to practise. In this respect, the register continues to fulfil its purpose, although there is an emerging ambition to enable individuals to find a health professional that meets their

needs. The current design and function of the LRMP is not currently meeting this need, and as such, perhaps unsurprising that patients and carers make up a small proportion.

The majority of users are professional stakeholders and repeat users, but for patients and carers this is not the case. Of those that completed the survey, 60% of patients and carers were visiting the online register for the first time.

**Chart 7: Is this your first visit to the site?**



Source: LRMP Pop-up survey, 2014 (Base 3,351). Figures may not sum due to rounding

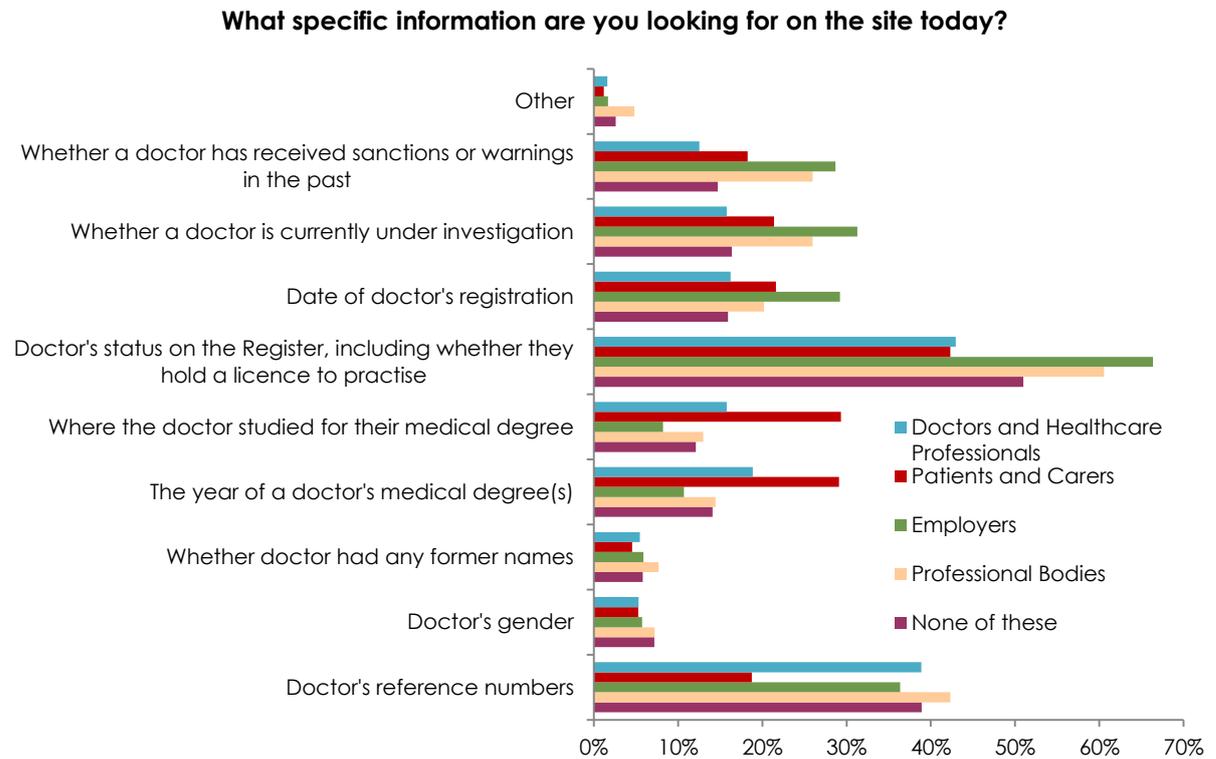
### 3.2 What information is being sought?

As we have already seen, the majority of current users of the LRMP are professional stakeholders, with only a minority (around 12%) patients or carers. Professional stakeholders are very likely to be repeat users of the register, and likely to visit the register on a regular basis. This no doubt gives them a greater knowledge of the information the register contains and how to access it. The information they are seeking is more directly linked to the core purpose of the register – checking a doctor’s identity and status on the register. Generally, professional stakeholder’s use of the online register is very specific – they are likely to know exactly what information they are looking for.

Patients and carers, on the other hand, are more likely to be first time users of the register, which means they are likely to be less certain of what information

is available on the register, or even what specific information they are looking for. They are also less likely to have detailed information (such as the GMC registration number of the doctor). When asked, they are more likely to be looking for details about a doctor's skills or qualifications – particularly where the doctor studied for their medical degree and the year of graduation.

**Chart 8: Information sought on the LRMP**



Source: LRMP Pop-up survey, 2014 (Base, 3,351)

This data provides a strong indication of the type of information sought by different stakeholder groups and the differing priorities required. While professional stakeholders are primarily using the LRMP to confirm a doctor's status on the register, patients and the public are as interested in gaining assurances about a doctor's qualifications and skills.

Other research has suggested that patients use this type of information in various ways. For some patients, information on the doctor's gender, ethnicity, age, technical competence and communication style have all been shown to be important<sup>12</sup> – and some of this information is contained within many of the online registers examined over the course of the research. While objective information is crucial, patients also value personal recommendations very

<sup>12</sup> Fang M C et al (2004), Are patients more likely to see physicians of the same sex?

highly, and are also influenced by 'softer' information about a doctor – such as their personality or manner.<sup>13</sup>

*'This is more a question for doctors. If I had to change a doctor, I'd ask family and friends – is their guy good? I don't need to look online for qualifications or anything.'*

---Glasgow, Female, 50-75<sup>14</sup>

*'Given a choice, a patient will choose a doctor with a video biography, they feel more comfortable with that doctor, because they feel they know them and can disclose more personal information.'*

-- Dr Evan Perrault, University of Wisconsin

*'Patients want personal information about the doctor – we feel more open and able to disclose highly personal information if we feel a sense of perceived similarity.'*

-- Dr Evan Perrault, University of Wisconsin

This finding was to some extent reflected by some of the responses to health information websites from patients and the public during the primary research. For some patients, there is a strong sense of needing to visit a doctor before forming an opinion on them – because communication and personality are important factors in the doctor-patient relationship. This of course presents a challenge to regulators and online registers, and such subjective information cannot be easily presented.

