

The standards expected of doctors

Patient & public attitudes



Final report

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Disclaimer

This research does not necessarily reflect the views of the GMC or GMC staff.

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1 Summary

1.1 Key findings – The standards expected of doctors

- Participants' initial reactions to the standards expected of doctors related mainly to doctors' professional abilities and the quality of the medical advice, treatment or care they provide to patients. While it was acknowledged that doctors have distinct professional responsibilities, they were considered to be *'only human'* and as such that there was no expectation that they would live their personal lives in a way particularly differently from that of the general public. In effect, there was recognition from participants that being a doctor is an important professional role but not the only identity an individual who is a doctor may have. However, as is explored below there was also an implicit expectation that doctors would live relatively 'normal' or 'good' lives alongside this.
- Doctors were expected to maintain a clear distinction between their private life and professional conduct whereby they did not allow their personal lives or beliefs to impinge upon their medical practice whatever may be occurring within it. A doctor's private life was of little concern to the participants, providing private activities did not affect a doctor's professional judgement or behaviour. However patients also implicitly assume doctors to be of good character in both their professional and personal life.
- All the discussions highlighted that having trust in doctors is important, and was a recurring issue raised by participants across the different aspects of doctors' behaviour explored. Maintaining the trust of patients underpinned the expectations the participants had in doctors. Though trust in doctors largely related to their professional conduct, probity of a doctor more generally across both their private and professional lives was also assumed. For example, behaviour outside of work such as serious criminal behaviour was considered to impinge on patients trust in doctors.
- Doctors were expected to act in patients' best interests. To ensure a professional and consistent level of care is provided to all patients, medical decisions were expected to be free from doctors' personal beliefs. Because patients expect doctors to remain objective, participants felt that personal beliefs (including

religious and moral beliefs) should be excluded from medical practice. A doctor *having* personal beliefs was not viewed as problematic, but *disclosing* personal beliefs to patients was considered unprofessional. There was a feeling that doctors should not pass judgment upon their patients and by disclosing their personal beliefs, they may be seen to be doing so.

- Patients want unrestricted access to care. It was felt that access to treatment should not be restricted in any way due to doctors' personal beliefs, though it was felt to be fair that access to care may be restricted or denied when patients behave inappropriately (e.g. are threatening or violent).
- This indicated that patients are viewed as active agents within the doctor-patient partnership – being responsible for seeking out and making the most appropriate treatment choices for their personal circumstances. Patients who may be considered vulnerable or lacking capacity were viewed as having less clear agency however and therefore requiring higher levels of safeguarding from potential (intentional or unintentional) exploitation.
- Patients expect information they provide to a doctor to be held in confidence. Confidentiality was noted as being integral to the doctor-patient partnership by participants and doctors are expected not to disclose information about their patients unless absolutely necessary (e.g. a safeguarding risk).
- “Soft skills” such as being friendly, listening and having a good attitude were viewed as positive attributes for doctors, which also helped to develop trust and confidence in individual doctors. Though these “soft skills” were not expected from all doctors all the time, they were felt to be desirable and to provide reassurance that doctors are professional and interested in patients, which in turn underpinned the quality of care and the ability to make an accurate assessment of patient need. Participants made allowances for doctors having different personalities and ‘*off days*’, however a doctor consistently displaying a poor attitude was considered unprofessional and would lower trust in that particular doctor.
- As the regulator of doctors, the GMC was viewed as having an important role to play in setting guidelines for doctors. There was a feeling that clear guidance would help doctors fulfil their role appropriately as doctors need to know what is expected of them in order to behave accordingly and operate well. For example, guidelines on when doctors should advocate for patients were suggested to assist

doctors make complex decisions around the issues of safeguarding patients versus maintaining confidentiality.

- Participants also acknowledged, in the context of a diverse population in the UK, that doctors may treat patients with different beliefs, lifestyles or characteristics from them. Therefore clear guidelines around the standards expected of doctors, such as those set out by the GMC in *General Medical Practice*, would assist to ensure a consistent level of care from doctors and expectations from patients.

2 Overview

2.1 Introduction

The General Medical Council (GMC), which is responsible for the registration and licensing of all doctors in the UK and for ensuring standards in the profession, first published *Good Medical Practice (GMP)* in 1995 as part of a move towards improving self-regulation. *GMP* is the GMC's core guidance to the medical profession and sets out the standards of conduct and care which both society and the profession expect of all doctors. It applies to all doctors in the UK, regardless of their grade, speciality or area of work. The latest edition of *GMP* was published in 2006.

GMP covers a very wide range of issues, including matters of clinical competence and standards relating to more personal and interpersonal skills and attributes, like probity, communication and doctor-patient relationships. Existing research with both doctors and the public¹ suggests high levels of support for standards relating to clinical and professional competence. However, some of the duties relating to more personal and interpersonal skills and qualities have attracted a more mixed response. For example, in their survey of doctors, McManus et al (2000 and 2001) found that while few (<10%) disagreed with restricting doctors' registration on grounds of avoiding abuse of position, being trustworthy, respecting confidentiality, recognising limits of competence and keeping skills up to date, a moderate number (>25%) disagreed on the basis of keeping patients fully informed, giving patients information in ways they understood, and treating all patients politely and considerately. More specifically, research with doctors and the public to inform the last revision to *GMP* in 2006 (Chisholm et. al., 2006) found differences of opinion among both doctors and the public in relation to issues including: the requirement for doctors to demonstrate probity in their personal as well as their professional lives; the right to refuse to treat on grounds of conscience; sexual relationships between doctors and (former) patients; and the ways in which any tensions between the duty to 'make the care of the patient your first concern' and other duties relating to good use of resources ought to be resolved in practice.

The most recent edition of *GMP*, issued in 2006, states that the guidance is addressed to doctors, but is also 'intended to let the public know what they can expect from doctors'. As discussed above, *GMP* aims to set out the standards 'society' expects from their doctors. It is therefore essential that it is informed by a clear understanding of what expectations society actually has of doctors. These expectations are unlikely to be fixed and may be influenced by broader social, moral and cultural shifts. With this in mind, the GMC commissioned NatCen Social Research to conduct qualitative research with members of

¹ E.g. McManus, I.C., Gordon, D., Winder, B.C. (2000) 'Duties of a doctor: UK doctors and Good Medical Practice' in *Quality in Health Care* 2000: 9 (14-22); McManus, I.C., Winder, B., Gordon, D. (2001) 'UK doctors attitudes to the General Medical Council's performance procedures 1997-99', *Medical Education*, 35 (suppl.), 60-69; Chisholm, A., Cairncross, L., Askham, J. (2006) *Setting standards: the views of members of the public and doctors on the standards of care and practice they expect of doctors*, Picker Institute; Peters, J., McManus, I.C., Hutchinson, A. (2001) 'Good Medical Practice: comparing the views of doctors and the general population', *Medical Education* 35 (suppl. 1), 52-9.

the public on the standards expected of doctors. Alongside a range of other consultation and information gathering processes, this will assist to inform a revised issue of *GMP*, planned for the end of 2012.

2.2 Research aims

The aim of the research is to explore public perceptions of the conduct of doctors, with particular emphasis on exploring the impact of the following issues on public trust in doctors and their ability to practice:

- Doctors' personal beliefs
- Professional boundaries
- Conflict of interest
- Access to care
- Doctors as advocates
- Doctors' lives outside medicine

2.3 Sample

A total of eleven focus groups and five in-depth interviews were conducted for the research. Fieldwork was carried out in rural and urban areas of England, Northern Ireland, Scotland and Wales. The research aimed to include harder to reach groups of people – those who may be less likely to engage in the wider consultation with the public being carried out by the GMC. The populations of interest included in this research were:

- Older people, including those living in sheltered housing,
- People from Black and minority ethnic (BME) groups,
- Gypsy and Traveller communities,
- Asylum seekers and refugees,
- Patients from deprived socio-economic groups, with a focus on people of no fixed abode/people who are homeless, and people who are economically inactive
- Younger people (16-25 years).

The sample was selected purposively in order to ensure that diversity of views and experiences among the population of interest were captured. As this was the case, it is important to point out that the views of the participants were not intended to necessarily be representative of the general population. Five one-to-one interviews were also conducted with non English speakers from the Asian and Polish community who would otherwise have been unable to engage in the research.

Table 1 shows the demographic characteristics of the participants who took part in the research.

Table 1: Key participant demographics and other information

Demographic information	Number
Gender	
Male	40
Female	49
Age group*	
16-20	12
21-25	9
26-45	25
46-65	21
66-70	7
71+	12
Ethnic group*	
White British	52
White Irish	4
Gypsy and Traveller	6
Other white background	3
Mixed – White and Asian	1
African	4
Indian	3
Pakistani	3
Other Asian background	1
Caribbean	4
Other	3
Frequency visit doctor*	
Regularly (5 or more visits in the last year)	35
Occasionally (2-4 visit in the last year)	34
Rarely (1 or no visits in the last year)	19
Disability*	
Self reported disability or long term condition	24
Marital status*	
Single	49
Married	32
Widowed	7
Parent status*	
No children	35
Children living at home	27
Children who have left home	18

*some information not disclosed.

2.4 Methods

A qualitative scenario based approach was adopted to discuss the issues outlined in the research aims. This involved presenting fictional scenarios to participants relating to the issues pertinent to the research, such those focussing on how doctors should respond to violent patients; or doctors having relationships with patients. Each scenario was then explored in-depth with the groups, with additional facets of the scenario added during the discussion. The scenarios can be found in Appendix A. A key strength of the scenario based approach is that it enables discussion of otherwise abstract principles and helps

reveal the underlying reasoning behind people's reactions to these principles. Another strength comes from enabling the presentation of the same scenario across groups, which allows comparisons between different views. However, as noted, the research included a diverse sample with many different views represented across different groups of participants. They will have brought their own personal experiences or expectations of doctors to bear on these considerations of the scenarios. Another challenge of the scenario based approach is extrapolating up from the particular scenario to the wider issue examined as part of it.

Each focus group and interview discussed two to three scenarios in detail providing a good amount of coverage of each of the issues across the sample. In addition to the scenarios, moderators also used a topic guide throughout the discussions which can also be found in appendix B. Each of the six key areas of interest for the research was covered in each group, with two to three being the focus of detailed scenario based discussions. Which scenario was used was rotated at each group to ensure the scenarios were covered by different groups, in different constituent countries of the UK, and a consistent number of times. In keeping with qualitative approaches to research the aim was to map out and explore a range of views among participants, rather than provide findings relating to how prevalent a view may be.

