



General Medical Council

Exploring the experience of public and patient complainants who have been through the GMC's Fitness to Practise procedures

Research Report

July 2014

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1. Executive Summary

1.1 Introduction and Objectives

In 2011, the GMC highlighted a need to conduct research to better understand the experience of both doctors and complainants who have been through fitness to practise (FTP) procedures. An initial research project with doctors was completed in 2012/13. This report presents findings from subsequent research undertaken with complainants. The GMC defines three types of complainant: patients and the public; persons acting in a public capacity (PAPCs) and others. This study has focused solely on the experiences of patients and the public.

The research explored perceptions of experiences throughout the FTP process, as well as broader issues of communication and suggested improvements. The structure of the interview guide asked for feedback from complainants on the following aspects of the process (where relevant):

- How did complainants hear about the GMC?
- Who did they complain to first?
- Views on the ease of making a complaint.
- Whether they received any (advocacy) support.
- Tone of voice in GMC correspondence.
- Did individuals feel they were adequately informed of progress?
- Perceptions of the extent to which decisions are explained and supported by a rationale.
- The extent to which individuals felt supported throughout and after the process.

1.2 Methodology

The sample for this project was focused on complainants who were members of the public or patients and who had submitted and had a complaint taken through to investigation stage and then through to completion of the investigation between July 2012 and September 2013. Qualitative in depth telephone interviews were conducted in two phases. During both phases, complainants were first sent a letter by the GMC and given the opportunity to opt-in to the research by making contact with Community Research. Those who did so were re-contacted and an appointment for interview was made. The final achieved sample was as follows:

- Phase 1 -10 interviews
- Phase 2 - 34 interviews

The opt-in recruitment methodology means that it is not possible to provide profiling information about respondents. In total, 5 respondents reported that their case had resulted in a panel hearing and provided some feedback about this experience.

1.3 Overall Conclusions

Despite the fact that complainants were actively being asked, within this research, to concentrate and focus on possible process improvements there was a good deal of positive feedback about the GMC's process, including:

- The clarity of communications (other than with regard to the final outcome letter and supporting documents.)
- The initial speed with which the receipt of a complaint is acknowledged.
- The responsiveness and professionalism of Investigations Officers was widely praised, although there was some inconsistency.
- The hearings process being well organised and good support being offered at this stage.

Nevertheless, the research has highlighted a large number of issues that the GMC will need to consider. Key points are summarised below.

Submission of the complaint

Suggestions for improving the process for submitting complaints were as follows:

- Allowing complaints to be admissible when submitted verbally, or to have someone from the GMC (or from an independent advocate) to help complainants put their written complaint together.
- Making it clearer that complainants should submit any and all evidence at the outset.
- Making it clear and explicit that complainants may not be contacted again until the outcome of the investigation.

The investigation itself

Suggestions for improving the investigation element of the process were as follows:

- Speeding up the process.
- Allowing for more complainant dialogue and involvement within the investigation process, including:
 - Telephone calls or meetings to discuss and ask questions following initial evidence gathering.
 - Allowing complainants to provide a considered reaction to the doctor's response to the complaint and to the expert report.
- Greater transparency with more automatic sharing of full expert reports and doctors' responses to allegations.
- Provision of external, independent advocacy support, to help complainants navigate their way through the process more successfully.

Case Examiner decisions

Suggested improvements for the case examiner decision communication included:

- Improvements to the communications at this stage, including:
 - Making letters easier to understand, with less jargon.
 - Wording the letters more sensitively or sympathetically.
 - Including a summary of the key points contained in the annexes.
- Being warned that the decision is imminent in order to allow complainants to prepare themselves.
- Being told the outcome over the phone and being called proactively by the Investigation Officer at this stage to discuss the outcome.

Communication

Key improvements with regard to general communication were as follows:

- More communication from the GMC giving updates on the case, what is happening next and ideally what timescales are involved.
- More interactive communication. Phone calls are called for to ensure that the complainant is kept in the loop with the developments.
- Written communication having a more sympathetic tone and better reflecting the emotion and stress the complainant might be experiencing.

There was almost unanimous support for wider introduction of the current pilot meetings at the start of the investigation process. Many, though not all, also welcomed the idea of a further final meeting after the conclusion of the case.

Given the relatively small number of respondents taking part in this research who had experienced a panel hearing it is recommended that the GMC and the MPTS considers undertaking further, more targeted research to gain more feedback from complainants and witnesses about how such hearings might be improved.

2. Introduction, Objectives and Methodology

2.1 Introduction

In 2011, the GMC highlighted a need to conduct research to better understand the experience of both doctors and complainants who have been through fitness to practise (FTP) procedures. An initial research project with doctors was completed in 2012/13, with the final report being presented to the General Medical Council (GMC) in March 2013.

This report presents findings from subsequent research undertaken with complainants. The GMC defines three types of complainant: patients and the public; persons acting in a public capacity (PAPCs) and others. This study has focused solely on the experiences of patients and the public. This research will be used, alongside the research conducted with doctors, to help inform the development of potential changes to the FTP procedures. It is proposed that both elements of the research might be repeated periodically to track trends and identify areas for further improvement.

2.2 Objectives

The research explored perceptions of experiences throughout the FTP process, as well as broader issues of communication and suggested improvements. The structure of the interview guide asked for feedback from complainants on the following aspects of the process (where relevant):

- How did complainants hear about the GMC?
- Who did they complain to first?
- Views on the ease of making a complaint.
- Whether they received any (advocacy) support.
- Tone of voice in GMC correspondence.
- Did individuals feel they were adequately informed of progress?
- Perceptions of the extent to which decisions are explained and supported by a rationale.
- The extent to which individuals felt supported throughout and after the process.

2.3 Methodology

An iterative approach

The methodology for this project was iterative. At the outset, it was intended that an initial qualitative phase might be followed by a quantitative online survey, as had been the case in the research with doctors.

Learning from the initial phase of qualitative interviews, suggested that complainants found it very challenging to separate feedback about the GMC's process, from feedback about the details of their case. They required a good

deal of guidance and support. The response rate to this initial phase was in the region of 10%. In response to these two observations, it was decided that a quantitative survey would not be the right approach for the remainder of the project. This was for two main reasons – a tick box survey (even one that is well designed and allows room for open comments) was felt to be unlikely to ensure that complainants focus on process and differentiate this from feedback about their case. Secondly, the likely achievable sample size based on a 10% response rate was unlikely to result in a sample great enough to provide a robust quantitative result. It was, therefore, agreed to take a purely qualitative approach for the remainder of the project.

Sample selection, mailing and opt in process

The sample for this project was focused on complainants who were members of the public or patients and who had submitted and had a complaint taken through to investigation stage and then through to completion of the investigation between July 2012 and September 2013. These dates were selected, as representing a good compromise between ensuring that the complainants would have a reasonable memory of the events, whilst being sufficiently long ago for patients to have had time to reflect on the experience. Selecting cases within these dates resulted in total potential sample of 895 complainants.

A first phase sample of 101 cases was selected and sent an approach letter by the GMC. This initial sample comprised a stratified random sample of the available cases, stratified by case outcome categories to ensure that a mix of outcomes would be covered. The letter offered complainants the opportunity to 'opt in' to the research process by making direct contact with Community Research. From the responses to this first mailing, 10 interviews were conducted. However, only one of the respondents in this first tranche of interviews had been through a Fitness to Practise hearing. In addition, the majority of complainants included in this first phase had experienced a case where little or no action against the doctor had been taken.¹

Following this first stage a project plan was agreed to conduct between 15 and 25 further qualitative interviews in order to complete the project, but with a view to keeping this decision under review. It was felt to be important to try to focus the second stage interviews, if possible, on cases that had resulted in a hearing or where some form of action was taken against the doctor's registration so that the views of complainants with experience of such cases were adequately covered. In order to maximise the chances of conducting interviews with such complainants, the second stage mailing was conducted in two parts. The first

¹ Of course, cases resulting in a panel hearing are relatively few and the majority of cases the GMC investigates result in no further action against the doctor, so this result is not surprising. Ref. GMC's annual statistics - <http://www.gmc-uk.org/publications/23525.asp>

comprised all cases that had resulted in a panel hearing and/or 'positive' outcome from the complainant's point of view (i.e. some form of action being taken against the doctor.) Once interviews with this cohort had been exhausted, a subsequent mailing was conducted with the remainder of the available sample.