### **3.3 Satisfaction with the LRMP**

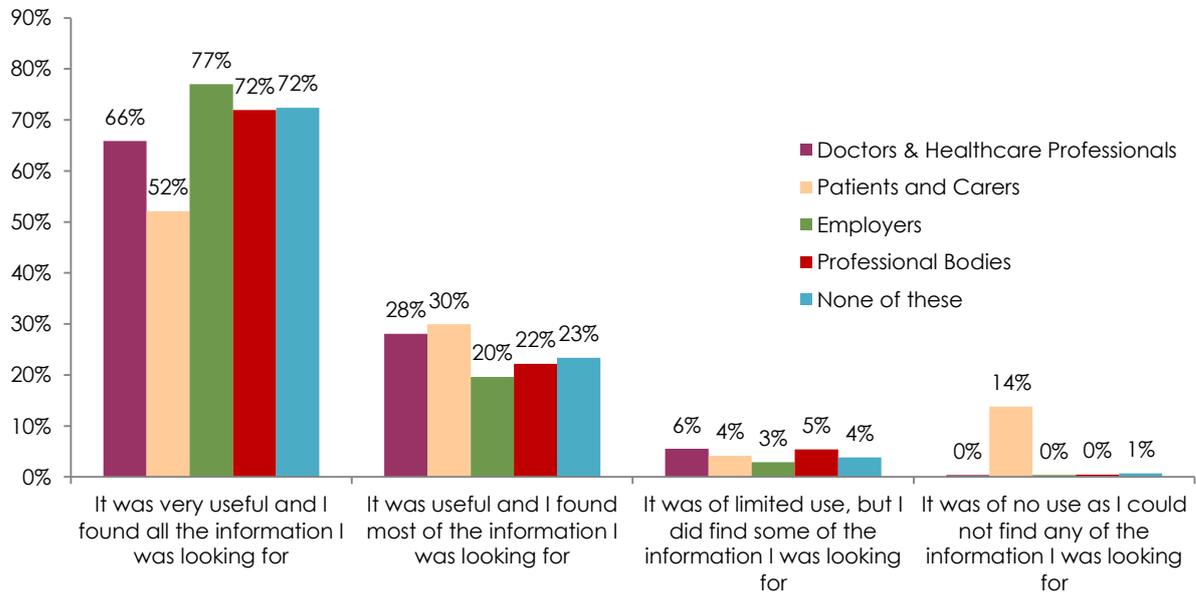
The pop-up survey found that the majority of current users of the site are very satisfied with the information provided. This is related to the user base – the majority of which are professional stakeholders who visit the register on a regular basis. For the public however, (only those who have used the site before) the register is considerably less useful.

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<sup>13</sup> Perrault E K et al (2013), What can we learn from physicians' online biographies to help in choosing a doctor? Not much. A content analysis of primary care physician biographies, *Journal of Communication in Healthcare* 6 2 122-127

<sup>14</sup> While the data above sampled patients who were users of the LRMP (as the survey was conducted on the site) the primary research found that many did not want to use the internet to find information about doctors.

**Chart 9: Thinking about your most recent previous visit to the site, which of the following best describes your view of the site on that visit?**



Source: LRMP pop-up survey October 2014. All those who have used site before - base: 2837

During the qualitative research, we found that patients and the public are generally unimpressed by the information the register contained; patients generally do not doubt that their doctor is on the register (and therefore feel no great motivation to check) and so this information is not considered relevant to them. Their view is that any doctor working in an NHS setting should be qualified to practice and do not regard it as their responsibility to check. Consequently, any service that only offers reassurances that a doctor is qualified to practice is of almost no use. In addition, there was reluctance from some respondents to take what they saw as an active role in ensuring quality in the health service.

*'It isn't my job to make sure doctors are up to scratch.'*

*-- Slough, Female, 35-49*

Beyond this, they also found the site difficult to use and interpret. Specific public/patient criticisms include:

- Difficulty identifying doctors – related to the information available and the search function. Many patients do not know their doctor's first name and a common surname can see dozens of doctors listed.

Adding more information would not only make the register more useful but would also improve searching and identification

- Suggested search – a prompt of 'Did you mean...' when no matches are found in a search would be useful (although the current 'sounds like' function exists on the LRMP, patients would find a suggested search more useful)
- Navigation – although the site is seen as authoritative and trustworthy, it is not considered easy to navigate. Users would prefer a more fluid and mobile customised design
- Jargon – the nature of the information is such that its meaning is not always immediately obvious to patients. Explainers would help make the information easier to interpret and more relevant

One example of the extent to which patients and the public can be confused by the current wording of the site is encapsulated in the quote below – which demonstrates that distinctions that are obvious to a professionally knowledgeable user of the site may mislead others.

*'My GP's not on the specialist register. Does that mean he's no good?'*

*-- Sheffield, Female, 35-49*

Professional stakeholders are far more frequent users of the register, far more aware of the information it contains and less likely to consider the information confusing or difficult to interpret. However, many professional stakeholders would like to see changes made to the LRMP, particularly making it more useable and adding more categories of information. Their responses to additional categories of information are explored in more detail in section 5.

### **3.4 Other online health websites**

The volume and nature of health information on the internet has changed dramatically since the LRMP was first placed online. As well as a myriad of sites providing information on health conditions there are also a growing number of sites allowing users to rate or review doctors or health services, as well as authoritative sites – such as the LRMP – which provide objective information on the status or performance of individual practitioners or services.