2.5 Recruitment

Recruitment for the focus groups and interviews was carried out using two methods - through specialist recruitment agencies and through gatekeeper organisations such as community organisations and charities. Specialist recruitment agencies were used to recruit participants for two older people groups, two younger people groups, an economically inactive group and a group of BME people. Gatekeeper organisations were used to recruit people for two homeless people groups, a refugee and asylum seeker group, a group of people from the Gypsy and Traveller community, a group of older people living in residential care and five interviews with Asian language speakers and Polish language speakers.

Key participant characteristics such as gender, age and regularity of contact with a doctor were carefully monitored throughout the recruitment process to ensure that a broad range of participants and experiences were included in the groups.

All groups and interviews took place in a location which was convenient for the participants. For groups recruited through gatekeeper organisations, the location was recommended by the organisation to ensure that it would be convenient and comfortable for participants taking part.

2.6 Ethical considerations

Ethical approval for the research was sought from NatCen's Research Ethics Committee and granted prior to the start of fieldwork. Informed consent was obtained from all participants who took part in the research. Information was provided to participants prior to recruitment (in the form of an information leaflet) and prior to the groups (via the

moderator) and it was made clear to respondents that they could withdraw from the research at any time. Focus groups and interviews were audio recorded so that an accurate record of the discussions was made; permission to audio record the groups was obtained prior to the group discussion. Some focus groups were also video recorded for which separate consent was obtained.

All participants were given £25 as a token of thanks for sparing their time to take part in the research and cover costs they may have incurred by taking part.

2.7 Analysis

A thematic approach to analysing the data was adopted for this research, facilitated by Framework in NVivo 9 software for qualitative data analysis. This involved developing an analytical framework following familiarisation of the focus group and interview transcripts. Each transcript was then coded against the analytical framework to allow for the systematic comparison of themes between groups. This approach helped to reduce the large volumes of data obtained and to facilitate systematic between case (looking at what different people said on the same issue) and within case (looking at how a person or group's opinions on one topic relate to their views on another) investigation of the data.

Through reviewing the coded data the full range of attitudes and behaviour described by participants was systematically mapped, and the accounts of different participants, or groups of participants, was compared and contrasted. The use of Nvivo software ensured that analysis was fully documented and conclusions could be clearly linked back to the original source data.

As noted earlier, the different populations included in this study, whilst sharing some characteristics, resulted in very varied group composition. Therefore the level of analysis possible for the research was at a relatively high level. Due to the diversity of participants and their experiences within groups it was not possible to drill down to deeper levels of analysis, for example, in terms of similarities within one particular ethnic minority group or geographical area.

2.8 Structure of report

The report is separated broadly into seven key sections. The first of these looks broadly at the participants attitudes to the conduct of doctors and draws information from all six of the key issues discussed as part of the focus group scenarios. This is then followed by a more detailed consideration of each of they key themes explored using the scenarios in section 4, 5, 6, 7, 8 and 9.

3 Attitudes towards the conduct of doctors

3.1 Introduction

In this opening section broad implications arising from the research are outlined. As has been found in previous research to inform *GMP* (Chisholm et al, 2006) it was once again found that participants hold mixed views with regards to the conduct they expect of doctors. However there also appeared to be a generally pragmatic attitude towards the expected conduct of doctors. Participants repeatedly noted that doctors are '*only human*' and, while it was acknowledged that doctors have distinct *professional* responsibilities in relation to the medical care or advice they provide, there was little expectation that doctors should behave in a manner greatly different from that of the general public in their *private* lives. There were however some implicit assumptions participants had of doctors generally, which underpinned a belief that doctors would generally have a reasonable level of personal probity.

3.2 Expectations of doctors

Participant expectations of doctors mainly focused on their professional ability and the treatment provided to patients. Although the 'ideal' patient/doctor relationship was described as one characterised by the doctor being polite and informative, the onus was on quality of treatment and access to care. Participants did not expect doctors to advise them on personal or pastoral matters; they also noted that doctors could not be expected to all have similar personalities – in effect, that some doctors may be more friendly or personable to patients than others, but that in itself was not necessarily felt to be problematic provided comparable medical care or advice was received by the patient.

One personal attribute that participants did expect of doctors however was that of '*listening*' to patients. They expected doctors to try to understand their health needs or problems by being able to communicate with them. For example refugee or asylum seeker participants spoke of how difficult it could be for them to communicate with a doctor and access the appropriate treatment if a translator was not also available and the doctor did not take time to listen to them or communicate effectively with them. The onus was felt to lie with the doctor to ensure that on a professional level they could communicate with patients, so they were to be able to provide adequate medical treatment, care or advice.

There was some sympathy that doctors work with finite resources, and as a result may become overworked or stressed at times. However there was an expectation that doctors provide a consistent level of treatment to all patients, and even if they are under stress this should not affect their professional judgement.

Doctors' conduct in their personal lives was felt to be of little importance to participants, provided this did not affect their standard of professional conduct, and the treatment they provided to patients.

Doctors engaging in criminal behaviours, in particular serious crimes such as assault were one of the few areas where participants felt a doctor's private conduct overlapped sufficiently with their professional status as a doctor to impinge on the trust a patient may have in them. This included incidents outside of a doctor's workplace that may have had little direct impact on the quality of medical care they provided.

So although providing good quality medical care and professionalism at work were viewed as the explicit standards expected of doctors, a relatively '*good character*' was also implicitly assumed.

3.3 Patient care: Quality and access

As noted in the previous section, a key finding to emerge from the research was that above all else, good quality medical treatment is expected from doctors. Through each theme discussed with participants, at the very basic level and across the groups, the key role of doctors was described as providing the medical treatment or advice needed by the patient. Participants were less concerned with other aspects of doctors' conduct, provided patient care was of a high quality.

However the quality of patient care was felt to potentially be affected by certain aspects of a doctor's personal conduct - either directly by doctors being unprofessional (e.g. refusing to discuss treatment options such as abortion due to their personal beliefs) or indirectly, by a patient's trust in a doctor being undermined (e.g. a doctor passing judgement on the patient or being rude and abrupt with patients).

As is explored in section 7 however, within this, it was also acknowledged that patients also have a responsibility to behave in a suitable manner in order to assist the doctor in providing care. What could be considered 'tipping points' where doctors' responsibility to provide good quality treatment or care to patients may be altered, was explored in a scenario discussing aggressive patients. Participants tended to support doctors refusing to treat violent or threatening patients, or if they required emergency treatment supported the patient being sedated or restrained by other staff as a means to ensure they still received treatment. Therefore patients were also viewed as having a level of conduct they should maintain, with threatening or violent behaviour from patients seen to be unacceptable:

F: I don't think doctors should be abused because they're not meant to be abused, and get hurt and spat on and God knows what. I mean they're there to do a job.

(Female, homeless people group)

M: It depends how serious the person's illness is. Because if it's non-essential then maybe, if they're violent then they've blown their chance of that treatment.

(Male, young people group)

Although doctors were not expected to accept the behaviour of abusive and aggressive patients, participants felt that a refusal to treat patients completely with no further support or information provided to them would be *'unethical'*. Communication was again viewed as important in such situations – though was not necessarily an expectation of individual doctors but perhaps from the surgery or hospital more broadly - whether it be information about possible waiting times to ease patient frustrations, or communicating warnings and consequences of inappropriate patient behaviour.

3.4 Expected professional conduct

Across all the issues explored in the research the foremost concern regarding doctors' conduct was that they behave in a professional manner and provide good quality medical treatment, care and advice. Given the onus on this expected level of professionalism from doctors, doctors were also felt to have a responsibility to leave their personal life *'outside of the door'* when they were at work, and not allow it to interfere with the medical care, treatment or advice they provide. They were expected to maintain professional boundaries (as explored in section 6).

Participants felt that professional conduct involved doctors providing medical advice free from personal opinion. Participants therefore felt that it was unacceptable if a doctor *'passed judgement'* or provided advice on personal matters to patients. The following quote illustrates this point:

M: It's like we said before if you've got any problems, including religion, leave them at the door before you start work.

M: Exactly.

F: I just think that if you go to a doctor, you're expecting medicine [not advice]...
(Male and female, homeless people group)

Unprofessional conduct at work that affected the quality of patient care, such as making mistakes and prescribing the wrong medication, would obviously lower patient trust in doctors. However instances where a doctor's personal conduct spills over into their professional conduct were also typically considered unprofessional. Poor appearance of doctors for example, looking hungover or smelling alcohol on a doctor's breath were considered unacceptable, and would lower confidence in the doctor's ability to provide good patient care.

Maintaining confidentiality was viewed as another key component of professional conduct. The only exception to breaching confidentiality, as discussed in section 8 is where a patient has disclosed they are a risk to themselves or others or there is a safeguarding risk. Communicating or signposting to more relevant bodies was seen as a professional approach to advocating for patients in such a situation. Breaking confidentiality outside of this situation (for example *'gossiping'* about patients) was considered a major breach of professionalism.

F: [The doctor] can't break that confidentiality but he can try and help the patient the best way he can, to make sure that [the patient is] going to be all right.

M: But he has to let the patient help themselves.'

(Female and Male, economically inactive people group)

Consistent professional conduct was also considered important in ensuring the same level of medical treatment is accessed by patients, even when they are treated by different doctors.

3.5 Personal vs. professional conduct

As noted participants tended to identify a clear divide between a doctor's private and professional life throughout the themes discussed. On the whole they wanted each to be kept separate from the other.

Participants felt that doctors are entitled to a private life, which is of no concern to patients or the public. However, there was also a clear message that if a doctor's behaviour outside of work may affect their ability to practice medicine in terms of their professional judgement or conduct it could compromise the core aspect of doctors' conduct expected by patients and therefore be unacceptable. The following quote illustrates this point:

M: As long as whatever he's done in his private life doesn't affect professional life, that's fine, but if your doctor is addict on drugs or alcohol, that's gonna affect his professional life, and that's not good. But if he got like I mean family problems – and as long as he can split his private life, and keep it at home, that's fine, but if he got something that gonna affect the professional life – the addiction – that's definitely no. He can't be a good doctor, you know? He will have a bad judgment on the patient.