When 14 interviews had been completed in the second stage, further discussion was held between Community Research and the GMC about whether to continue interviewing further complainants. The decision was made to continue conducting further interviews for the following reasons:

- Whilst the feedback being gathered from interviewees was relatively consistent, and therefore new interviews were unlikely to uncover much further insight, the occasional new piece of learning was still being gained.
- Only one additional interview with someone whose case had gone to a panel hearing had been undertaken and it was, therefore, felt important to continue interviewing, in the hope that feedback from further such cases would be uncovered.

Qualitative interviewing

During both phases, complainants who made contact with Community Research, to express an interest in participating in the research were re-contacted and an appointment for interview was made. All interviews were conducted by one of two senior researchers. Interviews followed a semi-structured discussion guide, which was amended slightly between the two phases of interviews (both versions of the discussion guide may be found at Appendix 1.)

Since recruitment was undertaken on an opt-in basis the researchers were not able to cross reference information held by the GMC about the complainant or about their case.

All interviews were audio recorded and just over half of the interviews were fully transcribed. In the first phase, all 10 interviews were transcribed in full. As interviews progressed, during the second phase, the researchers made detailed notes of any new learning points. Interviews that raised significant new points of learning were selected for full transcription. All 5 interviews where the complainant had experienced a panel hearing were also fully transcribed. All interviews, whether transcribed or not, were included in the analysis process.

Final Sample Mix

The final achieved sample was as follows:

- Phase 1 -10 interviews
- Phase 2 - 34 interviews

The opt-in recruitment methodology means that it is not possible to provide profiling information about respondents. In total, 5 respondents reported that their case had resulted in a panel hearing and provided some feedback about this experience.

In the second phase of interviews, participants were asked to report the final outcome of their case. Outcomes as reported by participants cannot necessarily be relied upon as an absolutely accurate reflection of how the GMC may have recorded the case outcome. Nevertheless, the final sample did contain a range of reported outcomes, including cases where no further action was taken against the doctor; cases where advice was given; cases where warnings were given; a case where a doctor was suspended and cases where undertakings were applied. Only one of the cases appear to have resulted in a doctor being erased from the register, some other cases did result in the doctor no longer practising either because of voluntary erasure, the doctor leaving the country or taking early retirement. Whilst it is clearly impossible to judge whether the range of interviews comprises a representative sample of complainants, we are confident that a wide range of case outcomes has been covered.

A note about reading this report

Whilst complainants were asked to try to be objective and to feed back on the process itself rather than the details of their case, it should be recognised that, for many, the process and the case will have been a distressing experience and remain inextricably intertwined. Furthermore, the research focussed on suggestions for process improvement and as such actively asked complainants to be critical. It is unsurprising therefore that the research revealed many concerns about the process.

In addition it should be noted that the GMC has changed some aspects of their process and communication since the time that complainants included in this sample experienced the process. It is not possible to be certain of which versions of the GMC's communications individual complainants may have seen.

3. Expectations of the Process

3.1 Motivations

Complainants tended to mention one, or more, of three motivations when approaching the GMC to complain about a doctor:

- To seek some form of justice (for example, in relation to the death or injury of a family member).
- To gain answers to outstanding questions in relation to a medical incident or issue.
- To protect other patients.

Clearly, the GMC does not share all of these motivations and whilst some complainants did (or had come to) understand this fact, others remained dissatisfied based on an ongoing misunderstanding of the role and remit of the GMC. These misunderstandings did not necessarily arise because (objectively) the GMC's communications do not explain its remit, rather it appears that complainants do not necessarily absorb, retain or understand the reality of the GMC's position. Many complainants' initial expectations are never likely to be fulfilled by the GMC's process and it is therefore perhaps unsurprising that, for some complainants the process ultimately proves unsatisfactory.

"I feel there has been no justice for my son."

"These three things were the main questions I wanted answers to...and I felt that I didn't really get an answer to those points, and I still haven't got that now."

3.2 Barriers

Complainants did not make the decision to submit their complaint lightly. Firstly, this was because they anticipated that the process would be quite a significant undertaking for them, often including having to recall and recount experiences that had been emotionally distressing. A number of complainants identified that they had been in a delicate emotional or physical condition at the time of contacting the GMC and some complainants discussed deciding to wait a while before making a complaint until they felt better able (emotionally and/or physically) for the undertaking.

"When you make a complaint about anyone it's a hard thing to do, it's not an easy thing to do...I found it really hard because I was frightened."

"I waited a year because I was so wrapped up in pain and grief, so I left it a whole year."

Secondly, complainants often commented that they felt that making a complaint against a doctor was an extremely serious step. They understood that it would have an impact on the doctor and their career. However, when asked if they had hesitated before making the complaint, most said that they had not. They had felt strongly that it was something that they wanted to do, or something that needed to be done (e.g. for future patient safety).

"I had no hesitancy about reporting him at all because he was telling lies about people."

Some complainants had decided independently to make the complaint to the GMC, however many had been encouraged by others, including friends and family as well as other health professionals. Receiving encouragement from medical or other health professionals seemed particularly impactful – there was a sense that if other doctors (or nurses) think that the doctor in question has done wrong, then their case is strong.

"I'm not sure I would have done it without him {a friend who was a doctor}. I thought about it and I thought perhaps I'm making too much fuss but he assured me that, no, this was worth going on with..... I would not have known really where to go or where to start."

3.3 Expectations

Most expected the GMC to be an independent, fair and impartial organisation at the outset.

"So I think we probably went to the GMC with hope and a certain expectation that we were dealing with a very independent professional body who would objectively look at all the evidence."

For some, however, this view shifted as a result of the process and outcome of the investigation.²

"But I did honestly believe that the GMC would be impartial and would do the right thing, and they haven't....but the problem is you don't know that at the time, its only really when you get to the end of the process that you become fully aware that actually they did nothing."

A minority of complainants said that, even at the outset they had thought that the GMC might not be impartial, but rather tended to side with doctors (a perception they reported having taken from the media or from others they had spoken to). Despite this, they had decided to make a complaint to the GMC as

² See Section 5.3.2 with regard to the perception of GMC bias amongst some complainants, at the end of the process.

they felt their case to be sufficiently strong to overcome this perceived imbalance.

In terms of the process, complainants were frequently unsure what would happen and how long it would take, prior to submitting their complaint. The common assumption was that their involvement in the process would consist of:

- Form filling or writing an initial letter about the complaint.
- Sending in documentation and further evidence.
- Answering questions (most assumed this would be undertaken verbally and after the doctor has responded to the complaint and additional evidence might have been gathered.)

"What I expected was for me to make a complaint and then to have an answer, to speak to somebody maybe on the phone or face to face and then for it to be followed up."

"I thought there would be an opportunity to have a face to face meeting, I didn't realise that wouldn't happen."

At the outset, most expected that the complaints process would take some considerable time. They commented that the GMC may have to gather information from a number of sources, which might take time and there was a general sense that such a bureaucratic process, involving the NHS, would not be expeditious. However, even those who expected that the investigation would take a relatively long period of time were still often surprised by the actual length of time the process took.

"I knew it would take months rather than weeks."

"I thought it would take about 6 months. I didn't expect it to take longer."

"There was an awful lot to investigate and it was a doctor's reputation, they obviously had to be very, very careful."

A few complainants mentioned looking at the GMC website for an indication of what the process might entail. They said that they found the website a useful source of information at that time.

"I remember looking up the procedure and everything on the Internet so I knew how in a way it was going to be done. So that was helpful."

A number of complainants expected, from the outset, that their case would go to a formal hearing. Some assumed that this happened in all cases that were

investigated, or they thought that their case was sufficiently serious (e.g. involving a death) to automatically warrant a hearing.

4. Feedback on the Process

4.1 Before approaching the GMC

4.1.1 Previous and parallel actions

Some of the participants in this research had made complaints to other bodies, before they approached the GMC and some did so concurrently. Other bodies included GP practices, NHS Hospitals and Trusts, the Health Service Ombudsman as well as linked cases to other health professions regulators. One or two respondents had also previously or concurrently taken legal action against the doctor who was the subject of their complaint. One complainant's case had also been investigated by the Health and Safety Executive. Some of these complainants had decided to approach the GMC because they were unhappy with the outcome of their prior avenues of complaint. In some cases they were advised (for example by a lawyer) to take the case to the GMC, alongside the action they were already taking, as doing so might improve the chances of a positive judicial outcome.