Our primary qualitative research revealed that the public (including patients) do use the internet for health information, although this is far more likely to be regarding information on symptoms, illnesses, treatments, therapies and

health conditions, rather than information on health services or practitioners. There are various reasons for this:

- Low awareness – especially amongst older respondents, awareness of this type of information is very low
- Low motivation – the public generally do not want to assume that they will receive anything other than excellent care, and so are not motivated to continuously 'check up' on their doctor. Those who do are usually motivated by a significant health event
- Shallow searching – even when sufficiently motivated to search, individuals are easily reassured by the information they find (such as confirming that a surgeon is a member of a particular hospital's staff)
- Illusion of choice – many individuals do not feel that they have a choice over who treats them, and therefore see little need in searching for information about services or practitioners. This is perhaps the most significant barrier, as this applies not just to major health events, but also to ongoing encounters with GPs surgeries and other primary care

There is also an issue of fragmentation – while some patients do use the internet to find health information, different types of information are currently isolated in different sites, with information on symptoms generally separate to that on practice locations or professionals.

As the pop up survey demonstrated (and was later confirmed during the primary research with patients and the public), although current usage of the internet to find information about doctors is low, this is very likely to change in the future as awareness of websites providing this information rises and the understanding that patients can choose their doctor widens. The primary research also indicated that demographic change will also have an impact – as a younger generation that is more naturally inclined to search for information online become increasing users of the health service, the demand for health information online will increase.

The primary research with patients and the public also demonstrated that currently, the lack of awareness of choice within public healthcare is inhibiting the extent to which individuals are exercising that choice. Part of this low awareness is caused by the public not wanting the responsibility that comes with choice – they simply want (and expect) all health care received through the NHS to be of an equally high standard.

An example of this is the NHS Choices website, which was explored during the public/patient focus groups. Many of the respondents had experience (occasionally deep experience) in using this website to find information on health conditions or to check symptoms – but there was no awareness within

these focus groups of the part of the website that allowed the user to access information – including ratings and user reviews – of health services in their local area. Many respondents, on seeing this function for the first time, were impressed with the information the site contained – particularly on the availability of online services (such as online booking, prescriptions etc).

## 4 Developing the LRMP

Overall, the LRMP currently meets many of the needs of a number of key stakeholders, but falls far short in meeting the needs of the public. Even amongst those stakeholders who are current and frequent users of the LRMP there is a consistent appetite for it to change and develop (with some exceptions).

Overall, views on the current scope and content of the LRMP fall into two categories: the majority view, which expresses a clear appetite for change, and a minority view, which would prefer to see the LRMP remain as it is, and offer no additional information.

This minority view is supported, according to the primary research, predominantly by primary care doctors and some employers. Their view on the content and scope of the LRMP relates to their view on regulation – they believe the GMC should provide only objective information that distinguishes between those with and without a license to practice.

*'All the GMC site is designed to tell you is that the doctor is licensed to practise in the relevant specialism, and that's all the regulator should be required and invited to provide.'*

-- NHS Employer

The second viewpoint was held by a majority of stakeholders, including other employers, secondary care doctors, many educators and the public and patients. This viewpoint advocated change and a strong appetite for the LRMP to offer more than it currently does – crucially, to offer information that would enable users to find a suitable professional based on their specific needs. There is a feeling within the GMC itself that the LRMP has not kept pace with other developments relating to revalidation and postgraduate training.

*'It would be very useful to have more information on there. I would find a professional address useful, for example.'*

*'We live in a different era now. Patients demand more information.'*

-- Secondary Care Doctors

Overall, there is a clear appetite for the LRMP to develop and change, with changes to both the type of information provided and the nature of its presentation (both of which will be explored in greater detail throughout this

section). It is important, however, to note at this stage that almost any change (in type of information provided or even design or functionality) will be met with some objection from one or more groups of stakeholders or subsets of them – highlighting the importance of clear communication and consultation, and the provision of a rationale may reflect the evolving role of the GMC and regulation.

In addition, given patients' views that health information is currently fragmented around the internet, there is also an opportunity for one online service to house or connect all information that patients may require – from symptoms and health condition information to information on hospitals or practice sites and professionals.

## 4.1 Changing the LRMP – adding information

Throughout the primary research, patients and the public expressed the view that they would like to see the online register offer more information – this is an essential pre-requisite for the site to be considered useful. The information they would like to see is more depth on a doctor's skills, practices, location of work and qualifications.

Over the course of the research, the suitability and desirability of new categories of information were explored in great depth. These range from greater personal information about doctors (such as their date of birth) to information about their employment or practice (such as current scope of practice such as details of areas in which the doctor currently practices, job title, career history) and to subjective and objective ratings (patient reviews, performance data). These new categories of information elicited a wide range of responses from each of the different stakeholder groups. The first table, below, summarises the response to each one.

**Table 3: Views on additional information categories**

	Primary Care Doctors	Secondary Care Doctors	Employers	Educators	Patients/Public
Scope of practice	✓	✓	✓	✓	✓
Revalidation dates	✓	✓	✓	✓	✓
Sub speciality	✓	✓	✓	✓	✓
Location of work (region)	✓	✓	✓	✓	✓
Languages spoken	Mixed	Mixed		✓	✓

Membership of professional bodies		✓		✓	
Conflicts of interests			✓		
Qualifications	Mixed	✓	✓	✓	✓
Age/date of birth	X	✓	✓	Mixed	✓
Former/other names	Mixed		✓	✓	✓
Employment history	X	✓	✓	✓	
Nationality/birth nation	X			✓	
Working practices	X	✓	X		✓
Qualification country		Mixed	✓	✓	
Photos	Mixed	✓	✓	✓	Mixed
Public reviews	X	X	X	X	X
Official' ratings	X	Mixed	X	X	Mixed
Outcome data	X	X	X	X	Mixed
Place of work	X	✓	Mixed	Mixed	✓
Contact details	X	Mixed	Mixed	Mixed	✓

As the table shows, there was wide support for a range of potential additions to the information on the LRMP. Within this, however, some stakeholders expressed doubts over some suggestions, meaning that only a limited number of categories were met with universal approval.

In many cases, this reflects the two dominant viewpoints referenced earlier: while the majority of stakeholders are not only open to change but would actively encourage it, a minority oppose almost any deepening of the information the LRMP provides. As explored earlier, this viewpoint is driven by a narrower view of the role of the regulator and of regulation, and not by doubts over the usefulness or relevance of various information types to patients or other stakeholders.