(Male, refugee and asylum seeker group)

As discussed above, there was an implicit assumption that doctors are generally 'good' people in and outside of work. For this reason it was assumed that doctors would maintain a degree of good standard of behaviour within their personal life but the detail of this was of little consequence to patients. The following quotes illustrate how doctors were felt to be responsible for maintaining a certain level of personal integrity:

M: But again I think it goes back to the expectation of the general public that doctors, surgeons, police officers, school teachers, they've got to be that little bit sort of better, or cleaner than anybody else.'

(Male, older people group)

F: You expect them to be normal, don't you? I know they've got personal lives. But you just want one that's got, that's married and has kids at home and things like that.

(Female, economically inactive people group)

However doctors were also described by participants as *'only human'*. As a result of this certain issues a doctor may experience such as difficult personal relationships, becoming inebriated over a weekend or holiday periods when they would not be working, or minor offences such as parking tickets did not cause any concern for participants.

Participants assumed that in instances where a doctor was experiencing difficulties within their personal life, they would be supported internally by other staff. There was a trust in surgeries or workplaces being responsible for supporting doctors to avoid their personal lives affecting them to the point where patient care was affected.

3.6 Patient conduct

Patients too were viewed as having a responsibility to maintain certain standards of behaviour. Participants expected patients to have realistic expectations of their doctors and of the treatment they would be provided; for example, to understand that there may be delays to appointment times. Furthermore, patients were generally felt to be responsible for their own actions and to understand that there would be consequences for poor behaviour, including a doctor's right to refuse to treatment if patients are abusive, as illustrated in this quote:

M: If you wanna be treated by a doctor then you have to behave properly.

F: That's right.

M: It's no good sort of going to the surgery and yelling and shouting, or going into the clinic being abusive because the doctor can't get his job done properly.

M: He's got his other patients to worry about as well. I mean I keep on coming back to this, it's a two way thing, the patients have got a responsibility as well so I think they can actually, after a certain time say, 'Well I, we've warned you and warned you.

(Male and female participants, older people group)

Participants viewed patients as active agents within the doctor-patient relationship – being responsible for seeking out and making the most appropriate treatment choices for their personal circumstances. There was also an acknowledgement that patients may challenge doctors about diagnoses or treatment provided, and should be responsible for the final decision on their treatment or care (this included for example, investigating care homes to move into or choosing which pharmacy to collect their prescriptions from even if their doctor had suggested one, as the following quotes allude to):

M: The onus also is on [the patient] a little bit to say, 'Well thank you very much for that recommendation I'll have a look at that one and I'll have a look at some of the others'.

(Male, older people group)

M: You'd look at it yourself, wouldn't you?

M: Yeah, you would check it out first, wouldn't you?

M: Yeah.

M: Then you'd obviously pick the best [care home] for your grandma.

(Male participants, young people group)

There was a feeling that patients have a role in helping to create an environment in which doctors are able to provide the best care possible. Similar to patients being able to expect doctors to provide a consistent level of behaviour and care, participants felt that doctors too should be able to expect a certain level of civil behaviour from their patients.

3.7 Trust in doctors

Having trust in doctors was central throughout the discussions in all groups and seen as the basis of a good doctor - patient relationship. Participants assumed they are able to trust doctors in their ability to treat medical conditions until that trust is challenged. Being professional, as discussed above, is key in building and maintaining patient trust in doctors.

M: So it's trust it is, a lot of it is. You've got to put faith in them otherwise where are we going?

(Male, older people group)

M: I would put my faith and my trust in [the doctors] 'cos obviously I don't know his private life. So, I come to see him and obviously he will take care of me.

(Male, homeless people group)

However participants' trust in doctors related mainly to their professional conduct. Doctors are expected to and trusted to act in the patient's best interests in ensuring they provide the right medical care, treatment or advice for them. Participants across the groups clearly saw this role as separate from the personal life of a doctor however, and acknowledged that doctors in their personal life were '*only human too*'. Indeed it was felt to assist in maintaining trust in doctors for patients to know nothing about their personal life and for professional boundaries to be maintained. That is to say, participants did not feel patients would like to know if a doctor is experiencing challenges or difficulties as this may undermine how confident they felt about their medical judgement.

3.8 Role of the GMC

The role of the GMC was viewed as helping to regulate and support doctors, and uphold the expectations participants had about doctors. There was support for the GMC providing guidelines for how doctors should behave, particularly for challenging situations doctors may encounter (e.g. when to breach confidentiality), in order to support their decision making. Participants felt that the GMC should investigate all complaints made against doctors on a case by case basis to ensure the specific contexts are understood. There was also an expectation for the GMC to support doctors, in the event of a complaint from a patient that was unfounded. It is important to note that the role of the GMC from

participants' points of view was based on their perception of what the GMC does, rather than a detailed knowledge of how the GMC operates and so some of the expectations participants had of GMC may fall outside of their organisational remit. Please see Annex A for more details about the GMC fitness to practise procedures for dealing with complaints against doctors.

In the next section the findings from specific scenarios focussing on doctors' conduct that were explored with participants are outlined in more detail. This begins with a consideration of the extent to which doctors' personal beliefs should be able to influence their professional conduct.

4 Doctors' personal beliefs

4.1 Summary

Whether participants supported doctors' personal or religious beliefs being taken into account when they treated patients was discussed during the research. This discussion focussed on a scenario in which a pregnant patient who did not wish to have a child visited their GP to discuss options, including abortion. The doctor was opposed to abortion and participants were asked their views on how the doctor should respond to the patient. For the full scenario, please see appendix A.

Throughout the group discussions the issue of doctors' personal beliefs affecting their practice attracted two contrasting themes. One view was that doctors' personal beliefs should remain *entirely* separate from their professional life (*'when you're in certain professions like that you can't bring your personal beliefs into it, full stop'*). In contrast there was a view that doctors should be able to maintain their personal beliefs but should refer any patients on if an action would compromise their beliefs (*'I don't think they should be forced to, into doing something that's against their faith or their principles'*). The overriding issue – regardless of which opinion participants held - was the view that patient interests should be at the centre of the care given by a doctor and that the doctor should respect the choice a patient makes.

4.2 Reasons for participants' views

There were a number of reasons discussed as to why it was important for doctors to keep their personal beliefs separate from their professional life, relating to the following issues:

- Consistency of care
- A doctor's role as a provider of medical treatment
- Professionalism

Ultimately it was seen to be unprofessional for a doctor to allow their personal beliefs to affect the care they provide. It was felt that patients should be able to expect a consistent level of service and access to care and treatment; which doctor a patient is treated by should not affect the treatment they receive. If a doctor allowed their personal views to affect the care a patient received there was felt to be potential for different doctors to provide different types of treatment based on personal belief and not on the basis of what may be considered the best medical option.

M: [Doctors] should do the whole field. Otherwise you could pick and choose. Somebody may say, 'Well, I don't like treating dirty feet'.

(Male, older people group)

Providing an inconsistent service would also be at odds with the expectations patients have about what they expect to receive and the professional standards they expect of doctors:

F: We've got different GPs [that we see] every time and so you expect them to be the same as each other. Almost as if they've all come out of medical school as robots and we expect the same care all the time. We don't expect, maybe this time I'll have a little bit more care. You want that exact same mould of each doctor to make sure that, well, you're confident enough to go, really.

(Female, younger people group)

It was also not felt to be appropriate for personal beliefs to affect a doctor's professional judgement because of the recognition from participants of the diverse nature of British society. There was widespread acceptance that both doctors and patients may hold a range of personal, cultural or religious beliefs, which they were entitled to, but that these different views should not affect the medical treatment, care or advice a patient receives.

Participants talked about the expectations patients have when thinking about whether doctors should be able to maintain their personal beliefs in the workplace. It was discussed that when a patient goes to see their doctor they are expecting medical advice and knowledge rather than religious or personal advice:

F: [The patient] wanted advice, didn't [they], not an opinion. If [they] wanted an opinion [they'd] go to [their] mother or a friend.

(Female, younger people group)

F: I just think that if you go to a doctor, you're expecting medicine. And medicine in the western world is based on science.

(Female, homeless people group)

If participants felt it appropriate for a doctor to refer a patient to another practitioner rather than compromise their personal beliefs, it was felt to only be acceptable to do so if it was done in a professional manner. For participants this meant not disclosing the reason for onward referral as this may constitute a '*judgement*' of the patient. It also meant ensuring that there were no time delays in the receipt of care or treatment for the patient. Essentially it was felt that the patient should not experience a poorer quality of care or treatment because the treatment was opposed by one doctor on the grounds of personal belief.

4.3 Role of the GMC

The discussion regarding the role of the GMC in relation to doctors' personal beliefs influencing their professional conduct was centred around ensuring that patients did receive the level of care and access to treatment that they expected, regardless of the

personal beliefs of the doctor. In situations where that did not happen, participants felt that the GMC had a role in investigating the situation and disciplining the doctor. This could take the form of a reminder about the role of the doctor and the standards expected of them or suggesting that the doctor changes the area in which they work so that they are less likely to be placed in situations which may pose a challenge to their personal beliefs. The GMC was seen to be responsible for ensuring that doctors were aware that access to care should not be dependent on a doctor's personal belief and that the same information and care should be offered to all patients, whether this was from the doctor themselves or from another practitioner the doctor referred the patient to. As noted previously, participants based these views on their assumed role of the GMC as opposed to detailed knowledge of their actual remit (see Annex A).

4.4 Similarities and differences between groups

Doctors being able to maintain a divide between the personal and the professional areas of their lives was a key issue that arose when discussing how personal beliefs could be managed in the workplace. Those participants who had strong personal beliefs themselves about the topic being discussed were more likely to be sympathetic to a doctor being at conflict with their professional duty and personal beliefs. Participants who felt that a doctor should not be made to go against their personal beliefs or morals were particularly found within the non-English language interviews, the Gypsy and Traveller group, the refugee and asylum seeker group, the unemployed group in Northern Ireland and the BME group.

This may also have been a reflection of the topic of the scenario used to explore this issue – those who supported doctors being able to refer the patient on to another doctor also opposed abortion. Indeed in Northern Ireland abortion is illegal and therefore it was acknowledged in the discussion that doctors in Northern Ireland would not be faced with this dilemma. With regard to religious belief, it was sympathetically noted in one group that if a doctor's religious belief opposed abortion the doctor would have to *'live with the judgement of God'* for being privy to abortion making it entirely justifiable for a doctor to refer a patient onto another doctor. However, even in these instances participants still ultimately felt the patient was entitled to respectful treatment; participants noted that abortion was legal in England, Wales and Scotland and therefore doctors may have a professional expectation to deal with cases of abortion even if it is against their personal belief.