Where separate or parallel investigations did take place there was some evidence that this caused frustration and confusion, particularly where the ongoing investigations of one body led the GMC to delay their investigations, or vice versa. One complainant had assumed that he didn't need to complain to multiple sources, because he thought that they would work together and the relevant regulatory bodies would be contacted and involved as and when necessary.

"They were all separate investigations and one would not act if the other one was acting, it was just really frustrating."

"That also caused a lot of confusion because the Health Authority tried to tell me I couldn't complain to them and the GMC at the same time, which was wrong, but I was advised to go through them in the first instance which made the whole thing very drawn out and it ended up taking nearly three years."

"I assumed that when we put complaints in at the xxxx hospital it would automatically be dealt with, it would go through and be dealt with by a higher body, an overseeing body, but this didn't happen so it was down to us."

In addition, there was a feeling that the various investigating bodies should share information, in order to minimise the burden placed on complainants.

"It went from the PCT to the Ombudsman and then they had to start and do their investigation, which took two years or more, and then it got

passed to the GMC and they had to start all over again. It was all taking too much time, people were at risk."

Conversely, a benefit of having made a prior complaint, for example, to a PCT was that much of the material and evidence had already been collated and therefore submitting the complaint to the GMC was a less time-consuming task.

4.1.2 Awareness of the GMC and what prompted complaints

Many complainants had known of the GMC prior to making a complaint, but levels of knowledge and understanding varied considerably. A number of participants were health professionals themselves who knew the GMC as the regulatory body for doctors and so felt confident that the GMC was the appropriate route for their complaint. Those who had made previous or parallel complaints to other bodies, such as Trusts or GP surgeries, were sometimes signposted to the GMC by these bodies as a potential next stage, if unsatisfied.

Others had heard of the GMC, perhaps in the press, and knew only a little about them, but perhaps not enough to be immediately confident that the GMC was the correct route for their complaint.

"I did a search on them because I had heard of them before but I was unclear exactly what they did. I knew they had some involvement in regulation of doctors so I searched them and found the complaints procedure on their website."

A few had not heard of the GMC themselves and had found out who to make their complaint to via a recommendation or through their own research.

"I asked around a little bit but there happened to be a visitor in the hospital when my wife was in the ward, she heard me talking and she said 'I know where the right place to write is' and she told me. It was, in fact, a place in Manchester."

"I didn't really know that you could complain to the GMC to be honest. There was nothing in the doctor's surgery to say 'if you have a problem.' It didn't say anything about GMC or taking it further."

In summary, complainants had been prompted to approach the GMC in a number of ways:

- Recommendations by others, frequently health professionals (and often family or friends.)
- Signposting by other complaint routes (e.g. following complaining to an NHS body some were told that they could approach the GMC as a next step.)

- Signposting by other professionals, including solicitors, Patient Advice and Liaison Services, Independent Complaints Advocacy Service.
- Their own research online.

“My friend used to be a nurse, her husband is Chief Medical Officer and she made me. Well, she didn’t make me but she suggested to me that I should complain to the GMC about it.”

“During this time (of complaining to the hospital)... we went online and you can search for doctors and their records, and we found out this particular doctor was on a five year warning,it was open to the public, luckily we found that so then I thought I would write to the GMC about this doctor.”

One complainant felt that her expectations had been raised inappropriately by the GMC. When she made the initial phone call she was really unsure about whether or not to progress the complaint, but the person on the phone said it was potentially a very serious complaint and the doctor could get ‘struck off’. It was because of this that she pursued the complaint (at significant cost and upheaval). Ultimately, the case examiners decided in the doctor’s favour and she felt that this possibility should have been flagged more clearly at the start.

4.2 Submitting the complaint

4.2.1 Ease of submission

Most complainants said that they found the process of submitting their complaint relatively straightforward.

“It was pretty self-explanatory. I think there were a couple of things I looked up on what I needed to do and I was able then, through that, to send them all my paperwork.”

Most had completed a form, although some had written a letter. Some had completed a form after submission of an initial letter. A number of complainants had phoned the GMC initially to make the complaint and had then been asked to complete a form. Most accepted this, but a few did comment that it had taken them considerable courage to phone the GMC and that then being asked to complete a generic form was disappointing.

“My understanding is, the only reason you would contact the GMC is to make a complaint, and just to get someone to take your name and your address and ‘we will send you out a complaints form’, a generic complaints form which in itself is sort of telling you from the very onset how you’re being dealt with.”

"I had to fill a form in. And that, if I think about it, was quite quick after they received my letter, which was quite lengthy as you can imagine. No, I have no faults at all."

Views about ease of submission were connected with how able complainants felt to express themselves in writing. A number of complainants commented that in their job/professional capacities they often had to write expansive letters or reports and so felt comfortable writing up their complaint. A few commented that having made complaints to other bodies, they had gone through the process of writing up and summarising their complaint previously, which made submitting their complaint to the GMC easier.

"I found it okay but I'm used to paperwork and doing things like that, through my job I do report writing and things like that."

"It's not difficult for me because that's the sort of work that I do, I work in an office and I've got a background but I think somebody else might have found it a lot more difficult than I did. I'm used to writing letters, do you know what I mean?"

However for some, the process of trying to express and summarise, in writing, what they often saw as complex issues was more difficult. The difficulty was often compounded by their emotional or physical state at the time of making the complaint. Even those who found the process of writing up their complaint relatively straight forward, often commented that they were concerned that others might not find it so (particularly those less experienced at writing letters).

"I feel sorry for people who have had things worse than us, anything that's gone wrong, if they haven't got time like I had and letter writing abilities and computers and stuff, they'd just fall by the wayside. We feel quite guilty how we managed to pin them down but we certainly had to work at it, but if we hadn't got these things at hand I couldn't have done it. And it would be even more daunting for someone."

"It was very emotional writing it and I'm quite articulate and I'm thinking there are people with genuine complaints against doctors who wouldn't have been able to cope with the paperwork."

"If I hadn't have been a nurse I probably wouldn't have known what the process was or how to get there, how to start the ball rolling."

Some received help in developing their submission from family or friends and a couple had received more formal help (from ICAS and from a solicitor).

"I'd contacted ICAS at the time, they helped me with my complaint... They gave me tips and things what I should do, how I should go about it. So that obviously helped me."

Most also commented that they found the process of submitting supplementary documentation straightforward. However a couple of complainants commented that the amount of photocopying required and the subsequent recorded delivery postage was difficult and costly (with one request for reimbursement by the GMC).

"He asked for all the paperwork, I think that was at my own cost actually. That was a bit miffing, that I had to send all the paperwork over at my own cost."

4.2.2 Receiving acknowledgement

Complainants tended to be very positive about this part of the process. They often spontaneously commented that the initial response to their complaint had been very quick and the letter clear. They had been impressed by the responsiveness of the GMC and it gave them high expectations for the rest of the process.

"They must have thought there was a case for what I had actually written and very quickly they wanted more information and that they would take my case up."

"When I submitted my complaint that was absolutely fine. I received an email and I think a phone call from a gentleman saying that they'd received it, I think it was a letter as well."

4.2.3 Suggested improvements – submitting the complaint

Some found the process of submitting their complaint in writing very onerous, costly and time-consuming. There were suggestions for complaints to be admissible when submitted verbally, or to have someone from the GMC (or from an independent advocate) to help complainants put their written complaint together.

"I do think that maybe I should have had somebody help me in the respect that I could have worded it better. How I worded it, it didn't come across too good. It helps sometimes if you have the right words to make it sound a bit more... to get your point across."

A number of complainants commented that it should be made clearer that they should submit any and all evidence at the outset and that the initial submission

might be their one and only chance to put their argument across. A few complainants explicitly stated that they had not submitted all possible supporting evidence with their initial complaint. This was for one of two reasons, either:

- Because they did not recognise the relevance of the additional evidence they held (and only recognised this once they had seen the doctor's response or the expert report by which time it was too late to make further submissions) or;
- Because they had assumed that they would be much more involved in the investigation, for example through dialogue or questioning following the doctor's response and during which time they would have the opportunity to put forward their supplementary evidence.

"I wrote to them and said 'you didn't look at the evidence....you haven't even asked me for the evidence'."

As will be explored further in Section 4.3, not being questioned or asked to feed in to the investigation process was a significant cause of dissatisfaction for many complainants. The GMC making it clear and explicit that complainants may not be contacted again until the outcome of the investigation (and explaining why this is the case) might help manage this dissatisfaction and ensure that complainants do submit all the evidence they hold at the outset.