The addition of several information categories is supported by the majority of stakeholder groups – scope of practice, revalidation dates, sub-specialisms and the location of work at regional level. Furthermore, the languages a

doctor speaks and their qualifications were met with generally (although slightly mixed) approval.<sup>15</sup>

The research indicates that all of this data could be added to the LRMP without incurring major opposition from any stakeholder group. All would have the effect of making the register more relevant and useful, while also allowing for more search options (a major complaint from patients and the public). Patients saw these categories of information as essential to making the LRMP a tool they would use. Objections from professional stakeholders were very limited – some doctors acknowledged, for example, that the languages a doctor spoke was relevant to patients, but disagreed on whether it was within the remit of the GMC to provide this.

Perhaps the most substantial concern of these five categories came from employers and educators on revalidation dates. Generally, all saw revalidation as being something poorly understood by the public but potentially invaluable in demonstrating that doctors are monitored and checked on during their careers – as such, including the last and next date of revalidation on their register entry would be useful. The concern arose regarding incidences when revalidation has been deferred – seeing this could be interpreted in the wrong way by patients (i.e. assuming wrongdoing), although this issue could presumably be addressed with suitable explanation.

There are three information types that, based on this research, would be met with widespread objection if added to the register: public reviews, official ratings and outcome or performance data. Patients and the public have very mixed views on the latter two, with some concerned that outcome data would exaggerate negatives while others would be very keen to see any such official data before (for example) having surgery.<sup>16</sup> Their views on ratings are equally mixed, if slightly less polarised. Overall, patients and the public do not have a great deal of trust in them, and, due to the widespread belief that they have at best a limited degree of control over who treats them or where they are treated, they would be made more anxious than empowered by such data.

The development of sites which allow patients to review or comment on their doctors was explored throughout the research, with one expert who has been prominent in this area (Neil Bacon, the founder of [iwantgreatcare.org](http://iwantgreatcare.org)

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<sup>15</sup> It is important to note that some categories of information were not spontaneously raised in every item of fieldwork – meaning the opinion of every stakeholder group for every information category is unavailable

<sup>16</sup> In two focus groups conducted with the public, outcome data was considered the top priority, while in others it received a far more muted reception

and Doctors.net.uk) stating that such transparency and continuous feedback is a mechanism which drives improvements in the sector.

*"The comment we hear most often [from doctors on iwantgreatcare.org] is "it makes me a better doctor – it allows me to focus on what's important: the needs of my patients." It's continuous, real time, transparent feedback, and the fact that it's all open and transparent on the internet is a key success factor."*

---Neil Bacon, founder of iwantgreatcare.org and Doctors.net.uk

Consistently, however, the public consulted during this research were suspicious of patient led reviews, and would object to them being included on the register. This view was also reflected by the doctors consulted during the primary research.

Despite this, evidence uncovered by the Rapid Evidence Reviews found that in international studies (focussing on ratings sights and patient feedback from the US and Germany) the vast majority of patient ratings are positive.<sup>17</sup> However, a challenge appears to be encouraging patients and the public to leave ratings in a volume sufficient to be meaningful. A German study from 2012 found that only 37% of doctors had been rated, with only 2% rated more than 10 times (half had been rated only once).<sup>18</sup>

Opposition to these three categories of information from professional stakeholders is less mixed and more consistent. Public or patient reviews and official ratings are seen as unreliable, unhelpful and inappropriate for an official register. Outcome data was also opposed, although with greater nuance. Some secondary care doctors believe the data is useful and relevant, but are wary of the complexities of interpreting it – specifically, expressing concern that the public or patients may misinterpret such data.

Between the five information categories generally supported and the three that are generally opposed, there are a number that elicited far more mixed reactions. One particularly divisive issue was listing place of work or contact details. Primary care doctors are generally opposed to this – either because they feel it is well beyond the function of the register or the remit of the GMC to be providing such information or simply because they feel it is unnecessary. Some patients agreed with this assessment, taking the view that they knew how to get in touch with their doctor. Other patients, however, did see the need for this information, especially when trying to identify and find a specialist – in particular as it would help distinguish between doctors with the

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<sup>17</sup> Emmert M et al (2013), Eight questions about physician-rating websites: a systematic review, Journal of Medical Internet Research

<sup>18</sup> Emmert M et al (2013), An Analysis of Online Evaluations on a Physician Rating Website: Evidence From a German Public Reporting Instrument, Journal of Medical Internet Research

same name. Ultimately, it is likely that were this information available on the LRMP patients and the public would find it more useful than not (especially as it would help them identify the doctor they were looking for, when that professional might have the same name as another).

Other stakeholders were divided on this issue, with some voicing concerns over the suitability of the GMC in providing such information, with a handful suggesting that it could be used to make threats against doctors involved in controversial decisions (i.e. abortions). Although they would concede that this information would be freely and often easily available online, they would be unhappy with it being sourced from the GMC as they did not think the GMC should assist in this process. This was a common concern from primary care doctors – while aware that the internet means that the public have access to a great deal of information (including in many cases, on their own surgery website), they are reluctant to see the GMC provide this directly. While this opposition is perhaps in conflict with information they might themselves present on their own surgery sites or profiles, their objection is related to their view of the purpose of the regulator – a body which should provide information on whether or not they have a license to practice and little more. Interestingly, many other regulators – including the registers of physicians in both Australia and Ontario, Canada (both of which were consulted during the research) – provide this information. Indeed, Martin Fletcher, chief executive of the Australian Health Practitioner Regulation Agency, was surprised at the opposition, stating that in his jurisdiction, this information is 'a complete non-issue, bottom of the list of anyone's concerns'.

More detail on the responses to each of the categories of information, by stakeholder group, is provided in the appendix.

## 4.2 Design and functionality

Various stakeholders referenced the useability, design and functionality of the online register, with many suggesting minor changes that would improve the site and make it easier for them to use. The most substantial of these came from patients and the public, who, on seeing the register for the first time and without in-depth knowledge of the information the register contains, think it compares very poorly to other websites. However, even more regular users offered some suggestions for improving the site's design and functionality.