M: I don't think [doctors] should be forced into doing something that's against their faith or their principles. But the patient should be referred on.

(Male, economically inactive people group)

5 Doctors' lives outside of medicine

5.1 Summary

This issue related to the extent to which doctors' personal lives – such as their family relationships or social activities they engaged in - were felt to have a bearing on their capacity to practice medicine. The scenario used to facilitate this discussion focused on a doctor who had a difficult personal relationship with his ex-partner, which had resulted in a restraining order being issued against him. For the full scenario please see appendix A. Participants were asked if they felt that doctors' conduct in their personal lives influences their ability to practice or the trust in doctors patients held.

Participants noted that there should be a clear distinction between a doctor's private life and professional life. Provided their activities outside of medicine did not affect their professional capacity in any way then the general view was that doctors were entitled to their own private, personal life and that this had little bearing on, or importance for their patients.

5.2 Reasons for participants' views

Doctors were seen by participants as being entitled to have a private life as long as this did not affect their professional judgement or behaviour.

M: I think everybody's entitled to a private life. Although he's a professional person, he's still entitled to a private life.

(Male, BME group)

M: We've all got our own personal feeling, personal lives. And, as long as we leave it at home and don't bring it to work; the doctor's entitled to be human.

(Male, BME group)

There was a desire amongst participants that doctors should keep their private lives separate from their professional conduct. In this respect the issue was also one of professional boundaries. Patient care continued to be the central concern for participants throughout the discussion in all groups. Behaviour that was not felt to affect their ability to practice medicine - alcohol consumption when not at work, minor criminal convictions such as a parking ticket or speeding tickets, for example - were seen to be inconsequential.

Behaviours which participants felt were unacceptable for doctors to engage in outside of medicine tended to be those they felt would affect a doctor's ability to do their job or would compromise the care received by patients as opposed to being unacceptable on the basis

of the participants own morals or principles. Such behaviour included doctors being under the influence of alcohol or drugs at work.

5.3 Inappropriate behaviour

The 'tipping point' however, for when doctors' behaviour outside of medicine was seen to be of consequence to participants were criminal behaviours. Having a criminal conviction was felt to bring into question the character of the doctor, and impact on the trust and confidence patients had in them generally. This was in the context of older participants expecting doctors to make 'house calls' for example and not feeling comfortable with them being in their home if they had a criminal conviction. Behaviours which would undermine such trust involved criminal convictions involving violence or dishonesty. So while participants were clear that they felt doctors' conduct outside of medicine was of little consequence to patients, there was a limit to this. Participants also discussed how they wanted to assume that a doctor was a *'good human being'*:

F: We want them to be ethical all round because you go to a doctor thinking they're a decent person all round as well as a decent doctor [and] medical professional.

(Female, homeless people group)

Some participants also talked about the doctor being a *'role model'* and being a *'guide'* and so they should try to live in a way that patients can respect.

5.4 Performance and support

Participants recognised that being a doctor could be a stressful job and that doctors would also inevitably face difficult periods in their lives outside of medicine, such as bereavement or a divorce. To address this, participants felt that there should be support for doctors at work through supervision and from colleagues. There was also a feeling that as a professional, a doctor would be able to self assess when they not able to perform and should be able to take time off work if required rather than risk compromising patient care:

F: It depends on the, [the doctor's] personality, nature and character. Possibly then it would be up to [the doctor] and [their] colleagues and whoever else around [the doctor] to say that at this moment in time you [the doctor] should not be seeing patients [if they have a difficult time outside or work].

(Female, BME group)

5.5 Role of the GMC

Participants felt that if a complaint was received about a doctor's conduct outside of medicine the GMC had a role to ensure that a doctor was providing adequate medical care and that this was not being affected by their private life. It was felt to be important that the GMC investigate each case individually as circumstances would be different from case to case and it would be important for the GMC to collect evidence from colleagues

and patients. It was suggested that doctors may need to be suspended pending investigation to ensure that patient care was not compromised.

There was also support for doctors having to inform the GMC if they had a criminal conviction and for not allowing doctors who had committed serious offences to practice.

5.6 Similarities and differences between groups

All groups felt that doctors were entitled to a private life as long as this did not impact on their professional judgement and patient care.

Participants in the non-English speaking interviews and those in the refugee and asylum seeker group were more likely to talk about the doctor being seen as a *'role model'* and someone from whom they expected certain standards within their private life to ensure that patient trust was not undermined. However, they still felt that doctors were entitled to their own personal and private life and this was of little consequence to the patient.

Among all groups, this assertion was however underpinned by an assumption that doctors would exhibit a degree of probity in their personal as well as professional life.

6 Professional boundaries

6.1 Summary

Doctors maintaining professional boundaries may include such issues as not treating their own family or friends, not entering into relationships with patients, or not disclosing personal information to patients. Participants' opinions on what they consider to be appropriate boundaries between doctors and patients were explored during the research. The discussion of this theme focussed on a scenario in which a young doctor in A&E treated a 17 year old girl and then a year later they meet again and start dating. For details of the full scenario, please see appendix A.

Similarly to the views expressed in the previous section on doctors' lives outside of medicine, the general view here was that doctors are entitled to a private life and that this includes their personal relationships. In the instance of the scenario however there was some overlap with their professional realm and this could be considered more problematic. The main concern regarding doctors' professional boundaries was patient care and that this should not be affected by doctors compromising professional boundaries. It was considered acceptable for a doctor to have a relationship with a previous patient as long as that relationship had not come about following an abuse of trust. It was also felt that a degree of personal/friendly relationships between doctors and patients may improve patient care but it was always important that professional boundaries remained.

6.2 Reasons for participants' views

The initial response by participants to the scenario was that the behaviour of the doctor was acceptable. This was for a number of reasons relating to the details of the scenario. One reason it was acceptable was that the relationship commenced after the doctor had ceased treating the patient and so the doctor was no longer seen as the patient's doctor. The relationship had also started outside of the doctor's professional environment which further removed it from the doctor's professional life:

M: If they then saw each other in the pub that evening, that's a different situation. Yes he's still your doctor but he's not your doctor there.
(Male, younger people group)

F: As long as [the doctor] keeps it professional while [the patient] in the hospital, I think it's up to [the patient] outside hospital; I think they're both grown ups.
(Female, economically inactive people group)

Relating to this was the fact that the doctor was not the patient's long term doctor, such as their GP. If the doctor was the patient's long term doctor this was felt to compromise professional boundaries. This was because the doctor may have a more in depth knowledge of the patient, or there may be more ambiguity in terms of a doctor exploiting

their position of trust if they begin a sexual relationship with an ongoing patient. However, there was also a pragmatic approach applied, particularly by those who lived in rural areas or who were registered at small family GP practices, whereby they accepted that it may be inevitable or at least likely that a doctor might go on to date a patient.

If the scenario was changed and the doctor and patient became close during a hospital stay and started dating immediately, this was less acceptable. Participants felt that here the lines between personal and professional relationships were being blurred as both were occurring at the same time. This could affect the trust other patients have in a doctor as they would think that the doctor might be viewing them in a personal or sexual manner. This was in relation to examples given by participants such as having a smear test or mammogram carried out by a doctor. Participants preferred to think that doctors viewed patients as '*just a robot with bits and pieces which aren't working properly*' rather than in a sexual manner.

6.3 Patient vulnerability

Participants felt that patients may also be in a more vulnerable position when receiving treatment. Participants discussed the idea that a patient may feel obliged to their doctor and that a doctor was in a position of trust and power:

F: I think it's the trust thing and then they have to be seen not to be taking advantage of the natural vulnerability of a patient.

(Female, economically inactive people group)

Interestingly, there was a distinction made between mental and physical health. Participants felt that if the patient was particularly vulnerable or had poor mental health then doctors should be careful not to cross professional boundaries even if this occurred after they had ceased to be their doctor – this was in light of a vulnerable or mentally ill patient being viewed as potentially having less capacity to judge appropriate behaviour from their doctor. Therefore doctors should exercise greater care in these situations as a means to ensure vulnerable patients are not (inadvertently or advertently) exploited:

M: As long as a relationship with a patient is not sort of founded on the fact that the patient has been influenced by the doctor. The patient would come to rely on the doctor. That way then the doctor could take an advantage.

(Male, older people group)

6.4 Doctors treating family members

The issue of whether doctors should be able to treat their own family members was also discussed in relation to professional boundaries. Participants tended to feel that doctors should not treat their own relatives as the emotional attachment they have to them may affect their professional medical judgement. It also constituted the crossing of boundaries between personal and professional life which is something the participants clearly desired be kept separate. It was discussed that doctors themselves should take the lead in

advising family members to register with other doctors and maintain professional boundaries between themselves and their patients.

However, participants (particularly those from the non-English speaking interviews) could also support doctors being able to treat their relatives; they felt they would be likely to provide a high level of care to someone they were related to and this was therefore seen as a positive outcome.

6.5 Doctor / patient friendships

Whilst participants felt that doctors' private and professional lives should be kept separate there were some instances where it was viewed as a positive to allow some personal/friendly treatment between doctors and patients. It may help a doctor to empathise with patients who may be experiencing similar issues. This was considered to improve patient care:

M: If [a doctor] sees fit to divulge something so that they can show that they're empathetic and they understand the patient's scenario that can only help the patient, I would have thought.

(Male, younger people group)

Participants felt that for doctors with whom they have a stronger relationship such as family GPs, it was sometimes acceptable for that doctor to share some of their personal life. This may help the patient to know that the doctor is a '*human being*' and '*normal*' but it was still important that some professional boundaries were maintained while providing medical treatment or care.

6.6 Responses to patient and doctor relationships

Participants tended to note that doctors would inevitably have personal relationships and there may at times be a 'blurring' of the line between a professional doctor and patient relationship. In these instances the onus should be on the doctor to ensure they ceased to have a professional, medical relationship with the patient if their relationship became personal. All of the groups felt that it would be acceptable for a doctor to have a relationship with a previous patient as long as that relationship had not come about following an abuse of the trust or commenced while the patient was still under their care. Doctors were also considered to have a responsibility to protect themselves by making such a relationship known to their managers:

M: He has to protect himself so I would imagine he would have to tell his boss if he did start having a relationship with [a patient] during [their] aftercare.