4.3 The investigation process

4.3.1 Initial communications and expectations

Most were satisfied with the initial communication from the GMC confirming that their complaint would be subject to an investigation. Complainants frequently remembered the letter outlining the name and contact details of their Investigation Officer. They welcomed having a named point of contact and someone who they could speak to if and when they had any questions or concerns.

"You're given a person's name who you can always ring if you have queries which, whenever I did ring, absolutely brilliant, no problems at all, very courteous, and professional actually."

"When the guy did respond he was very helpful and he did put everything that he'd said in writing. And then I had a contact name to speak to, he was the one that rang and said we are going to investigate this further."

However, not all complainants recalled having this information in their letter and they were subsequently much less satisfied as a result.

A number of complainants did recall, and were very positive about, the factsheet that the GMC sends at this time. Some also mentioned the Investigation Officer explaining the process to them directly (either within the letter or in subsequent communication). Complainants were particularly satisfied when they had had this personal explanation.

"It was quite long, I think it was about three sides of A4 and it described quite fully and very clearly and very well the outcomes there might be as a result of an inquiry of the complaint. Yes, it was very simple to understand, it wasn't all wrapped up in medical jargon."

There was widespread satisfaction at the speed of this communication, in the main, and generally at this point of the process complainants were both hopeful and expectant. For most at this stage, the GMC had represented themselves as professional and responsive, giving strong hope for a positive and timely resolution of their case.

Those complainants who had to give consent to access to their medical records were also satisfied with how this process was handled, with no concerns being raised about this part of the process. All such complainants reported that they understood why this was necessary and were happy with how the GMC handled this request.

"I think I got fairly prompt attention to start with, initially, they wrote and asked me this and that. First of all, like you say, things like permission to see my wife's medical records and the likes. All that was done fairly straightforward, I don't have any complaints there."

4.3.2 The Investigation Officer

Satisfaction levels with regard to the investigation process seemed to depend, in part, on the complainant's perceptions of their Investigating Officer, both at the point of initial communication and throughout the course of the investigation process. Those who were more satisfied with the investigation frequently reported that their Investigating Officer adequately explained to them:

- *What would happen during the investigation:* including what their involvement might be, for example the ability for the complainant to see and respond to the doctors' response.
- *How long it might take:* including why things take time (such as obtaining hospital records.)
- *What the GMC can do and what it can't do:* for example the GMC can't answer specific questions relating to their case.

As well as clearly setting expectations about the process, Investigation Officers were frequently praised for being responsive, polite and sympathetic (to a point,

whilst maintaining a professionally impartial stance). There was mention of Investigation Officers being very helpful once contacted, responding quickly and effectively to questions or concerns raised by complainants, including answering questions about what was going on with their case at that time.

"He was an easy guy to talk to ... a nice bloke doing a difficult job, so he came across to me very well."

"The person that it went to initially, the Investigation Officer, was very good at keeping in touch and letting us know, and I could ring her at any point and ask her what was happening."

"I phoned up after a few months and said 'can you tell me what's happening, has anything been resolved yet?' and they replied... they were very good at replying... and they said 'we're very sorry, but not all our investigations have been carried out yet, but we will let you know as soon as we can what has happened'."

"I was very impressed by the Investigation Officer because I had phoned him on a couple of occasions and he was very helpful, he did his best and if he said he was going to contact me, he would and then he would put it in writing. That always happened. I felt he was very good at his job."

"He phoned, or I phoned him to explain something and he would say if you need any additional information just phone me. I couldn't fault him, I thought he was very efficient."

However, although there were very many examples of good experiences with Investigation Officers, there were also some examples of poorer experiences. There were a few mentions of complainants not knowing who their Investigation Officer was at the outset and not having a named point of contact at the GMC.

There were also mentions of complainants not being able to reach their Investigation Officer (complainants trying to contact, but not hearing back, or hearing back from someone else at the GMC) and dealing with multiple people at the GMC.

"I had this contact, this name, and this telephone number who I could contact with anything but, after that initial one, when I phoned up I never got to speak to that person again, it was just somebody telling me that it was all in hand and that he would email me or whatever, but he never did."

There were also mentions of Investigation Officer sickness causing delays, without the case being taken over by someone else, or Investigation Officers leaving the GMC without complainants being notified of the name of the person now handling their case (and having to chase the GMC before they could find out who was their new point of contact).

"I do remember thinking that the actual investigation officers that deal with the complaint changed constantly. There were lots of different members of staff actually dealing with it, so the point of contact were constantly changing which made communication quite difficult."

"It actually sat on somebody's desk....about 6-10 weeks... and apparently a member of staff was off sick and it was just sat, in a heap of files on somebody's desk, nobody'd looked at it or done anything with it."

4.3.3 The investigation process

Many complainants expressed considerable dissatisfaction with the investigation process, which centred around four main themes: time taken; insufficient complainant involvement; perceived inadequacy of the investigation and perceived lack of transparency. Each of these themes will be examined in turn below.

- **Time taken**

The most mentioned cause of dissatisfaction was the much longer than expected length of time taken from start to finish. Whilst there was some understanding of the fact that investigations do take time, complainants were generally not prepared for just how long their case would take to resolve.

"I imagined it would be quite quick, I was shocked to find that... it seemed to be years. I don't know, perhaps I hadn't really thought about the time, but it did go on an awful lot."

"It (time taken) came as a surprise because I don't think they ever said in a letter 'this will take some time' or anything like that. They just said they would investigate and they would let me know when it had been resolved. But I don't think they ever said this could take months, because I think then I wouldn't have been surprised that it did take so long."

The protracted time scale was reported to be a considerable cause of stress for complainants, who were anxiously awaiting an outcome. Some complainants were waiting for the GMC's outcome before launching further action against the doctor (e.g. legal action), which might carry time limitations and so they needed a more timely resolution from the GMC.

"I began to think perhaps I'll never hear, they've lost me somewhere. I suppose I do wish I had known why it had taken so long because, heavens above, it was a long time for the doctor as well, not knowing what was going to happen."

Some complainants felt that they had to remember the details of their case whilst the investigation was ongoing and so it remained at the forefront of their minds. They reported being unable to 'move on' from their experience whilst the investigation was ongoing and thus, the longer the investigation took the harder it became, on an emotional level.

"The length of time it all took made it difficult. Because you are living and going over what actually happened constantly. You are having to recall it and keep it at the front of your mind."

"Also, for us, because it took so long we had to hold as many details about what happened on that day as we could, because we knew we were going to have to give evidence, we could never let go of it, we had to keep it as fresh as we could."

There was mention that the longer the investigation, the weaker the complainant's case became as memories of events became more obscured.

"I think that the big thing really that probably helped the doctor concerned avoid the proper penalties for what he did, was the sheer length of time that elapsed between the incident and the hearing, and in that time there were sufficient opportunities for very minor details that one may recollect being ever so slightly wrong."

Complainants tended not to understand why the investigation took as long as it did. Concerns about length of time were compounded by lack of communication both in terms of a lack of direct explanation about delays, and a general quietness from the GMC, which caused complainants to assume that nothing at all was happening with their case. This had ultimately led some complainants to believe that the GMC must be under-resourced.

"We were just left high and dry for months."

"I just got the impression that they were a little bit under resourced."

"They did write to me in the meantime and said 'we're very sorry it's taking a long time but we want to investigate it,' and I wondered if anyone else had complained as well and that's why it was taking a long time."

- **Insufficient complainant involvement**

Another key cause of dissatisfaction with the investigation process was the perceived lack of complainant involvement in the investigation. There was a general expectation that, at a minimum, complainants would be asked questions once evidence (such as the doctor's response) is collected to try and explain any inconsistencies in the different parties' perspectives. Many complainants expected that when an expert was appointed to review the case, this expert would naturally get in touch with them to hear 'their side of the story' and ask questions to get to the bottom of the case. Some had the expectation that medical experts called to advise upon the case and/or the medical case examiner would even conduct a physical examination of the complainant (where this was perceived to be relevant.)

"How do you know what the patient is saying is true, unless they physically examine you?"

The lack of further questioning of the complainant produced the impression, for a number of complainants, that the investigation was cursory and superficial and did not adequately or thoroughly interrogate the evidence. Complainants had an expectation that the investigation would work along similar lines to a criminal investigation where all relevant witnesses might be called and questioned in detail, prior to a decision being made about the veracity of the evidence presented.