In addition to a more detailed and responsive search function (including a 'suggested search' prompt) suggestions included:

- Being able to search by pressing 'enter'
- Having a 'back' button to aid navigation

- Make different categories of information – especially details on conditions or restrictions – more obvious
- Better signposting around the site
- Mobile customisation – the site is currently difficult to use on mobile/tablet devices

Despite these criticisms, one consistent positive was the overall look and feel of the site, which was regarded by patients and the public as being authoritative and trustworthy.

### **4.3 Changing the LRMP – wider issues**

In addition to understanding what changes could be made to the LRMP, the research also considered how these changes should be made and the complications associated with doing so. One potential issue is where the data is sourced from – and whether or not all data and information on the LRMP should be directly sourced and verified by the GMC. Consistently, from all stakeholders, there is an emphasis that any information should be objective and factual (for example, not subjective reviews or ratings), and that data should be available for all doctors on the register, rather than the majority.

Several alternative sources of information are options. One is other major health bodies or organisations – such as the NHS. Any data sourced by the NHS would be considered authoritative and reliable by the LRMP stakeholders, although those with a narrow view of what the register should offer are unconvinced of its relevance or suitability. The patients and the public consulted in the course of this research demonstrated a strong awareness of the GMC and an understanding of its role, although at the same time were unlikely to distinguish between different national health bodies or organisations – and would actually prefer to see data from them more joined up.

Another potential source is that doctors themselves provide this information (or some of it) to the GMC or their entries on the register. This is generally opposed, and was met with derision by some professional stakeholders. This view was driven by the perceived unreliability of 'exaggerated' profiles elsewhere, for example, on private medical sites or review sites that contain unverified information added directly by the doctor (including non-medical information such as personal interests or hobbies). Even if the LRMP restricted doctor-added information to objective and medical fact, the nature of the source could compromise the authority and integrity of the register. This view was taken by the majority of professional stakeholders, including employers,

educators and primary care doctors, although some professional stakeholders (secondary care doctors) suggested that a doctor would be less likely to exaggerate their skills or practice to the GMC, especially if the provision of inaccurate information itself was a disciplinary offence.

Professional stakeholders also considered a secondary benefit to new types of information being placed on the LRMP – provided it was verified by the GMC. Detailed and accurate information of specialisms and procedures performed could contradict exaggerated personal profiles elsewhere, making the LRMP the true authoritative voice on doctor's skills and practice. Consequently, this could help to drive up standards across the profession.

Considering the impact of multiple information sources and patient's clear desire for a more joined up health system (and a health information system), the possibility of the LRMP including links within a doctor's entry to external sources of information was also investigated, with some experts seeing this as the first step in providing patients with all the information they would need to make an informed choice.

*"I would see MyNHS as the first part of a proper NHS based consultant directory.<sup>19</sup> So even if you don't have outcome measures [on the LRMP] you should still be able to find that information – meaning the link from the GMC should be to a definitive list like that."*

---Ben Bridgewater, Director of Outcomes Publication,

Patients were generally very relaxed about this, and would welcome such links if, for example, they redirected the patient to the next stage of their journey – having identified a doctor, a link could send them to the GP surgery or hospital website. Professional stakeholders were more mixed in their views, with some very wary about the implications of providing links to external content – implicitly, this could be seen as an endorsement of the content of a website for which the GMC have not responsibility or control. Others also question the practicality of providing external links, given the need to update and monitor the status of the link.

One further and very significant issue raised by professional stakeholders is the possibility of creating tiers of access within the LRMP. This was suggested spontaneously by a number of educators and employers who considered certain information types – such as career history, responsible officers (for trainees) or contact details – interesting and relevant for their uses, but not for the wider public. The public themselves may benefit from this approach, as they consistently expressed the need for clear, accessible and understandable information – which maybe complicated by the information

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<sup>19</sup> <http://www.nhs.uk/Service-Search/performance/search>

that is only relevant to employers or educators. An additional benefit of this approach would be to mitigate the concerns that many doctors expressed on the availability of their personal information.

## 5 Conclusions and implications

The online LRMP is currently used by a diverse range of stakeholders, both public and professional, and for a range of purposes.

Professional stakeholders are the most extensive users of the site, and are generally content with the information provided and the useability of the site, although this may in part be because they are repetitive users and professionally knowledgeable about the information it contains. The online register is primarily used by these groups to confirm a doctor's identity or to check their status on the register.

Patients and the public are minority users of the online register, and those who do use it are more likely than professional stakeholders to be looking for information on the skills or qualifications of the doctor. Insights gained from the primary qualitative research indicate that the public is largely unaware of the register, and many cannot see why they would use it in its current form.

Some other online medical registers around the world are more developed than the LRMP, with one example being the public register maintained by the College of Physicians and Surgeons in Ontario. The depth of information provided here is part of an extensive transparency initiative, which has seen a number of public consultations aimed at providing individuals with information that allows them to make a more informed choice about their doctor.

A clear finding from the collective research elements is that changing the online LRMP is necessary, both in terms of its content and its functionality. It is considered unhelpful by patients and the public who are the key potential future audience, (although not the intended prime audience when the current LRMP was designed) and will increasingly struggle to meet the needs of professional stakeholders and regular users without change. In some respects, the online register is more limited than other international examples – for instance, the level of search function and specialist, address and professional information provided by the College of Physicians and Surgeons of Ontario.

However, it is important to note that almost any change to the status quo will be met with some objection from some stakeholders. There is a small minority of users – chiefly primary care doctors and some employers – who would resist any changes that they considered to be a broadening of the scope or remit of the register. Of all the categories of potential additional information explored, only a handful gained approval or support from the majority of stakeholders. In the light of these inevitable challenges, it is clear that

communication about the nature and reason for any developments will have to be transparent and detailed.

More broadly, it is clear that the evolving role of regulation is relevant to the development of the LRMP. While this minority who would oppose any significant change to the register see the role of the regulator to provide an objective list of who has a license to practice in the UK, others (the majority) see it increasingly as a tool that enables individuals to research and find a professional with the skills to help them. As such, any changes, and the explanations that accompany them may be as much about the future of role of the GMC as they are about information provision.