(Male, economically inactive group)

6.7 Similarities and differences between groups

In all of the groups the main concern regarding doctors' professional boundaries was patient care and that this should not be affected by doctors compromising professional boundaries. In addition to this, all groups recognised there may at times be a 'blurring' of the line between doctor and patient relationship. All of the groups felt that it would be acceptable for a doctor to have a relationship with a *previous* patient as long as that relationship had not come about following an abuse of the trust or the patient was not considered vulnerable.

Exactly where professional boundaries lay was not always clear and these appeared to lie in different places for different groups. Some participants maintained that a personal relationship with a doctor may benefit the doctor-patient relationship as a whole. This view was more common in some older people, refugee or asylum seekers and Asian language interviewees.

In instances where it was viewed as positive for there to be a more personal/friendly relationship between doctors and patients this could be a means to improve the quality of care the patient received. Participants talked about how taking an interest in patients and their lives allowed them to develop a good relationship with a family doctor which led to a better understanding of the patient than that experienced from doctors who participants did not know. This was particularly a view held by older participants. This may also have been in the context of older participants often having existing medical conditions and feeling more comfortable when they were sure the doctor was already aware of this, rather than relying on their written records to ascertain their health needs. Therefore a 'friendly' relationship in this sense tended to equate to a professional relationship, with the onus on the effect this would have on the quality of care a patient received rather than it being felt to be appropriate for doctors to treat their friends.

7 Access to care/ treatment

7.1 Summary

The appropriateness of doctors refusing to treat certain patients or to provide certain types of treatments was explored in the research. The scenario used to facilitate the discussion of this theme focused on a doctor based at an out-patient clinic who refused to treat a patient who was being verbally aggressive. For the full scenario, please see appendix A. The scenario focusing on whether doctors' personal beliefs should affect the type of treatment or advice they provide was also pertinent to this topic.

In relation to the scenario that focussed on a violent patient, there was broad agreement that a doctor does have a right to refuse treatment in some circumstances such as when a patient displays violent or aggressive behaviour, particularly when providing primary health care such as a GP. Participants were less clear about whether this should be the case in other situations such as mental health services and felt that in these cases there should be measures in place, such as trained staff to handle a situation, particularly if it might be predicted from previous experience. As was clear from the discussion around a doctor refusing to provide advice on abortion because it opposed their personal beliefs, it was felt that doctors should generally not refuse access to care. The exception to this was in cases where the patient posed a risk to doctors, staff or other patients. In such circumstances the priority lay with ensuring other patients and medical staff could conduct their work or access treatment without being threatened by other patients.

7.2 Reasons for participants' views

There was a strongly felt view that there should be a *'zero tolerance'* approach to aggression and violence from patients and that doctors *'don't sign up for it [violence]'* and so there was support for the doctor in the scenario.

Participants also felt that the doctor had a responsibility to the other patients in the clinic and that this should be taken into account when deciding whether to refuse access to care or treatment.

M: I suppose if it's the GP's practice and there's one GP, he's got a responsibility for all his other patients and all of his staff, so he's got to make sure that they're safe.

(Male, younger people group)

It was also felt to be acceptable for the doctor to recommend anger management or counselling for the patient as this might then prevent this happening in the future and address the mental health needs of the patient.

7.3 Appropriate response to aggressive patients

Participants identified that there were some factors to consider when deciding whether it was acceptable for a doctor to refuse access to treatment or care. If the service was likely to treat patients with behavioural problems or those who had difficulty controlling their emotions then it was considered less acceptable for a doctor to refuse treatment. Instead participants suggested that there should be specialist staff and training available to deal with the situation. Here the doctor was seen to have a responsibility to pre-empt the behaviour as it was seen to be less in the control of the patient and so refusing care was less acceptable:

M: Surely a psychiatric clinic would be prepared for people like that because it would happen quite regularly. It's completely different from an ordinary hospital or clinic.

(Male, older people group)

In these situations doctors were considered to have a role in preventing situations from occurring, particularly if patients are waiting for long periods to be seen, as the following quotes illustrate:

M: I think the human touch is needed. If people are waiting around, it doesn't take anything for someone to say, 'we are delayed, I'm sorry about this'. But some people are just blatantly left sitting there waiting not knowing what's [happening]. It takes a second to explain something to someone and it could put a patient at ease, or diffuse a situation. Sometimes it's when people feel like they're not being listened to or being seen to at all, [that's] when they get agitated.

(Male, BME group)

M: If [the clinic is] running late then a bit of pre-emptive medicine, is that what they call it? Pre-emptive rather than curative, would be better. You know somebody comes and flags it to [the patient] and says, 'Look we're running half an hour late'.

(Male, older people group)

Similarly participants felt that patients should be provided with sufficient information about what would happen to them. Posters and information notices explaining there is zero tolerance to violent or aggressive behaviour were noted as being common in public spaces and this was seen as useful so that patients know what is expected of them. However, if patients repeatedly behave inappropriately, then actions should be taken to respond to this:

M: It obviously would depend on the severity of the situation. If it's happened on multiple occasions then they've got to take different steps each time. As a one off situation then they should have the right to no toleration and make them get off the premises. Then if it happens a second time increase the severity. If it's repetitively happening, say we're

warning you if you have an issue with our practice they should take it up with someone higher, they can complain, they can express what they're unhappy with. Then obviously give them sufficient warning to say we will ban you from the practice if you carry on as you are.

(Male, younger people group)

7.4 Role of the GMC

If a patient complained to the GMC about being refused treatment then participants felt that the GMC should investigate this. As noted in previous sections, cases should be investigated with evidence being collected from all relevant sources including in this case, analysis of CCTV if available. Depending on the outcome of the investigation participants felt that the GMC should then support either the patient or the doctor. In the original scenario posed to explore this area, participants would like to see the GMC support the doctor's conduct in refusing to treat an aggressive patient to ensure the safety of other patients and staff.

7.5 Variations in context

It being felt to be acceptable conduct for a doctor to refuse access to care or treatment also depended on the severity of the illness or condition. Minor conditions or illnesses that wouldn't worsen without treatment were considered different to more serious illnesses and conditions. It was felt that treatment should always be provided in the latter case, although staff would have a right to restrain or sedate the patient.

M: It depends as well how serious the person's illness is. Because if it's non-essential then maybe if they're violent then they've blown their chance of that treatment. But if it's something that needs to be treated or it might worsen, then maybe they should be treated a bit more leniently.

(Male, younger people group)

7.6 Similarities and differences between groups

Participants across the groups felt that all patients have a right to care and even when a patient had behaved in a way that justified a doctor refusing to treat them on one occasion, the patient should be referred onto another area or doctor to ensure they did receive the care they needed eventually. This supported the strongly felt view discussed in section 4 that access to care should be made as widely available as possible and that a doctor's key role is to provide access to good quality medical treatment, care or advice:

F: I think [patients] should be removed [if they are abusive] but I think they still have a right to care. So maybe [doctors] should refer them to another doctor that can cope with sort of behaviour. So [patients] should still have an option to go to somewhere else because otherwise they might just not get any treatment at all which is not really fair.

(Female, younger people group)

This theme related to the earlier theme of doctors' personal beliefs in that both discussed the potential to limit access to care or treatment for patients. In all groups, participants were very clear that access to care should not be limited on the grounds of a doctor's personal belief but that in some situations, it was acceptable to limit access to care if a patient was abusive or aggressive. Here the key difference seemed to be that a doctor's personal belief is outside the control of the patient, and something over which patients have no control, however being abusive or aggressive was something the patient has control over, and so if they choose to behave in this way, the consequences were felt to be partly the responsibility of the patient. This may also be why participants considered it less acceptable for doctors to refuse access to care when mental health patients displayed violent or aggressive behaviour as here, participants felt that the patient may be less in control of their actions and so it would be unfair for them to be held responsible for this. This also highlighted an overarching view that participants held of patients being 'active' agents within their health care, with doctors being enabling agents in this process.

8 Doctors as advocates

8.1 Summary

Doctors advocating on behalf of their patients may include doctors speaking up for patients who may be vulnerable because of bullying or abuse or doctors enabling one patient to receive an expensive treatment even if that means that others may not be able to receive it due to resource constraints. The extent to which doctors should advocate on behalf of their patient was explored during the research. The scenario used in the discussion of this theme focussed on an 18 year old man who visited his GP and disclosed that he felt he was being forced to marry but said that he did not want his GP to get involved and speak to anybody about it. Participants were asked what they thought a doctor should do in this situation. For the full scenario please see appendix A.

This was an area with much discussion among the groups and little consensus. The central matter was the issue of patient confidentiality and the potential breach of this. As the patient in the scenario was an adult it was seen to be their choice whether the doctor intervened or not, and that the doctor should respect this. There was also discussion about the circumstances in which doctors could or should advocate for their patients even if this went against the wishes of the patient. Children under the age of 16 potentially being at risk of abuse or violence was viewed as one of the only clear examples of where a doctor intervening and reporting this to social services or the police would be appropriate conduct.

8.2 Reasons for participants' views

The central issue discussed around this theme was that of maintaining confidentiality and with it, patients' trust. It was important to all participants that patient confidentiality was not compromised even if it was during the process of a doctor advocating for a patient, as this would impact upon the trust a patient had in their doctor which was seen as a foundation of the doctor/patient relationship. The scenario that was used to hinge this discussion may have influenced this view as it focussed on a situation where a patient asked their doctor not to disclose the issue that was concerning them and involved an adult patient. Also, the issue at stake (the patient being forced to marry) may not have been viewed by participants as a health related issue (although the patient feeling ill with stress due to this situation and whether this would affect their view of the appropriate response from the doctor was raised with some participants).

8.3 Appropriate advocacy

If the doctor felt that the patient might benefit from taking the matter further it was deemed acceptable for the doctor to signpost his/her patient and provide information but not to advocate directly in terms of actually involving other agencies:

F: [Doctors] can try to the best of their knowledge to give [patients] information on where to go to help with bullying or forced marriage. They could probably think of avenues in which to direct them because there's nothing wrong with that.

(Female, homeless people group)

There were also situations where it was felt that the doctor should get involved and advocate on behalf of the patient: in situations in which the doctor felt that the patient was at risk of harm to themselves or to others. In these cases the doctor was considered to have a duty of care to act on this information:

F: If [a patient] says 'I wanna kill myself' that's a different kettle of fish all together.