"They never asked for anything else – literally what you put on that form and send off, that it was they're basing the complaint on."

"They failed to investigate....They never came back to me to ask me a single question."

Some complainants wanted to, or had been told that they could, respond to the doctor's response to their initial complaint. Those that did so had really welcomed this opportunity. A few complainants were particularly disappointed that they had not had this opportunity, since the doctor had decided not to respond to the complaint at all. This situation both confused and angered complainants, whose expectation tended to be that a doctor would be compelled to respond when a complaint is made about them.

"She wouldn't take part in it, she said 'I'm not doing it,' and they let her get away with it...she just sat and said 'no comment' to everything. She should be held accountable by somebody."

- **Perceived inadequacy of investigation**

As outlined above, some complainants were dissatisfied that relevant medical experts or the medical case examiner had not contacted them and consequently this led to a perception that their case had not been thoroughly investigated.

Furthermore, some complainants expressed dissatisfaction about the content of the investigation conducted by the medical expert. They had drawn this conclusion either from extracts of the report (appended as part of the outcome letter) or when they had requested and seen the full report. Some complainants even felt, when reading the expert report (or extracts thereof), that the expert had not properly grasped the basis of their complaint. A couple of complainants also commented that the expert's investigation had little or nothing to do with their complaint and they did not understand why this was the case.

"I was dissatisfied with the way they conducted the investigation, with the importance they'd placed on the medical records and the way they didn't take into account what I was complaining about."

"It (the annex) didn't address the issues that I had. I didn't feel that my case was taken into account."

There was mention by one or two complainants that the expert appointed was inappropriate (i.e. from a different discipline or background from the doctor being complained about).

Other concerns about the experts stemmed from the quality of the written medical expert's report (or excerpts of the report) with some mentions of poor writing, typos, grammatical errors and a mention of an error in the name of the patient concerned in the investigation. These errors, when seen, had a significant impact on the complainant's perception of the adequacy of the investigation; causing them to question the quality of the expert used and thus the quality of the investigation conducted.

"It was littered with spelling and grammatical mistakes. They called my husband a doctor when he wasn't."

"It makes nonsense reading. Stupid spelling. Very badly written."

"There's spelling mistakes, grammar mistakes just those sorts of things are bad enough. On the front of the report there was a reference to someone else's report...I queried that with the Investigating Officer and she said 'that just would have come from someone else's report' and I was like 'what? do you think that's all right?'"

There was considerable concern from complainants whose investigations drew heavily from hospital or doctors' notes. There was a perception that notes alone (even if they contained gaps, inconsistencies or had been falsified) were not properly interrogated by the GMC; but instead were taken at face value, and held as more important than the evidence of the complainant. A couple of complainants commented that, if they had known what was contained in the notes, they could have submitted additional evidence to counter some of the points therein, but they were not given an opportunity to do so.

"I've now had the opportunity to view the expert report... he's clearly based his opinion on the information available to him in my Mum's hospital medical notes, without taking notice of the facts and concerns raised in my complaint. It's clear from reading his report that much of what actually happened to Mum was not recorded in her medical notes, or even worse, in some instances has been mis-recorded giving an inaccurate record of what happened."

One complainant pointed to the fact that the initial complaint form asks – 'did anyone else see or hear the things you're complaining about?' This, in the complainant's view, raised the expectation that other witnesses listed on the form would be approached and interviewed. This had not happened, according to the complainant, and was seen as a clear indication that the investigation was superficial and cursory.

"You kind of think they're going to use that information, but they didn't."

Those complainants who started with the expectation that there would be a hearing tended to be extremely aggrieved that this did not happen. Some said that they wanted to face the doctor and contest their case. Others said that a hearing would have been a much more thorough form of investigation, with cross examination and full interrogation of the doctor's version of events.

- **Perceived lack of transparency**

There was a sense amongst some complainants that the GMC was not sufficiently transparent during the investigation process, which fed into a perception amongst some that the GMC was not impartial in its investigation, but was rather trying to protect the doctor under investigation. This view tended to be based upon:

- Complainants not being kept informed about what was happening during the investigation.
- There being, in the complainant's view, little or no proactive communication from the GMC.
- The GMC not automatically sharing the doctor's responses or the expert's report.

A couple of complainants had requested the expert report and had been denied access to it. One complainant had only gained access to the expert report after submitting a Freedom of Information request to the GMC.

"I was also told at the beginning that once the doctor was told that I had made a complaint against her, that any response she had that they would let me have, and I never heard anything about that."

"And they all talk about transparency, that seems to be one of the key words at the moment, but there's no transparency none at all."

"I wrote back to them for the expert report and I had to do an FOI request – that was just nonsense, they knew I wanted it."

Some complainants commented that the GMC did share information when asked, but complainants had to 'know to ask'. If they didn't ask they simply wouldn't get access to much information that might be highly pertinent to their case. Complainants perceived that they were not routinely told what information they were entitled to receive, or how they might feed further information into the investigation process.

"I was never advised by any of the Medical Council people that I could get a copy of his notes, which I certainly could and did. I only found that out because I'd got connections that helped me to find out."

"I remember she did tell me that when the case was finished and the doctor did receive a warning on his record that I would be able to ask for the paperwork under the Freedom of Information Act, and I was told who to contact and when I contacted them, I think I

had to do it in writing, and I got a letter back to the effect that they couldn't release it."

"I wanted the main report. I am still waiting because the GMC have a policy. Their policy is that the person's main report can only be released by that person. But X is dead and I can't see the main report."

It should be noted that some complainants praised their Investigation Officer for proactively giving them the full range of relevant information related to their case. However, there appears to be some inconsistency of practice within the GMC on this point, since not all complainants reported that this had been the case.

4.3.4 Support

Participants were asked if the GMC mentioned or discussed support available to them from other sources, such as Victim Support. Many had no recollection of being offered any external support (despite the fact that standard letters from the GMC to point out this service) and many such complainants also said that this is something that they would have welcomed, if it had been offered.

Some complainants did recall and had been surprised by the mention of Victim Support; saying that this service didn't seem relevant to them because they did not perceive themselves as 'a victim', or because they assumed that Victim Support provided support for victims of crime, rather than people who may have a complaint about a doctor. A number of complainants also reported feeling that what was offered was a counselling service, which was not what they needed and they would have preferred access to advocacy support.

"I wasn't writing to them as a victim, I was writing to them about this particular doctor. So they kind of turned me into a victim really which I wasn't very impressed with."

One complainant had noted the e-mail address of the support service as ending with '@gmc-org.uk' and therefore questioned whether the support provided was genuinely independent of the GMC.

Many complainants, in fact, spontaneously mentioned a need for external support, in the form of some kind of external and independent advocate. There was a requirement for help in navigating the complaints process; someone who is firmly "on their side." Some commented that the doctor received professional external help (e.g. from their Unions or their solicitor) and that the complainant was at a disadvantage for not having a professional adviser, with a knowledge of the GMC's systems and processes, to advise them.

"It would just be nice to feel that you have got a person to talk to, you have this one person who is your person. The guy that I spoke to within the GMC was from the Investigations Unit but obviously he works for the GMC, it would have been nice to have another point of contact to mull things over with."

"Somebody a bit more independent who's going to listen to you saying 'I'm thinking about moving forward with this', somebody who's just going to listen to you."

Such complainants suggested the need for a number of different types of support, including:

- Assistance with making the initial complaint, including helping to draft letters. Whilst some were confident in conveying the complexities of their complaint in writing, some did feel less confident and wondered if there was a more effective way of putting across their complaint. With the benefit of hindsight complainants wondered whether they might have profited from the help of someone who could put together the complaint in the most appropriate (and effective) manner. Such an advocate could also help to ensure that they put forward all of the necessary evidence.
- Supporting them in any interaction with the GMC: including any meetings.
- Keeping them updated: including finding out the details of what was happening with their investigation; advising as to whether the timescales are reasonable and (if appropriate) pushing for a speedier resolution by the GMC.

One complainant mentioned that as a result of complaining about their Investigation Officer, they had received an alternative contact for support (provided by Witness Support). This complainant said that this individual had made a big difference to her and was extremely helpful in terms of proactively keeping her up to date with progress on her case and thereby helping to ease anxiety. This complainant felt strongly that this service should be routinely available to all complainants.