This changing nature of the regulator involves a shift from being perceived (as many internal stakeholders do)<sup>20</sup> as being for solving or curing problems to preventing them – from reactive to proactive regulation, or from providing reassurance to actively driving up standards. As we have seen through reactions to proposed changes to the register, some information provision could result in improved standards and clearer information (for example, doctors would not be able to exaggerate their skills on a GMC verified register as they are able to do elsewhere on the internet).

The implications of these findings are extensive – but naturally will vary depending on the course of action taken.

Not changing the LRMP is one option – indeed one favoured by a small minority of professional stakeholders. The key benefit of such an approach is that those opposed to any broadening of the GMC's remit are appeased - although the majority of users would like to see changes to the site. Not changing not only runs counter to the direction of travel in regulation and in good practice generally for the presentation of information on a website, but will also greatly inhibit the chances of patients and the public using the register.

A second option is adding information but making some available only to certain stakeholders. For example, the 'public' register could be broadened to include sub-specialisms, revalidation dates and other information categories that met with least resistance. It could also be redesigned to make it clearer and easier to access, including explainers where appropriate. A second 'professional' register could be open only to employers and educators, containing all of the above but additional information on employment history, contact details etc. In this option, no part of the register should include reviews, ratings or self-completion by doctors.

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<sup>20</sup> This view was expressed both during focus groups with GMC staff and during the focus groups conducted with doctors

A third option would be to revolutionise the content of the site, and develop one register, available to everyone, that has all of the categories of information except those met with universal disapproval. The most significant risk of this is the extent of opposition from many stakeholders – not only the minority opposed to any change, but also many employers and educators who consider some information useful to their needs but not for the public.

A final option is to develop a new GMC site designed purely with the needs of the patients and public in mind, and not intended for use by professionals. In terms of the information it contained, it would build on the existing LRMP only slightly – by adding those information categories most positively received. This new site would explicitly remind patients of their options (i.e. they have a say in their treatment and who treats them). The core benefit of this approach is that a separate service would allow for a different tone and style of presentation, and could make it less controversial to include external links. A separate service would not necessarily be called the LRMP, and would be entirely public facing (with the content written with lay people rather than professionals in mind) – meaning patients would not see it as ‘for doctors’ as many currently view the LRMP.

## 6 Appendix: Categories of information

**Table 4: Doctors (primary and secondary)**

	Primary and secondary care doctors - notes
Scope of practice	Doctors generally happy with this
Revalidation dates	Doctors generally happy with this
Sub speciality	Patients apparently happy to take GPs recommendation on experts - only extra detail/criteria they might require or have a preference for is gender (which is on the LRMP currently)
Location of work (region)	Happy with region - can see it makes it easier to use
Languages spoken	GPs acknowledged this was useful, but weren't sure it was within the remit of the GMC
Membership of professional bodies	Useful to know - another way of indicating genuine MEDICAL qualifications, rather than just academic qualifications
Conflicts of interests	This was not spontaneously raised by doctors
Qualifications	Concerns that this data will allow public to trace doctors - and their history - very easily, lead to being stalked. Secondary care doctors more relaxed about this
Age/date of birth	Seen as private personal information by primary care doctors and not necessary as a user can work out a doctor's rough age from their qualification date. Secondary care doctors more relaxed
Former/other names	General sense that it isn't necessary information. Some stronger opposition around relevance and privacy
Employment history	Seen as unnecessary private information by GPs – the sort of info you only need if selling services. Secondary care doctors far more relaxed – and would see it as beneficial for recruitment
Nationality/birth nation	Unspoken, but some unease we suspect about concerns about prejudice against some nationalities. This is our interpretation of the response rather than a direct response or quote from the respondents
Working practices	Primary care see this as commercial - relevant only for a doctor that is selling themselves
Qualification country	Some secondary care doctors worry about patient bias against apparently less prestigious academic institutions
Photos	Help with identification (and misidentification) / but immediate concerns around personal security
Public reviews	Immediate negative reaction: 'All you hear is the moans.'
Official ratings	Consistent negative reaction
Outcome data	Secondary care doctors see the attraction, but warn about the complexity and difficulty in interpreting
Place of work	GPs have their own surgery sites - unnecessary, not the function of the GMC. Very strong opposition from primary care doctors, although secondary care doctors much more relaxed
Contact details	As above for primary care - 'If anything, we want less availability'.

**Table 5: Educators and employers**

	Employers and Educators - notes
Scope of practice	Generally seen as very useful – for both public and professional stakeholders
Revalidation dates	Spontaneously suggested. Also suggested Designated Bodies and Responsible Officers as well. But difficulties with locums emerged. Also information needed on whether or not revalidation has been deferred - but big concerns for doctors themselves (as information could be interpreted in the wrong way by patients)
Sub speciality	Generally seen as very useful information
Location of work (region)	No objections
Languages spoken	No objections – although not raised as an issue by employers
Membership of professional bodies	Mentioned by some educators, although generally considered a minor issue
Conflicts of interests	Value understood - but question how widespread/impactful the data would be (seen as a minority issue)
Qualifications	Generally seen as very useful information
Age/date of birth	Can see it would be useful, but expect opposition - personal information
Former/other names	Employers talk about confusion arising from use of different names by doctors (e.g. people using a middle name, rather than first name). Would be useful to have 'name as written on passport' as an entry
Employment history	Considered very useful - but not for the public
Nationality/birth nation	Assumption it was all in there. Surprised it is not
Working practices	Useful, but 'horrendous' to get together. Not the function of the GMC. NHS choices has that
Qualification country	Mentioned by some employers and educators - would help them locate foreign universities. Also a UK issue - knowing if an English born doctor went to a Scottish university etc.
Photos	Considered useful in terms of identification of doctors – but expected opposition from doctors themselves
Public reviews	Consistently opposed or dismissed
Official ratings	Consistently opposed or dismissed
Outcome data	Don't see value of much of these - many doctors work in teams
Place of work	Some support and recognition that it would make identification easier. But concerns around ability to update information. Very strong opposition from some
Contact details	Divided on the usefulness of this – sense that it would be very difficult to keep updated. Some concerns about the GMC providing this information to the public