(Female, BME group)

In the case of child safeguarding issues it was also felt that the doctor should advocate for the patient. However, this should start with providing information and advice to the child and only involve breaching confidentiality if the doctor felt the child was directly at risk. The following extended quote from one group encapsulates these points:

M: The age thing would be key if we're talking about the patient running away. If you're 18 and you're therefore legally an adult and responsible for your[self]. I think as a doctor if somebody had come to me and was 14 and talking about running away, then it would be much more difficult for me to instantly not refer them to social services or to any organisation, to a charity, to counselling. It would be a different situation if the age was different.

M: I think they've still got a right to privacy, if they don't want you to tell anyone then you can't tell anyone.

Researcher: What do you mean exactly when you say refer?

M: You could say to [the patient] 'I can't get involved, I won't get involved but if there is somebody that you would like talk to'.

(Male participants, younger people group)

8.4 The challenges of advocacy

Despite participants noting that confidentiality is extremely important, the overriding feeling was that doctors should act in the best interests of the patient and sometimes that may mean breaching confidentiality. There was recognition that doctors may be placed in difficult situations deciding when to advocate for patients that are potentially at risk. It would be difficult to deal with if someone comes to harm following a disclosure to the doctor that they are at risk, if the doctor has taken no action. This needs to be taken into account when deciding on whether advocating for the patient should happen to prevent

repetitions of high profile cases such as the Baby P² case where doctors may be seen to have played a role in not preventing abuse:

M: There's been so many cases where [doctors have] not really intervened. You look at the Baby P situation, they had to do all these enquiries and investigation and the doctor was saying, 'How could we have done things differently?' So, yes, I do feel that [intervening] should only happen if there's a cause for concern 'cos if I was a doctor now and something was going on which I was suspicious about, I want it to be investigated because if I did not and something happened, it would be on my conscience even though I've been professional about it, I would have failed my patient.
(Male, homeless people group)

Conversely, if a doctor made a disclosure and subsequently the patient was not found to be at risk it was also recognised that this could be reported in the media and would reflect negatively on the public image of and public trust in doctors as a whole. Here the choice a doctor makes is not only one that affects them and their patient individually; it is something that may affect the profession.

M: I think a doctor leaking some private information that someone had confided in them could even get into the press and leads to a bigger inquest and people's confidence in doctors [would] go down.

Researcher: So there's an issue there about wider confidence in the doctor as well?

M: Yeah, if someone sees something in the news. They might not think immediately that they've been affected by it but the next time they go to the doctors they might just think twice about saying something to them that could help them.
(Male, younger people group)

So participants recognised that doctors may have difficult decisions to make when choosing when to advocate for patients or not. As a result participants felt that doctors should have clear guidance about this. Participants felt that the GMC had an important role here to make sure it is clear in the guidelines for doctors what is expected of them in terms of advocating for patients and what they should do if a patient discloses they are at risk or pose a risk to others. This ensures that the doctor is not forced to make decisions without guidance and also protects the doctor in the event of a complaint following the breach of confidentiality:

F: It should be in the guidelines that the doctor should have to [report issues where a patient or other is at risk] and then the doctor is protected.

² The high profile 'baby P' case was widely covered by the media in the UK. On 3 August 2007, Peter Connelly was found dead in his cot 48 hours after seeing a doctor who had not identified the child's severe injuries, including a broken spine. The toddler was on Haringey Council's child protection register throughout eight months of abuse he experienced. His family had been seen 60 times by agencies, including social workers from the council.
<http://www.communitycare.co.uk/Articles/09/12/2010/109961/baby-peter-case-in-haringey.htm>

(Female, homeless people group)

An issue particular to the scenario but which sparked wider discussion was the cultural differences between doctors and patients and the idea that a doctor may not have enough knowledge about something or may have different personal beliefs about something. In this scenario it was not felt to be appropriate for the doctor to breach confidentiality but instead to provide the patient with information on support services. This also overlapped with the discussion of doctors' personal beliefs explored earlier in the report. In both cases, it was felt a doctor should not allow their personal beliefs to affect their professional judgement.

M: Maybe [the doctor could] signpost to some organisation who'd have a bit more experience. If a doctor starts meddling in a personal, cultural thing you can completely say the wrong thing. So if, [the doctor] could say 'well I know about this organisation who you can speak to'. [The doctor's] done a little bit more but he hasn't meddled at all, [the patient] can take or leave the information if he wants to.

M: Unless the doctor's been in that situation himself it would be very difficult for him to act in a manner that isn't based upon his own opinions and his own experiences.

(Males, younger people group)

Again clear guidelines on when it was appropriate for a doctor to advocate for patients, and in what way they should advocate, was felt to be an important aspect of doctors' conduct GMP could be used to advise upon. This would assist doctors to deal with complex situations regarding advocating for patients.

8.5 Similarities and differences between groups

All groups felt that doctors had a role to play in advocating more widely for patients and this was strongly felt with regards to vulnerable patients being at risk of abuse or harm. Advocacy started with advice or signposting to external agencies that may be able to help patients to help themselves. However, all groups felt that there were situations where it was appropriate for a doctor to breach confidentiality and go against the wishes of the patient. This was only felt to be appropriate if the patient was at direct risk of abuse or violence however.

Confidentiality was also felt to be an integral part of the doctor/ patient relationship however that should be maintained wherever possible provided the patient was not at risk.

A difference between groups was seen with younger participants when looking at the roles of doctors advocating for children. The younger group felt that the first step for the doctor advocating for a child patient should be signposting and information provision. Other groups were very clear that doctors should advocate on behalf of children who are at risk, and that this involved notifying agencies such as social services or children and family units. This might be due to other groups viewing children as being more vulnerable than

younger people themselves do. A similar reversed group difference can be seen in the discussion around conflicts of interest in section 9.

9 Conflicts of interest

9.1 Summary

This theme related to the extent to which conflicts of interest may affect patient care and how these should be managed. Conflicts of interests include situations where a doctor may gain financially from patients' illnesses or from recommending certain outcomes for them, such as doctors owning shares in healthcare related businesses. The discussion regarding this theme centred around a 72 year old man who was under the care of a surgeon in hospital who owned shares in a residential care home and who recommends that care home to his patient. The groups were asked whether this was acceptable. For the full scenario, please see appendix A.

There were mixed feelings around this scenario with no real consensus. There were strong feelings that doctors should in some way declare their interests clearly, but equally there was a view that as long as patient care was not affected then disclosure of interests didn't really matter. Others felt that it was not appropriate for doctors to have such conflicts or to 'profit' from patients and that this should not be allowed.

9.2 Reasons for participants' views

The main concern around doctors having a conflict of interest was that patient care should not be affected as a result of the potential conflict. As long as this was the case, there was little concern regarding doctors owning shares in health care related businesses or care homes as long as this was disclosed; this would be of benefit to the patient *and* doctor as patients would be fully informed and able to choose to access this service; and the doctor would clearly not be appearing to deceive patients for financial gain. It was felt that it would be best to give patients options about care and treatment so that patients could decide for themselves which option was best for them, based on all available information.

It was not necessarily the financial benefit that participants objected to (*'everyone's allowed to make money'*) rather the idea that it may affect a doctor's judgement or patient care in some way. If it could be ensured that patient care was not compromised, it was not felt to be a significant issue.

Conversely, it was also felt that care may actually be better as a result of a doctor being involved in other aspects of a patients care (such as owning pharmacies or care homes) because doctors would want to ensure their own business was of high quality. However, as a doctor is in a position of trust this may affect the decision a patient makes. If a doctor declares he/she has shares in a pharmacy or residential home, patients may decide to go there in part because of this information either because they wish to help their doctor or because they feel obliged to.

9.3 Avoiding conflicts of interests

The issue of doctors prescribing certain medicines or outcomes to patients (such as recommending they move to a care home) purely to profit from the patient financially was a concern raised about such conflicts of interests. However this behaviour was felt to be far beyond that of just having a conflict of interest that should be declared. This type of behaviour was also felt to be deceitful and to go against the key aim of doctors' conduct that participants sought - providing the right medical treatment. It was therefore not classed as being necessarily the same as having a conflict of interest, but of going beyond it. For this reason it was felt by participants to be important for a doctor to declare potential conflicts of interest and provide options for patients that may also include facilities or services that they do not have an interest in. Essentially participants did not necessarily feel that doctors having interests in other aspects of health care (such as shares in a pharmacy) compromised their conduct *per se* – but that the doctor was responsible for ensuring that this did not influence their professional judgement in relation to the medical advice or treatment they then recommended to the patient. By being transparent about the interests doctors held, patients may have more reassurance that doctors are not being influenced by financial gain, as the following quote illustrates:

M: [Doctors have] gotta be seen to be cleaner than clean. There can't be any suggestion that [the doctor] was making the recommendation because he had shares.

(Male, older people group)

A key part of the discussion around this topic involved choice. There was an underlying feeling that patients should always have choice regarding their care and treatment and where this wasn't available, participants felt this could be an indication that the doctor was merely profiting from the patient. As long as choice was available and promoted by the doctor, participants felt that patients could choose the right option for them, and if the doctor also had shares in the option they chose this was a secondary outcome and acceptable, as the following quote illustrates:

M: Well, surely for [the doctor] to keep himself right, he should've recommend three [care homes] that he's not involved in.

M: Well, because it sounds as if the doctor [is saying] you're going into my care home so his shares will go up. But if he said 'there's three care homes in your area; this one, which I would highly recommended, and two others', and then if he goes, 'well, okay, I'll go to the one the doctor recommended', which happens to be the one he's got shares in, well, that would be reasonably all right. Because at least he had a choice.

(Male, economically inactive people group)

9.4 Role of the GMC

As with all themes discussed, if a complaint was raised by a member of the public about a conflict of interest it was felt that the GMC should investigate the situation. If it was seen that it was an isolated incident of referral/recommendation of the care or treatment option

in which the doctor benefited from, the doctor should be advised to offer all options for care or treatment in the future. If it was a recurring issue where the doctor was continually referring or recommending care or treatment that benefited the doctor then GMC should continue to monitor the doctor in the future to ensure all options are given to patients so that patients can make an informed choice about their care.

