General Medical Council

Exploring the experience of doctors who have been through the GMC's complaints procedures

Final Research Report

March 2013

Contents

1. Executive Summary

1.1 Introduction, objectives and methodology

In 2011, as part of a review, the GMC's Fitness to Practise Directorate highlighted a need to conduct survey research to better understand the experience of doctors who have been through fitness to practise (FTP) procedures. This research will be used to help inform the development of potential changes to the procedures. It is proposed that the research be repeated periodically to track trends and identify areas for improvement.

The objectives of the research were:

- To explore perceptions of experiences at various stages of the FTP process and suggested improvements at each stage.
- The stages were identified as:
    1. The initial letter informing the doctor of the complaint and the accompanying leaflet.
    2. Communication with employers/contractors about the complaint.
    3. The investigation process.
    4. Interim Orders Panel hearing.
    5. Case examiner decision and outcome.
    6. FTP Panel Hearing.
- To explore perceptions of communication throughout the process and overall suggested improvements to the FTP procedure

The methodology consisted of the following 3 stages:

Project component	Description
Cognitive pilot	Testing of the quantitative questionnaire with 3 doctors and 2 medically trained GMC staff
Research with doctors	Quantitative survey (postal and online) with 169 doctors 20 in depth interviews following up issues raised in quantitative survey
Research with doctors who had been erased by an FTP panel	5 in depth telephone interviews, based on the online questionnaire, with doctors erased by an FTP panel

The results of the cognitive pilot were fed back to the GMC and the questionnaire amended accordingly. This report therefore only includes the results of the other two project components.

1.2 Overall conclusions

The vast majority of doctors who go through the FTP process have not chosen to do so (although some self-referrals do occur). The nature of the process generally means that a doctor has had a complaint made about their practice or a negative event has led the GMC to investigate the doctor. As such, doctors are unlikely to view the experience positively. Whilst doctors were asked to be objective and to feed back on the process itself rather than the details of their own case, it should be recognised that, for many, the process and the case will have been a distressing experience. Furthermore, the research focussed on suggestions for process improvement and as such actively sought doctors to be critical. It is unsurprising therefore that the research revealed many concerns about the process and that there was considerable strength of feeling about some aspects of the process. Despite this, there were also some positive messages regarding the process, particularly in terms of the clarity of GMC communications.

1.2.1 Survey findings

Initial letter and leaflet.

The initial communications from the GMC following the complaint received mixed feedback. On the positive side, over three quarters of doctors (79%) agreed that the initial letter informed them of the concerns that had been raised. However, views were more evenly split about whether the letter is clear about the process that would follow (51% agreed and 44% disagreed). The most common suggested improvements about this early stage included "give me more information on the different routes and outcomes" and "keep me informed/ up to date/ copy me in to all correspondence" (with 18% of individuals reporting this in each case). Whilst almost a third of doctors couldn't recall the leaflet, the majority of those who could recall it found it 'quite helpful' or 'very helpful'.

Communication with employer

Respondents were divided on perceptions of the GMC's communication with their employer and there appeared to be some uncertainty about these communications. Almost half (49%) expressed dissatisfaction with regard to how well they were kept informed about communications between the GMC and their employer. Responses suggest that whilst doctors are told that their employer will be communicated with, they don't know exactly what is being disclosed in this communication. The most common suggested improvement to the GMC's communication with employers is more transparency and the sharing of correspondence across all parties (53% offered this response to the open ended question regarding improvements).

The investigation process

In terms of the investigation process itself, there was considerable agreement that the GMC gave doctors and their representatives enough time to comment (80%). Other aspects of the investigation process received a more mixed response, with opinion divided on whether or not they were 'kept informed of

progress' and whether or not 'their comments were considered as part of the investigation'. Almost two thirds (62%) disagreed that the investigation was conducted in a timely manner and the most common suggested improvement was to speed up the process (23% gave this response to the open ended question regarding improvements).