**Table 6: Patients and the public**

	Patients and the public - notes
Scope of practice	Not referenced directly, but part of what some patients have searched for when looking up surgeons/consultants (along with job title etc)
Revalidation dates	Not raised directly, but a perception that doctors, once they qualified, aren't checked on, or required to update their skills/complete training
Sub speciality	Seen as essential to making the LRMP a tool they would use
Location of work (region)	Useful primarily as a search function
Languages spoken	This was interpreted in some places as guaranteeing the doctor could speak good English, rather than it being helpful to have a doctor who speaks another language
Membership of professional bodies	Not raised
Conflicts of interests	Not raised
Qualifications	No opposition – but any information like this would need to be clearly explained
Age/date of birth	No opposition – but not seen as crucial
Former/other names	Would help with searching, but not as much as speciality/region would
Employment history	Not raised
Nationality/birth nation	Not raised
Working practices	Would help them know when/if a doctor was available, but not raised frequently
Qualification country	Not raised
Photos	Some resistance from patients - worried about choosing for the wrong reasons
Public reviews	Would not trust. The public not as well informed as they might be
Official' ratings	Not a huge amount of trust in them. A sense that this is the GMC's job - but not necessarily something that NEEDS to be made public. There's a danger in being told that your hospital is only 2 stars if you don't feel like you have a choice in staying there. Also - if the doctor isn't any good - they shouldn't be a doctor
Outcome data	Suspicion that poor outcomes would be over-exaggerated. 'The facts could lead to more anxiety - I'd like the information, but it needs to be dealt with carefully and sensitively'. Sharp polarisation, however - others would be very keen to see them
Place of work	Wouldn't oppose them but not a great sense of need - they know where their doctor is
Contact details	As above. Could only imagine using them if they needed to change their doctor (which many have rarely/never done)

## 7 Appendix: Research details and core materials

1. Pop-up survey of users of the LRMP
  - a. Survey conducted between 25/9/2014 and 9/10/2014
  - b. Hosted on the LRMP website
  - c. Accessed by 28,093 people, with 3,351 completed responses
  
2. Online survey of international regulators
  - a. Survey conducted between 25/9/2014 and 10/11/2014
  - b. Developed and hosted by Trajectory on Smartsurvey.com
  - c. Invitations to complete survey sent directly to sample of international medical and non-medical regulators
  - d. 45 completed responses
  
3. Expert interviews
  - a. 9 interviews in total
  - b. Conducted between October 2014 and January 2015
  - c. Sample included national and international medical regulators, academics and medical professionals
  - d. Interviews conducted by Trajectory over the phone, using an approved discussion guide (included below)
  
4. Primary research with professional stakeholders
  - a. 2 workshops in central London in November 2014 with health educators & employers
  - b. Series of telephone interviews with educators and employers around the UK (conducted between October-December 2014)
  - c. Two focus groups with doctors (primary and secondary care) held at the GMC's offices in Manchester on 12<sup>th</sup> November 2014
  
5. Primary research with patients and public
  - a. 6 focus groups conducted in November 2014 in three locations (Slough, Sheffield, Glasgow)
  - b. Groups moderated by Trajectory, using an approved discussion guide (included below)

## **Telephone discussion guide for experts and professional stakeholders (adapted to suit each interview)**

### **1. Introduction and background**

#### **Purpose of the interview:**

*“Trajectory has been commissioned by the GMC to review the current use of the online List of Medical Registered Practitioners and explore options for its future development. As part of this review we are investigating wider changes in the way the public, patients, doctors, employers and professional bodies use the internet to search for information about a health service or details on medical professionals. We’d like to know how interested people are in this type of information, whether they’re using it and whether their use is driving up standards within the profession. As part of this research we are talking to a range of experts from a range of fields, to understand how regulatory information is presented online and how other developments – such as ratings sites, social media and patient portals – are affecting both patient expectations and medical practice. Ask the interviewee if they’re happy for the call to be recorded (as it improves accuracy and allows the interviewer to concentrate on the call rather than take notes), and if they are happy for quotes to be attributed to them in the final report. Any quotes will be checked with them for approval first. But first would you mind telling me a little bit about your role/your area of expertise....”*

### **2. Current and future use of the LRMP**

*If necessary, explain the function and remit of the GMC and explain what the LRMP. If they are completely unaware of it, much of this section will not be relevant to them as it is.*

*Explore current usage, especially amongst academics and researchers*

- In what ways have you or colleagues ever used the LRMP?
  - What did/do you use it for
  - How useful is the information provided?
  - How complete is the data?
- How else do you expect the register is used?
  - Who are the primary audience?
  - Can registers of this kind ever meet the needs of multiple audiences?
  - How can patients and the public be encouraged to use it more?
- How useful would it be for the public?
  - Are they interested in this type of information?
    - If not – why?
  - Is this likely to change?

- Are registers of this kind solely concerned with providing assurance or can they drive improvement? – How?
- What could be added to the register to improve it?
  - Is there any data that could be collected that would lead to new insights – such as identifying problem doctors or resource issues?

*(prompt for types of information if needed – revalidation dates, training, areas of specialty...)*

- Are there any barriers to collecting or providing new types of data on the LRMP?
  - What are they? Can they be overcome?
- How should this data be sourced? What are the issues?
  - Are there any issues in asking doctors to provide more details about their practice?
  - Can some data or information be presented with warnings? Or should everything be verified?
  - What about quality assurance?
- In summary, how should the LRMP change in the future?
  - Should it change at all? What are the risks of doing nothing?

### **3. Best practice in providing regulatory health information**

- Are there any examples of regulatory information being presented in a way that has been demonstrated to improve outcomes?
  - Specifically, what type of information is this (about individuals or services/performance based or descriptive?)
  - What are they? How did they come about?
- Can you think of an example of another register (relating to either individuals or services) that effectively engages its core audiences?
  - Why is it effective?
  - What can the LRMP learn from it – are there key principles?
- How frequently should regulators review and develop their registers?
- What role can performance based information play alongside the descriptive information currently set out on the medical register?
  - Do they have a positive or negative impact on health outcomes?
  - Should they be kept external to verifiable regulatory information?