"About a year went by and a very nice lady from the GMC help service called and asked me how I was getting on. She contacted the GMC on my behalf. That lady rang me every month and talked to me. Asked me how I was getting on."

Another interviewee had taken her complaint to the Health Service Ombudsman with the help of support from ICAS. Because of this ICAS had also provided

support during the GMC investigation and this complainant felt that the provision of this independent advocacy service had been invaluable.

“We responded with the help of ICAS, who were very, very helpful to us.”

4.3.5 Suggested improvements – the investigation

The most common suggestion for improving the investigation process was to speed up the process. Most complainants appreciated that investigations have to take a certain length of time, because of the inevitable processes involved with collecting information. However many complainants still held the opinion that there must be a way to shorten the time taken.

Another common suggestion for improvement was more complainant dialogue and involvement within the investigation process, including:

- Telephone calls or meetings to discuss and ask questions following initial evidence gathering.
- Allowing complainants to provide a considered reaction to the doctor’s response to the complaint and to the expert report.

There were frequent complainant calls for greater transparency with more automatic sharing of full expert reports and doctors’ responses to allegations.

There were also requests (outlined above) for external, independent advocacy support, to help complainants navigate their way through the process more successfully.

4.4 Interim Orders Panels and doctors’ suspensions

The discussion guide did not specifically ask about Interim Orders Panels (IOPs)³, since this is not an aspect of the process with which complainants are usually concerned. However, IOPs were proactively raised by two complainants who had serious concerns about the doctor’s continued practice whilst the investigation was ongoing, particularly with investigations taking a considerable time to conclude. These complainants expressed extreme dissatisfaction at their exclusion from the IOP process. In both these cases the initial motivation for the complainant in bringing the complaint before the GMC was to protect other patients and to prevent the doctor from repeating their behaviour or actions.

³ At any stage of the process, a doctor may be referred to an IOP hearing. This panel does not make findings of fact, but rather considers the potential risk to patient safety of a doctor remaining in practice while the GMC investigates. It has the power to suspend or restrict a doctor from practising temporarily while the investigation continues if the panel decide this is necessary to protect patients.

Having no ability to submit evidence to the IOP and having no opportunity to attend or gain feedback from the IOP hearing caused a good deal of distress to these complainants.

"Like the Interim Orders Panel, I did write and say 'I really disagree with your decision on this' but I didn't have any sway. I couldn't do anything about it."

"When it went before the Interim Orders Panel, we weren't allowed to know why they hadn't done anything with it."

"We were getting more and more desperate, because this GP was still working."

4.5 Case examiner decisions and outcomes

There was a mixed response to the communication relating to the case examiner decision which depended partly on whether or not participants were satisfied with the outcome; those unhappy with the outcome of their case tended to be more dissatisfied with communication, including the clarity of the decision and the rationale. Those who were satisfied with the outcome were, perhaps unsurprisingly, less concerned about the clarity and rationale.

"It said everything it needed to say but I think the whole crux of it was, I didn't really agree with the outcome."

Some complainants were surprised when they received the letter; they had not had communication with the GMC for some time and felt unprepared for this communication. A few said that they had expected some communication with the GMC to prepare them for the fact that their investigation was nearly complete.

"When the letter turned I was really scared to open it when I saw the GMC postmark. So maybe, I don't know, a hint in advance or an email that it was reaching the conclusion."

"At the time I got the letter because I hadn't really had good communications, I wasn't expecting the final letter like that, I was expecting the opportunity, because I knew about London, if there was a Hearing sort of thing. I honestly expected to go somewhere to be able to have my say so that's why I was quite annoyed with it."

4.5.1 Clarity of decision and the rationale for the outcome

When participants were asked if the outcome of the investigation was clearly explained, responses were mixed. Of all the communications sent by the GMC, this was the most frequently criticised in the interviews.

A common area of dissatisfaction included the perceived use of jargon (legal and / or medical in nature). A number of complainants said that their final outcome letter was not written in plain English. Or, if the letter itself were easy to understand, the annexes to the letter, including excerpts from the medical expert's report, were difficult to understand.

"It said 'the realistic prospect is not met' – I don't even know what the realistic prospect test is."

Some complainants, furthermore, felt that the letter was not worded sensitively and was too short and/ or curt.

"They're a little bit brusque, they say what they've got to say and no more. It didn't particularly bother me until that last one. Particularly with that last letter, it wasn't worded very nicely at all. Not that I was waiting for sympathy but you expect a bit of empathy really."

"I felt it was quite short and very formal, and I remember sitting with it in shock in a way. That's that, there's nothing I can do now."

"Well, they've kind of shut the door, or slammed it in my face is how I felt, the way they've decided to 'conclude the case with no further action, if you'd like to talk to somebody about how you feel'. It was a bit brusque really, a bit in your face I felt."

In addition to concerns about jargon, other common grievances with the annexes included:

- **The use of excerpts:** this was reported by some as being confusing with some excerpts seeming to conflict with one another. Using excerpts from the report, out of context, made the communication difficult to understand.
- **Poor writing:** including reports of typos, grammatical errors and even errors in the names of the individuals / places involved (these seem to have been found in expert's reports and / or supporting documents rather than in the GMC's letters, although given that respondents did not have documents in front of them it is difficult to always be certain where such errors were reportedly seen).⁴
- **Too long:** some complainants reported finding it challenging to pull out the parts most relevant to them (they would have appreciated a summary within the covering letter.)

⁴ See also 4.3.3

- **Not complete:** some complainants simply objected to being sent excerpts, rather than the full report.

A number of complainants commented that the mention in the decision letter of there being no right to appeal the decision was surprising to them. This complete closure, with no further avenues of redress, coupled with a sense that the letter was short or curt, compounded a feeling amongst some complainants that their views had not been valued in the process and they were left feeling dismissed.

"To be honest, I read the letter and I ripped it up. Because I was quite angry, I felt like I'd been disbelieved."

One complainant had made a request to see the parallel outcome letter that had been sent to the doctor in their case. On receiving and reading this letter the complainant found that it contained the phrase *'we do understand that this type of investigation can be stressful.'* This caused considerable anger, since the GMC had not said anything similarly sympathetic in the complainant's version of the letter.

4.5.2 Contact with the GMC after the case examiner decision

A few complainants mentioned contacting the GMC after receiving the case examiner decision. Some noted that the letter did mention that they could be in touch if they had any questions or concerns. Complainant experiences differed here. Some commented that the GMC contact was helpful in explaining the letter and clarifying points of confusion. However, since they could not change the outcome, some reported that they simply felt more frustrated.

A few of the complainants commented that as a result of their communication after the case examiner decision the case was 're-opened' for further investigation. They may have, for example, commented on something mentioned in the expert report and pointed to further evidence to refute the point made. Complainants in this position felt that if they had had a chance to be more involved in the investigation, for example to see and respond to evidence such as the doctor's response or the expert's report, they would have raised the issues at that point and avoided the need for further investigation at this late stage. These participants felt that their experience pointed to a key flaw in the current investigation process (see also section 4.3.3).

4.5.3 Suggested improvements

Suggested improvements for the case examiner decision communication included:

- Making letters easier to understand, with less jargon.
- Wording the letters more sensitively or sympathetically.
- Including a summary of the key points contained in the annexes.

Complainants who considered the expert report poorly written made broader suggestions about the quality of the expert used.

During the interview it was explained that the GMC is running a pilot project where complainants are invited for a meeting at the end of the investigation to explain the reasons for the GMC decision and to answer the complainant's questions about the outcome. Many were positive about the idea of a meeting at the end of the process, and indeed some suggested this as an improvement to the process they experienced.

There was also mention of wanting an opportunity to speak to their Investigation Officer. Some had expected to be told the outcome over the phone (or at least to have been told that a decision was imminent in order to prepare them) and some had called their Investigation Officer to discuss the outcome once received. There was suggestion that this communication should be more proactive, rather than the complainant initiating contact.

4.6 Fitness to Practise Panel hearings

Only five of the complainants interviewed had experienced a Fitness to Practise Panel hearing. Complainants who participated in hearings were realistic that their experience was unlikely to be anything other than difficult. Much of the feedback about the hearing process was positive and complainants did say that a good deal was done to prepare them for the hearing session; support them and keep them informed during the experience.

"I think the hearing was organised extremely well, it was very, very good in terms of organisation and the skill levels and experience they had on the panel."