9.5 Similarities and differences between groups

A difference relating to the scenario discussed in this theme of the research was seen between older people and younger people. Older people felt that recommending a care home for the patient in the scenario didn't matter as much because ultimately the responsibility for choosing a residential home was with the individual and their family. Here it was seen to be the responsibility of the patient and their family to find choices rather than the doctor to provide them:

M: I don't see a problem with him having a home; he can recommend all he likes. But it'll be down to the family choice.
(Male, older people group)

M: You're not going to suddenly go up and turn up and say, 'Oh Doctor Smith's recommended that I come here.' I mean the patient has a responsibility as well.
(Male, older people group)

However, younger people felt that the doctor did have a responsibility to provide more options as the older patient may be vulnerable. Here the issue remained centred around patient care but also who held responsibility for that care; where this lay was seen to fall differently for older people and younger people. Similarly to the difference of views with young people being seen to require doctors acting as advocates to a greater extent than adults in section 8, this view may be more to do with a view of vulnerability held by different participants. In this scenario, younger people may think that the older person is vulnerable due to their age, whereas older people may have been less likely to assume this and more likely to view the matter as down to the control and choice of the older patient. It may also be the case that younger people are less familiar than older people with the process of moving to a residential home.

10 Conclusion and reflections

The central issue for participants in this research was that they desired unrestricted access to consistently good quality medical treatment, care and advice. This was what participants expected doctors to enable or provide. In order to deliver this, it was felt that doctors need to maintain professionalism and preserve the trust that patients implicitly have in them.

Standards expected of doctors

When looking specifically at the standards expected of doctors, participants tended to focus more on professional ability rather than personal attributes. They focused on doctors' ability to deliver good quality medical treatment, care and advice and felt that to do this involved not only professional knowledge and experience but also qualities such as effective communication. This was important so that doctors really understand the needs of the patients.

Whilst initial reactions to the standards expected of doctors evoked the reaction that doctors are only human and as such, are entitled to a private life which is of little consequence to the public, further exploration of this uncovered some interesting findings. Participants did still expect or assume certain qualities in doctors such as good character, and felt that a doctor engaging in criminal behaviours outside of work was unacceptable. Whilst this may not directly affect a doctor's ability to perform professionally, it would undermine the level of trust patients had in that doctor. Trust was seen as an integral component of the doctor – patient relationship.

Consistency was also important to participants. Participants felt that patients should be able to expect the same access to and quality of care regardless of which doctor they consulted. In order to achieve this, it was not considered acceptable for a doctor's personal beliefs to influence their practice. Whilst participants wanted access to care to be as widely available as possible the exception to this was where patients behaved inappropriately by being violent or aggressive. This appeared to be about personal agency. It was felt that access to care or treatment should not be limited by something out of the control of the patient, such as doctors' personal beliefs, but the patient was also viewed as having a responsibility for their own actions.

Therefore patients were seen as active agents in the doctor - patient relationship, with some choice over their treatment and responsibility for their behaviour. Patients were seen as having a role in creating the environment in which a doctor can deliver what patients expect - consistently good quality medical treatment, care and advice. It was felt to be important that doctors communicate expectations to patients so that they know the consequences of their behaviour. Similarly participants felt it was important that doctors know what is expected of them, and that the GMC had an important role to play here with guidance like *GMP*. This emphasises the notion they expressed that the relationship

between a doctor and patient is a 'partnership', one in which each party has expectations of the other which both need to respect and observe in order to make it work.

Similarities and differences between groups

One reason for carrying out this research was to hear from different groups of people, particularly those who may not take part in the formal consultation. Perhaps a surprising finding was the degree of similarity of views that emerged regarding the standards expected of doctors, despite the diversity of the sample. The similarity of view within groups may have been influenced by the methodology of focus groups as people listen to the views of others, but this does not account for the similarity of view seen between groups.

As well as the similarities, there were also some interesting differences noted between groups of people in the research. It was clear that all groups wanted there to be boundaries between the personal and professional life of doctors and that such boundaries displayed a level of professionalism. However, asking a doctor to do something in their professional role which contradicted their personal belief was something which did divide opinion among participants. Those who held strong views themselves regarding the issue of abortion that was discussed were more likely to support a doctor being able to maintain their beliefs in professional practice. This may have been because such participants understood how difficult it would be for a doctor to separate their professional duties from their personal beliefs, as they were more able to imagine the scenario relative to their own moral standpoint. It would be interesting to broaden this further in the future and look at scenarios other than abortion to see how this affects views on doctors' personal beliefs in the workplace. The GMC are consulting on this issue as part of the review of GMP and this may shed more light on the issues.

There were also differences between older and younger people that emerged from their discussions of doctors having a potential conflict of interest. Younger people felt that the doctor had more of a responsibility to an older patient to provide information about future care than did older people. This was an interesting finding and one for which there could be various explanations. Younger people tended to view the older person in the scenario around this discussion as more vulnerable than older people themselves did. Some of the differences in views could be explained by perceptions of vulnerability. Indeed the younger group also differed from other groups in their approach to the scenario around advocating on behalf of patients. Younger people felt that the first step in advocating for children was signposting from the doctor, whereas other groups were more likely to support a doctor becoming actively involved and referring the child to other services. This could again be linked with perceptions of vulnerability, with younger people seeing children as less vulnerable than other groups did perhaps because they are closer in age. Further research into these differences could be interesting to try to tease them out and identify the reasons behind them.

The extent to which participants welcomed more personal or friendly relationships between doctors and patients also differed between groups, with some older participants

and those from the refugee / asylum seeker group and Asian language interviews more likely to be in support of doctors and patients having a more personal relationship. This appeared to be about increasing understanding and communication and ultimately, building trust. These were qualities all groups expected of doctors. It is possible however that people in the groups who supported more personal relationships were those that felt communication with doctors could be challenging due to a language barrier, for example, and therefore felt a more personal relationship would improve this.

Following on from this, it would also be interesting to look more closely at the relationship patients have with doctors, particularly their GPs and look at whether this affects the standards expected of doctors and patients' experiences of medical care, treatment and advice. There did seem to be some difference between participants who had a specific doctor whom they saw each time they visited a practice and those who saw one of a range of doctors at larger practices. Further research on the standards expected of different types of doctors would help to tease out these differences.

Despite the many differences and nuances observed in the research one similarly held view remained across the participant groups. Patients want to be listened to and want to have unrestricted access to consistently good quality medical treatment, care and advice. To achieve this requires an effective doctor and patient relationship. Within this relationship both doctors and patients have standards expected of them. These standards should be made clear to both parties to make sure that they are measurable and objective, where possible. The revised *GMP* should help to set out the guidance for doctors of the standards expected of them. Including harder to reach groups alongside a wider consultation of the public and doctors themselves should also assist to make the guidance as informed as possible.

Appendix A

Doctors' personal beliefs

Pamela is 39 years old who has two children. She has just found out she is pregnant for the third time but was not planning on having any more children. She has come to her GP surgery for advice about options including abortion.

Dr Knowles is a 45 year old female. Dr Knowles does not believe in abortion, as she thinks it is morally wrong. She does not provide any information on abortion to Pamela and refuses to discuss it.

Doctors' lives outside medicine

Mr Josh is a surgeon at a large London hospital. He has good relationships with his work colleagues and patients.

Mr Josh has a son Charlie, aged 8, from a previous relationship. Mr Josh has a difficult relationship with the mother of his child Lily, and they often argue. Their confrontations will sometime upset and scare the Charlie. Over the last year the relationship has worsened and Lilly has taken out a restraining order against Mr Josh.

Professional boundaries

Dr Kumar is a junior doctor on shift in Accident & Emergency aged 23. Dr Kumar provides treatment to Susan who slipped at school and has broken her ankle. Susan is 17. This is the first and only time Dr Kumar has treated Susan.

A month later Dr Kumar and Susan bump into each other in town. Susan recognises the doctor. He asks how her ankle is healing. Susan asks if she can buy him a coffee to say thank you. Dr Kumar declines.

A year later they see each other again, this time in a pub. They end up chatting and exchange phone numbers and arrange to meet again. They begin dating.

Access to Care/Risk to Doctors

Dr Larson is a consultant in an out-patient clinic. He has a very busy day and all appointments are running a little late. A regular patient, Karl becomes angry whilst in the waiting room and has become threatening to the reception staff, shouting at them that he needs to see the doctor or he will 'smash the place up'. Karl is well known to Dr Larson and his staff and has been verbally abusive in the past.

Dr Larson decides that Karl is a risk to himself, staff and other patients and ask security staff to escort him off the premises. He also will not treat him in the future or provide the treatment he attended the clinic for.

Doctors as Advocates

Raj (aged 18) has come to Dr Smith (his GP) to ask about vaccinations needed for travelling to India. Dr Smith asks about the purpose of the trip. Raj is going to India to get married. Dr Smith congratulates Raj and asks if he is looking forward to the big day. Raj says he isn't sure he wants to get married. The marriage has been arranged by his parents. He doesn't know much about his fiancé, he has never even met her and feels he is being forced into it.

Dr Smith asks if Raj has spoken to his parents about not wanting to get married. Raj says his parents won't listen. Dr Smith suggests they could speak to his parents about it together. Raj says no. He thinks this will make them angry and bring shame on the family.

Dr Smith arranges an appointment for the vaccinations and does not mention the marriage again or to anyone else, as Raj may not confide in a doctor again if he thinks they cannot be trusted.

Conflict of Interest

Dr Jackson is a consultant doctor at a hospital in his town. He also owns shares in two local residential care homes.

One of his patients, Alfie, 72, has been admitted to hospital after suffering a broken hip and arm in a fall at home. Alfie lives alone and Dr Jackson is recommending that he does not return home but that he move to a residential care home. Dr Jackson suggests that Alfie consider Milberry Care home, which is one of the homes he owns shares in. He does not suggest any other homes and Alfie asks to move there when he is discharged from hospital.

Appendix B

The standards expected of doctors Focus group with members of the public Topic Guide

The study

The topic guide should be accompanied by the focus group scenarios and handouts. Moderators should re-familiarise themselves with this prior to each group discussion and ensure they have the relevant scenario to be covered at each group. The proposal document outlines the aims and objectives of the group discussion in detail, but to summarise, the group discussion should:

Explore standards expected of doctors, including those relating to:

1. Doctors' personal beliefs
2. Professional boundaries
3. Conflict of interest
4. Access to care/treatment
5. Doctors as advocates
6. Doctors' lives outside of medicine
7. Trust in doctors

The discussion should explore participants views on a range of scenarios which may cover all or some of the issues outlined above. The scenario should be used to generate discussion but it is important to focus discussion on how the behaviour of the doctor discussed is felt to impinge on their ability to be a doctor, or the conduct expected by doctors, rather than focus on the participants views of that behaviour *per se*.

The discussion will also explore potential resolutions to the issue and the response from the GMC that participants favour.