### **4. Health information and the internet**

- What evidence is there of the impact of review sites on patients' choices or expectations?
  - How do medical ratings compare to those in other sectors – such as financial services or health, for example?

## 5. Final thoughts

- What information should the LRMP provide in 5 years time?
- Is there anything else that you'd like to mention?

**Thank the interviewee for their time and close the interview, offer your contact details in case they would like to make comments at a later date.**

## Discussion guide for primary research with patients and the public

### Introductions and warm up (10 mins)

*Objective: get participants relaxed and speaking about their life and the type of information they've searched for online*

**SCRIPTED INTRO:** The purpose of our research is to understand how people are engaging with online information relating to the provision, availability and quality of healthcare services and practitioners. The internet use can be on any device – a desktop computer or a mobile device, so we'd also like to know about any health apps that you might have used.

*The focus of the group should be on how they search for information online and how they discover and use different services. It shouldn't focus on the details or particular conditions or personal health information. Don't prompt for this, although respondents themselves may bring it up during the course of the group.*

- Could you each tell me a bit about yourself?
  - Could you please tell me:
    - Your name
    - Who, if anyone, lives with you
    - About your job, if you have one
    - About how you spend your leisure time
  - How frequently do you use the internet to search for information online (not necessarily health related)?
  - Typically, when you look for information online, are you looking for yourself or for other people?
  - Whilst we don't need to know any personal details, could you tell us if you have had a significant health issue in recent years (last 5 years) – treatment for an acute condition (a condition with a rapid onset

and/or short duration like a stroke, heart attack), a chronic or on-going condition (like asthma, diabetes) or any operations etc

### **Awareness and Usage (25mins)**

*Objective: understand what type of information people are searching for and what services they use*

- Have you ever looked for information about local health services – whether that's a local hospital, general practice or something else – or for information about doctors or nurses that work there?

*Some may have experience of this, and others not. To those that have, ask:*

- What type of information were you looking for?
  - Did they manage to find it?
  - Where did they look?

*Unprompted first of all, then... prompt for different types within broad categories – doctor's details (gender, nationality, registration number, specialism, experience, reviews), practice details (location, contact information, opening hours, staff details, reviews) etc.*

*Establish who searches for what – as some/all may have searched for a combination of different types.*

*To those who haven't, ask*

- Where would you start if you had to look for some of this information?
- [TO THOSE THAT HAVE SEARCHED BEFORE] What sites/services do you use most frequently?
  - How did they find out about them?
  - What type of information is on them?
- How useful do you find those sites/services?
  - Do you understand the information provided?
  - How are you using it?
  - Is the information on them what they need?
  - Are they easy to use?
  - How much do you trust the information they provide?
  - What reassures you about its quality?
- What are your expectations when searching for this information online?
  - Is there ever anything you don't expect to find (but search out of hope?)

*(We will have a selection of health related websites – LRMP, I want great care.com, other regulator sites, etc. - pre-loaded on to a laptop to use as stimulus if required. We will also use the laptop to look up any sites mentioned by respondents as being particularly good [or bad])*

### **The LRMP (30mins)**

*Objective: understand awareness of the LRMP, how it has been used, – as well as how useful they find the information it contains*

*Respondents were all asked to look at the LRMP website prior to the group – check who has.*

- Has anyone heard of the General Medical Council?

*See who has and ask them to explain in their own words what they believe the purpose or function of the GMC to be. If no one has tell them that the GMC is the body responsible for regulating doctors in the UK, all doctors wishing to practice in the UK must be registered with the GMC, and the GMC is responsible for handling any complaints and fitness to practice investigations) Does the fact that the GMC is responsible for this site affect your view about it in any way*

- Had anyone used or come across this service before?
  - If yes, explore – how and why did they come across it?
  - What type of information were they looking for – and how useful was it?

*With the rest of the group, ask them about their experiences looking at the site prior to the group.*

*(Again LRMP will be pre-loaded on to a laptop and used as stimulus throughout this part of the discussion)*

- How does it compare to other health information sites you've used
- How easy to use is it?
  - Do you understand the information being provided?
  - Which bits require clarification?
  - Overall, how easy do you think it is to navigate?
  - What do you think of the design/the look and feel?

*Look also at the search function – what do they make of it? How would they like to search for information?*

- Is this type of information useful to you? What might you use it for?
  - Can you see yourselves using this site in the future
- Could/should this site be providing any other information?

*Don't prompt initially, but then ask about:*

- *Reviews, doctor's specialities, recent training, nationality, gender, languages, former names*
- *Practice locations, opening hours, contact information, other staff details*
  - Would you only trust information displayed here if the information was collected by the GMC?
  - What about if it came from the NHS, Doctors or Government?
- How useful would this other information be?
  - How would you use it?
  - Where else could you find this information?
- Are there any types of information that the GMC should be particularly responsible for publishing online? If so, which and why?

### **Other services (10 mins)**

*Objective: understand how other services are being used – including social media and health apps. Also explore the link between online and offline health information*

- If they wanted to know about a doctor or hospital, who would you ask first?

*Friends, family, social media, online information?*

- Beyond specific health information sites, are there any other services you might use to look for this type of information?

*Prompt for social media, patient portals, forums, discussion sites*

- What type of information do you get from these sites?
- How useful is it?
- How much do you trust it? Do you seek verification elsewhere?
- How does using the internet to search for information about your local hospital, GP or doctor compare to other available services, such as phoning NHS direct or asking your local surgery/hospital?
  - Is one quicker/easier than the other?
  - Are there any other advantages to using the internet for health information (privacy, convenience, comparability etc)?

### **The ideal health information site (15mins)**

- *Objective: understand what patients/the public ideally want from a site providing information about doctors, their practice, where they work and doctor-related services. What would an ideal site look like to you? (write key words down on cards, and ask respondents to sort and prioritise)*
- Thinking about how you currently use the internet to search for information, what would be the ideal scenario?
  - Would all the information be in one place?
- Thinking about the services you currently use, what could be added to them to make them more useful
- Thinking about the LRMP, what could be added to improve this site?

**Thank respondents and close**