"We were treated very well, they were very kind to us, very respectful."

Key points of further feedback from the interviewees can be summarised as follows:

- One complainant raised the point that they had not had (and were not permitted to have) sight of the full written allegations against the doctor prior to the hearing. This was felt to be a major flaw since, on seeing the allegations, the complainant could immediately see that they contained factual errors. This undermined the case against the doctor and could easily have been avoided if the complainant had been allowed to see the full written allegations prior to the hearing.
- The process was perceived, by all who experienced it, to be overly formal and legalistic, which was alienating and very uncomfortable.
- Having the doctor present when giving evidence was particularly stressful and intimidating.

"I don't really understand why the doctor had to be present in the room because our version of events had already been put into a statement..... I didn't really understand what the benefit was of having us all in the room together was, and I found it very intimidating, not just because the doctor was there but that his team were there."

- One complainant expressed concerns over the order in which evidence was heard – the doctor's expert had time to listen to the complainant's expert witness and then had time to prepare to refute the evidence, but not vice versa.
- Complainants did not feel prepared for the perceived aggressive nature of the barrister's cross examination or, in one case, the line of questioning that the doctor's barrister might follow.

"I certainly didn't feel briefed as to what the line of questioning would be because the questioning wasn't all in the direction I expected it to be."

- After giving evidence, one complainant felt they were not kept sufficiently informed of progress, only hearing the result through a subsequent letter.
- One complainant felt that the layout in the hearing room could be improved in order to make the experience less intimidating.

"The layout of the room, I think, for me was one of the things I think they could probably improve upon, you don't need such a big room, bring the panel a bit nearer, get rid of the microphone and try and put the so-called public gallery not sat behind and quite close to the witnesses."

- A final but important point was raised by one complainant with regard to the toilet facilities at the hearing venue:

"The toilets at the GMC, the light's on a timer and I, for reasons, have to spend longer in there than I used to and I had a bit of a panic attack just before the hearing because I was in there and the lights went off. It's only a little tiny thing but basically the people that go to these hearings are not always going to be tip top health wise. That's a small thing that maybe they could do something about?"

Some of the above aspects of the hearing process are required by law (e.g. it is a doctor's legal right to be present whilst evidence is being given by a complainant.)

Whilst this limits the possibilities for acting on the feedback provided in terms of changing the hearings themselves, the GMC and the Medical Practitioner Tribunal Service may wish to consider whether, where this is the case, the reasons for hearings being run in the way that they are, might be more effectively communicated to complainants and witnesses.

5. Feedback on Communication and Overall Experience

5.1 Feedback on communication

Views on communication during the process did vary, with some more satisfied than others. Those who were more satisfied, included those with shorter investigations, or who felt positive about the responsiveness of the Investigating Officer. Some complainants were happier with a letter driven process than others.

Complainants were largely positive about the written communication received (with the exception of the outcome letter which attracted considerable criticism from some). Letters were generally felt to be clear and the tone appropriate.

"The letters are set out well, they may have taken a little bit of time to carry out the investigation but they did write at the appropriate times in the case and the letters are very well set out as well. You've got phone numbers there, contacts, dates, everything there. So the letters are easy to refer to in that respect."

"Some official letters can be very much to the point and quite cold but theirs weren't. I really did feel if I wanted to ring up and talk to somebody that would be fine."

However, whilst many were happy with the communication, when received, there was a common complaint about insufficient proactive communication. This included concerns about long periods of no communication from the GMC to the complainant during the investigation.

"It just sort of went silent."

Some participants in the research only remembered receiving two letters from the GMC throughout – an initial letter saying that they were going to investigate and a letter at the end of the investigation with the outcome. There were also participants who said that very long periods of time (up to 6 months in some cases) went by without them receiving any communication from the GMC about what was happening with their case

Commonly raised issues around communication included:

- **Little or no proactive communication:** although the GMC may be good at responding when the complainant gets in touch, the GMC were frequently criticised for not periodically contacting complainants on a proactive basis to give them updates. Participants may have received one letter during the investigation to reassure them that their investigation is still ongoing, but they wanted more frequent

communication and even a little more detail about what was actually happening with the investigation at that point.

"I think you need to be told what's going on during the process and not just be presented with a fait accompli..... That's not good enough, you're involved in it."

- **Too much reliance on letters:** many complainants found this approach difficult. They wanted to talk to someone either in person, in order that they might feel better understood and be reassured that the investigation is progressing and is sufficiently thorough. This reliance on the written word led complainants to view the process as too bureaucratic.

"It was a bit faceless, a bit blank. The way that you fill the thing in, you thought do they understand what I'm saying and how passionate I feel about what's going on. All I've got is like 76 letters or something left to write what I feel."

"They should be more open...it's a crusty old system with a lot of protocol,.. it needs to be a lot more customer focussed, a lot more down to earth...listen to people instead of all this letter writing."

- **Unsympathetic tone:** the GMC's communications were sometimes seen as overly formal and matter of fact. This was particularly the case in relation to the final outcome letters. Some complainants wanted the GMC's communications to demonstrate greater empathy for their situation, particularly at an emotionally difficult time.

"It wasn't very caring, I didn't think really."

"They never even said 'condolences' or anything, even though my daughter had died."

"It's like they didn't really seem to care. It was a really hard time, it put a lot of stress on me and it had been going on for over a year."

"I expected them to keep in touch with me a bit because of the bereavement I'd had and everything, I thought they would have been that little bit more supportive in the fact that I had to make the complaint, or felt I had to make the complaint, but I didn't feel that."

5.1.1 Suggested improvements

Complainants want **more communication** from the GMC. Some said that they think the GMC should be in touch every month to two, or every six to eight weeks, giving an update on the case, what is happening next and ideally what timescales are involved.

Complaints suggest **more interactive** communication. Phone calls are called for to ensure that the complainant is kept in the loop with the developments. Speaking to somebody can help ease the anxiety that complainants can feel about the process and the outcome. Some participants who were positive about the idea of pilot meetings mentioned this idea here, as a suggested improvement in communication.

Complainants suggest that written communication should have a **more sympathetic tone** and better reflect the emotion and stress the complainant might be experiencing.

5.2 Views about meetings pilots

During the interviews, participants were read a description of the current pilot exercise being run by the GMC where meetings with complainants are taking place (in London and Manchester). This includes both an early stage meeting (to ensure that the GMC has fully understood the complaint) and a meeting at the end of the investigation to explain the reasons for the decision and to answer any complainant questions about the outcome. Interviewees were asked whether they believed such meetings might have been helpful in their own case.

5.2.1 Early-stage meeting to discuss the complaint

Nearly all complainants said that a meeting at this stage of the process would have been helpful and that they would have welcomed it.

Many had spontaneously expressed their disappointment at not having had the opportunity to discuss their case with the GMC and not having had the chance to elaborate, or ensure that the GMC had understood the basis of their complaint.

This was particularly raised by those who felt less confident in their written submission. Complainants also assumed that in such a meeting they would be able to answer questions and point the GMC to any further relevant evidence. They further perceived that this could provide an opportunity to physically hand over any required documentation and that this, coupled with them directing the GMC to other relevant information, might have both speeded up and improved the effectiveness of the investigation process.

“I think the difference between writing things down and actually talking to someone about it face to face, the latter I think the other person can

understand. There might have been things that I didn't put in, that I might have said."

"That's what we wanted.... Sitting down and speaking to someone, you can fully understand."

"Because, in a letter you can miss so much."

There was also a feeling, from some, that they wanted to be able to express themselves and their concerns orally because this would be helpful for them personally. Some complainants felt that the GMC would have taken their complaint more seriously if the full impact of the doctor's alleged actions on the complainant could have been explained in person. This, in turn, in the belief of some complainants, would ultimately have resulted in more stringent action being taken against the doctor.

"It would have given me an opportunity to discuss and to ensure that I was getting over to them what my concerns were. Because I felt at the end of the process they had quite ignored the issues that I'd raised about the doctor and they'd supported him really rather than listening to what I'd got to say."

"Having a meeting with somebody to actually discuss the complaint would have helped a great deal."

Some wanted this meeting to be face to face; they wanted to meet the person reviewing their case and thought that a face to face meeting would work best to ensure that they were fully understood. However, some said they would have been equally happy with a telephone conversation. They might not want to travel, for example, or they might be concerned at the formality of a face to face meeting. Some complainants did ask whether a complainant would be able to bring someone along to support them, to a meeting of this kind.