To encourage moderators to probe each topic fully using a range of appropriate prompts and probes such as 'what', 'why' 'how' the questions are not written verbatim in the topic guide or scenarios. The moderators will ensure to explore all issues with the participants using a range of questions and probes. In each case the reason given for a point of view expressed will be asked for by the moderator.

1. Introduction (10 minutes)

- Introduce researcher(s) and NatCen
- Explain who the research is for (describe the General Medical Council and their role)
 - The GMC has set guidelines for all doctors called the General Medical Practice (GMP), this sets out the standards of behaviour expected of all doctors
 - The GMC are reviewing these guidelines and would like to hear and views and opinions of different member of the public
- Explain research:

- Gathering people's views on some of the key issues that GMP address and the conduct of doctors
- Group discussion allows these issues/ views to be explored
- May have different opinions but we would like to hear them all and work towards some agreement
- Focus is not on personal experiences – only have to discuss their views in relation to scenarios if they prefer
- Explain the discussion will last between 1.5 - 2 hours. The discussion will focus on:
 - 2 – 3 scenarios (explain – examples of) of different types of situations involving doctors
 - ask about the your thoughts on the doctors actions, how this may change depending on different factors and what would be the appropriate action for a doctor to take
- Emotive issue for some and potentially sensitive/distressing to discuss
 - No right or wrong answers – wish to hear from everyone
 - Participation is voluntary - can leave the room, have a break or choose not to discuss any issue.
 - Can have a short break in the middle of the discussion, depending on how we go
 - Participants should speak one at a time, listen to what other people have to say and respect one another's answers and different opinions
 - Would like an open discussion and debate – feel free to add your comments
 - Personal experiences with doctors – Do not wish to focus on this. Focus here on standards expected for different situations and circumstances though they may talk about some personal experiences if they wish
- Explain recording, data storage and confidentiality
 - Consent form signed if group agree video recording
- Explain reporting process and that individuals will not be identified in the report or the location of the group
- Check if any questions before we start (remind them they can have a break or stop at any time)
- Ask for permission to start recording

START RECORDING

2) Participant introduction (10 minutes)

Aim: to obtain information about the participants, introduce participants to one another and allow them to feel at ease in the group situation.

- Participant backgrounds – *very brief round robin, ask each participant to give details of:*
 - First name
 - How they feel about doctors generally
 - May be useful to know whether the group generally trust doctors or not but ensure this discussion is focussed

3) General awareness of different types of doctors/situations (5 minutes)

Aim: to allow the group to begin discussion on a neutral topic and set context of existing knowledge/awareness of doctors.

- Name different types of doctors and situations whereby they may have been in contact with them
 - *Allow group to list own suggestions and use as a prompt when needed:*
 - *GP – general health complaints / initial contact*
 - *Routine health care – further tests after smear tests, mammograms, perinatal*
 - *Surgeons – operations on body parts, emergency and planned such as hip replacements*
 - *Accident and Emergency*
 - *Specialist treatment – oncologists providing treatment for cancer, drug or alcohol treatment for addictions*
 - *Specialist type of patient – paediatricians (provide treatment to children); older people; dementia care*
 - *Psychiatric care – mental ill health*

4) First Scenario

MODERATOR: CHECK THE CORRECT SCENARIO FOR EACH GROUP IS BEING USED

(25 minutes)

Aim: to explore a number of interrelated issues relevant to the GMC via a detailed scenario with the group. Probe different opinions throughout the discussion and summarise the key issues.

Explain that the next 20 -25 minutes will be used to discuss people's views on the doctor's behaviour.

Read out the scenario and follow instructions on scenario for ensuring discussion.

Ensure coverage of:

- *General views on conduct/behaviour and reason given for this*
- *Variations to scenario*
- *Resolutions and responses*
- *GMC response*

- *Summary*

5) Second Scenario

MODERATOR: CHECK THE CORRECT SCENARIO FOR EACH GROUP IS BEING USED

(25 minutes)

Aim: to explore a number of interrelated issues relevant to the GMC via a detailed scenario with the group. Probe different opinions throughout the discussion and summarise the key issues.

Explain that the next 20 -25 minutes will be used to discuss people's views on the doctor's behaviour of a second scenario.

Read out the scenario and follow instructions on scenario for ensuring discussion.

Ensure coverage of:

- *General views on conduct/behaviour and reason given for this*
- *Variations to scenario*
- *Resolutions and responses*
- *GMC response*
- *Summary*

**Suggest five minute comfort break for participants at this point if needed*

6) Third Scenario

MODERATOR: CHECK THE CORRECT SCENARIO FOR EACH GROUP IS BEING USED

(25 minutes)

Aim: to explore a number of interrelated issues relevant to the GMC via a detailed scenario with the group. Probe different opinions throughout the discussion and summarise the key issues.

Explain that the next 20 -25 minutes will be used to discuss people's views on the doctor's behaviour of a second scenario.

Read out the scenario and follow instructions on scenario for ensuring discussion.

Ensure coverage of:

- *General views on conduct/behaviour and reason given for this*
- *Variations to scenario*
- *Resolutions and responses*
- *GMC response*
- *Summary*

- *Final comments on scenarios*

Signal to group moving onto final discussion session

7) Additional areas of Doctors behaviour (10 minutes in total)

Aim: Moderator to lead brief discussion on any issues that have not been covered in the scenario discussion from the following list depending on what has been covered in previous discussion.

- **Should doctors be able to refuse patients treatment** (in any circumstance/certain circumstance)
 - *Such as violent patient; patient who smokes; due to doctors own beliefs*
 - *Characteristics of patient – female, older, disabled,*
 - *Probe on degree of need – i.e. violent patient who requires life-saving emergency treatment vs. a prescription*

- **Doctors professional boundaries/life outside of medicine**
 - *Should doctors be able to have relationships with patients?*
 - *Does characteristic of patient matter (i.e. much younger than doctor)*
 - *Should doctors be able to treat their own relatives or close partners/friends?*
 - *Should a doctors behaviour outside of medicine matter?*
 - *Drunkenness, breaking the law such as a speeding ticket, breaking the law such as assault*
 - *Would any of these issues affect their trust in a doctor?*

- **Doctors as advocates/conflicts of interest**
 - *In a situation where treatment is very expensive and may lead to another patient not being able to access treatment should a doctors provide it?*
 - *Is the individual patient or the health system and access to all more important?*
 - *Should a doctor report concerns about a vulnerable patient to the police or social services even if they may not want them to?*
 - *Is the confidentiality of doctors and patients more important than doctors protecting patients who are at risk?*
 - *Should doctors be able to benefit financially from the treatment they provide for example owning a pharmacy where patient obtain prescriptions?*
 - *And does it matter if patients are informed of this or not?*

Trust in doctors – consider whether this has been adequately covered via the group discussion

8) Conclusion (5 minutes)

Aim: to summarise key issues that have come up, give participants the opportunity to raise anything that has not been covered and to wind down

- Single message to the GMC about doctors conduct/ behaviour

- Anything to add
- How does each feel about having taken part in the group now (return to round robin introduction process)

Explain that handouts provide details of how to make a complaint about a doctor if needed and more on the role of the GMC

**Stop recording * Thank participants * Reassure about confidentiality * Explain next steps of research
Encourage participants to remain for further refreshments or to ask questions/chat**

Complaints and the role of the General Medical Council³

The General Medical Council (GMC) regulates doctors in the United Kingdom. Its governing body - the Council - is made up of both doctors and members of the public.

The GMC:

- sets the standards of [Good Medical Practice](#) it expects of doctors throughout their working lives;
- assures the quality of undergraduate medical education in the UK and co-ordinates all stages of medical education;
- administers systems for the registration and licensing of doctors to control their entry to, and continuation in, medical practice in the UK;
- deals firmly and fairly with doctors whose fitness to practise is questioned.

What action can the GMC take?

Before the GMC can stop or limit a doctor's right to practise medicine, it needs evidence of impaired fitness to practise. This might be, for example, because they:

- have not kept their medical knowledge and skills up to date and are not competent;
- have taken advantage of their role as a doctor or have done something wrong;
- are too ill, or have not adequately managed a health problem, to work safely.

We can also issue a warning to a doctor where the doctor's fitness to practise is not impaired but there has been a significant departure from the principles set out in the GMC's guidance for doctors, Good Medical Practice. A warning will be disclosed to a doctor's employer and to any other enquirer during a five-year period. A warning will

³ Source: http://www.gmc-uk.org/concerns/complaints_and_role_of_the_gmc.asp
on 16 March 2012

not be appropriate where the concerns relate exclusively to a doctor's physical or mental health.

What the GMC can't do

The GMC cannot:

- deal with concerns or complaints about nurses, pharmacists, dentists, opticians, hospital or practice managers or administrative staff, or anyone who is not a registered doctor;
- normally give you a detailed explanation of what happened to you. This can only come from the doctor or health provider;
- order a doctor to provide the treatment you want;
- pay you compensation;
- fine a doctor;
- order a doctor to give you access to your records;
- make a doctor apologise to you.

Legal framework for Fitness to Practise procedures

The legal framework for our Fitness to Practise procedures is set out in Medical Act 1983 and the Fitness to Practise Rules 2004. You can view the legislation and supplementary information on the [Legislation page](#) in the *About Us* section of the website.

Medical Practitioners Tribunal Service

In July 2011 the GMC's Council approved plans to establish the new Medical Practitioners Tribunal Service (MPTS). The establishment of the MPTS is a key part of the GMC's plans to reform its adjudication work following the government's decision to abolish the Office for Healthcare Professional Adjudicator (OHPA). The reforms will introduce an even greater separation between the GMC's investigation work and fitness to practise hearings.

His Honour Judge David Pearl has been appointed as the Chair of the new MPTS that will manage all fitness to practise hearings for doctors from summer 2012.

Read the [GMC's press release announcing the appointment of the Chair of the MPTS](#).

Our role in identifying safeguarding risks to children and vulnerable adults

The Safeguarding Vulnerable Groups Act 2006 requires us to refer information to the Independent Safeguarding Authority (ISA) where we believe there is a safeguarding risk to a child or vulnerable adult in England, Wales or Northern Ireland. The ISA's role is to help prevent unsuitable people from working with children and vulnerable adults in England, Wales and Northern Ireland.

Read the guidance we provide to our decision makers about when to refer information to the ISA in [England, Wales and Northern Ireland](#) (pdf, 397kb) and [alternative trigger points for referring information in Northern Ireland](#) (pdf, 99.5kb)