"You are dealing with people ... about something that is extremely traumatic."

5.2.2 Meeting to discuss the outcome

The idea of a meeting at the end of the process received a more mixed response. Some welcomed the idea and would have both requested and attended this meeting, if they had been given the opportunity. Some complainants felt that they did not fully understand the reasons for the investigation outcome, or that they didn't understand what the outcome meant in practice.

"I would have loved that, in fact I would still love it now."

Others would have liked a meeting as they understood the outcome rationale, but were nevertheless unhappy with the reasons given and wanted the chance to argue their own perspective. Some perceived this meeting as a chance to change the final decision because they were unhappy with it. Others felt that a meeting at this point, when the decision has already been made, would be too late if they could no longer influence the outcome.

"I think I would have taken it (the meeting to discuss the outcome) actually because I think I would have been arguing my case. I think I would have been saying that's all good and well but this is how we feel, I would have felt that would have been more of a conclusion rather than just sort of saying this is our outcome and the case is now closed."

5.3 Overall experience

5.3.1 Single most important thing to improve

Participants were asked, towards the end of the interview, and thinking about their whole experience, what single thing would improve the process for other people complaining to the GMC in the future.

Consistently, the most frequent suggestions related to:

- Speeding up the process.
- More complainant involvement, greater dialogue and opportunities to discuss the complaint.
- More complainant support.

These points have all been covered in some detail at 4.3.3 and 4.3.4.

5.3.2 Other general comments

Cynicism and perceived bias

Some complainants (although by no means all) had been left cynical about the complaints process and the GMC as an organisation. A number of complainants expressed the perception that the GMC is an organisation who would "protect their own" and that doctors had the advantage of professional representation and knew how to "work the system." Some had thought that the GMC was biased in favour of doctors from the outset, but still hoped that they might have a successful outcome in their own case. Others had started the process optimistic of a fair, impartial investigation, but in their experience had led them to change their mind about this.

"I mean, here I am, the layman, and here they are with legal teams and professionals and insurance companies, they're all on the other side, aren't they?"

"I do feel sort of they have the backing of their Union, a lay person isn't potentially going to be able to... I mean, her response was probably what the Medical Union had said, you say this and this covers you. So as a lay person responding back to that, it was quite difficult."

"I'm being a bit cynical but it's very easy for a Medical Union to say we've had experience of this before and this is how you should approach it."

The parts of the process that were perceived to reinforce such perceptions were:

- A perceived lack of 'forensic' investigation: there was a feeling that some of the doctors' evidence is insufficiently scrutinised and, since complainants were often not asked to comment or counter doctors' arguments, the investigation was considered flawed and biased towards the professional.
- A lack of communication: long periods of time with no communication led some complainants simply to assume that nothing was really happening with their case and that enquiries into the true facts were not being assiduously pursued.
- Reliance on written submissions: this conveyed a sense of bureaucracy and paper shuffling making the investigation seem, to some, like a 'tick box' exercise rather than a thorough investigation.

These perceptions appear also to have been partially reinforced by the media, with some spontaneous mentions of high profile cases in which the GMC has reportedly failed to act against doctors who have harmed patients.

Misunderstanding of the GMC's role and the meaning of outcomes

For a number of complainants there was simple disbelief at the outcome of their case. As far as they were concerned there was no question or doubt that the doctor had done wrong and his or her fitness to practise was questionable. This disappointment in part stems from a lack of understanding of the GMC's role, remit and motivation in investigating complaints against doctors.

There was widespread lack of understanding of the GMC's actions and what they mean: participants had difficulty understanding why if the GMC say that a doctor's actions have fallen 'below standard', this may not warrant some form of 'punishment'. Several complainants did not understand the phrase 'not sufficiently below' standards, their perception was that being below standard at all must be unacceptable. In addition some complainants did not fully understand the impact on the doctor of the GMC's final actions (e.g. what goes on their record? Or; what limits are placed on their ability to practise in the future?)

One complainant could not understand the point of writing to a doctor's 'employers' about the advice the doctor has been given by the GMC, when the doctor was essentially self-employed within in a GP practice.

"The advice gets sent to his employer and, considering he is his own employer, it means absolutely nothing....they might as well have written 'don't get caught'."

Frustration that complaints can only relate to one doctor

Some complainants raised frustration at the fact that the GMC refuses to investigate multiple doctors in the same case. One complainant felt that the basis of the decisions made on the various doctors that she complained about were conflicting (junior doctors were 'let off' because they had insufficient experience, and the senior doctors were 'let off' because they had delegated to people they thought had sufficient experience). She thought that if the case had not been treated as numerous separate complaints, each with its own case examiners, but rather as one complaint with the same examiner, the outcome would have been consistent.

One complainant was frustrated that her complaint could not be heard about a whole GP practice. The complainant felt that the entire system at the practice had failed and that no one individual doctor was necessarily at fault on their own, the complainant argued that patients rarely see one single GP all the time nowadays and that there should be a simpler way for a case to be raised about more than one doctor.

"He saw more than one GP at the surgery, but you have to make specific complaints against one GP and, to be honest, I didn't have the energy."

Time frame for accepting complaints

A couple of participants mentioned that, due to slow recovery from procedures, their decision to make a complaint nearly fell short of the time frame permissible to make a complaint (taken from the procedure date). It was felt that because the outcome (or lack of outcome) from certain procedures can take some considerable time to show, the current timescales allowed to launch a complaint are not always appropriate and should be longer.

"There's a five years complaints procedure and they take that from the date of the operation.....there was some question mark initially as they' would investigate ...I don't think patients on the day of the surgery or for several month after would necessarily think there was something wrong. It seems very unfair using a fixed date rather than when the patient became aware of how wrong it is."

6. Conclusions and Recommendations

Despite the fact that complainants were actively being asked, within this research, to concentrate and focus on possible process improvements there was a good deal of positive feedback about the GMC's process, including:

- The clarity of communications (other than with regard to the final outcome letter and supporting documents.)
- The initial speed with which the receipt of a complaint is acknowledged.
- The responsiveness and professionalism of Investigations Officers was widely praised, although there was some inconsistency.
- The hearings process being well organised and good support being offered at this stage.

Nevertheless, the research has highlighted a large number of issues that the GMC will need to consider. Key points are summarised below.

Submission of the complaint

Suggestions for improving the process for submitting complaints were as follows:

- Allowing complaints to be admissible when submitted verbally, or to have someone from the GMC (or from an independent advocate) to help complainants put their written complaint together.
- Making it clearer that complainants should submit any and all evidence at the outset.
- Making it clear and explicit that complainants may not be contacted again until the outcome of the investigation.

The investigation itself

Suggestions for improving the investigation element of the process were as follows:

- Speeding up the process.
- Allowing for more complainant dialogue and involvement within the investigation process, including:
 - Telephone calls or meetings to discuss and ask questions following initial evidence gathering.
 - Allowing complainants to provide a considered reaction to the doctor's response to the complaint and to the expert report.
- Greater transparency with more automatic sharing of full expert reports and doctors' responses to allegations.
- Provision of external, independent advocacy support, to help complainants navigate their way through the process more successfully.

Case Examiner decisions

Suggested improvements for the case examiner decision communication included:

- Improvements to the communications at this stage, including:
 - Making letters easier to understand, with less jargon.
 - Wording the letters more sensitively or sympathetically.
 - Including a summary of the key points contained in the annexes.
- Being warned that the decision is imminent in order to allow complainants to prepare themselves.
- Being told the outcome over the phone and being called proactively by the Investigation Officer at this stage to discuss the outcome.

Communication

Key improvements with regard to general communication were as follows:

- More communication from the GMC giving updates on the case, what is happening next and ideally what timescales are involved.
- More interactive communication. Phone calls are called for to ensure that the complainant is kept in the loop with the developments.
- Written communication having a more sympathetic tone and better reflecting the emotion and stress the complainant might be experiencing.

There was almost unanimous support for wider introduction of the current pilot meetings at the start of the investigation process. Many, though not all, also welcomed the idea of a further final meeting after the conclusion of the case.

Given the relatively small number of respondents taking part in this research who had experienced a panel hearing it is recommended that the GMC and the MPTS considers undertaking further, more targeted research to gain more feedback from complainants and witnesses about how such hearings might be improved.

Appendix 1 - Research Instruments



Stage 1 interview
discussion guide FINA



Stage 2 interview
discussion guide FINA