Case examiner decision

The vast majority (92%) of those who had been through a full investigation agreed that the case examiner decision was clearly stated and 86% agreed that they understood its implications. The most common suggested improvements to this element of the process included having a better attitude towards / or more support of 'exonerated' doctors (28% gave this response to the open ended question asking for suggested improvements) and to speed up the process (23%).

Communications

Almost three quarters of doctors (73%) agreed or agreed strongly that the tone of the written communications from the GMC is professional. However, opinion was more divided about whether or not they were kept updated by the GMC about the progress of their case (49% agreed and 46% disagreed). The most common suggested improvement in relation to communications was to be given "more information / be kept up to date" (22% provided this response to the open ended question asking for suggested improvements to communications).

Single most important thing to improve

When asked, in an open-ended question 'what is the most important thing that the GMC should do to improve the Fitness to Practise procedure for doctors?', the most common responses with around 1 in 5 of all responses related to earlier vetting of cases or filtering vexatious complaints (21%) and making the process faster (20%).

1.2.2 In depth qualitative feedback

The findings from the qualitative interviews initially appear to be more negative than the findings from the quantitative survey; however this does not necessarily indicate that the two are misaligned. During the qualitative interviews, discussions focussed on the reasons behind answers given in the quantitative survey and it was often the case that more negative perceptions were revealed than had immediately been apparent from the bald quantitative responses. For example, in the survey, a clear majority of respondents agreed that they had sufficient time to comment, but when asked about this in the qualitative phase, they talked about the entire process being much too long, which was frequently a cause of considerable dissatisfaction, even though this, in turn, meant that they had had plenty of time to make comments.

The qualitative sample, although 'self-selecting' in the sense that they put their names forward for the qualitative phase, was nevertheless broad. Over two thirds (67%) of all those taking part in the survey volunteered to be

interviewed in the qualitative phase with actual participants selected at random.

Common Concerns

The responses of qualitative interviewees were remarkably consistent regardless of the parts of the process they had been through, suggesting common concerns across all those who had experienced the process. This commonality was also reflected in the survey, where analysis showed there to be no significant differences in the answers of respondents who had been through the different parts of the process.

The common concerns were as follows:

- A perceived lack of clarity within the process and insufficient information, particularly with regard to progress in their case.

- The perceived adversarial nature of the investigation and the sense that there is a 'guilty until proven innocent' attitude from the GMC.

- The protracted nature of the process.

- Perceived insufficient scrutiny of the complaint at the start (and whether it necessitates investigation at all).

- Inflexibility of the process (not allowing discussion between doctor and GMC from the outset).

- Doctors often perceived there to be a lack of understanding by case examiners, and sometimes assessors, about the nature of the complaint and surrounding issues.

    - Amongst the small number of respondents who had experienced a Fitness to Practise panel hearing, key suggestions for improvement included:
        - Improving the atmosphere of the hearing.
        - Ensuring hearings are run more efficiently.
        - Changes to the panel composition.
        - Improvement to the process of closure for doctors after the hearing.

At a broader level, the research highlighted fundamental issues of mistrust. There was a feeling amongst doctors who had been through the fitness to practise process that the GMC does not trust them and in turn these doctors do not trust the GMC – some believing that the GMC is 'out to get them.' The fact that the GMC investigates the doctor's practice as a whole, not just the individual complaint or concern, was seen as unfair and doctors criticised the 'creep in the scope' of the investigation, beyond the allegations. This indicates that doctors tend not to understand GMC's statutory obligations as a public protection body when examining complaints to examine the doctor's entire

practice and not to limit its investigations. This sense that there is 'creep in scope' feeds the overall sense of mistrust in the GMC.

1.2.3 Key Challenges for the GMC

The research highlights a number challenges for the GMC in seeking to improve the FTP experience, but two in particular will present a challenge because the responses from doctors are to an extent contradictory and therefore difficult to resolve:

- In terms of communication: some doctors wanted early reassurances from the GMC's staff that the chances are good that everything will turn out well in their case. However, others bemoaned being given false hope by having received such reassurances. It will be very difficult for the GMC to tread the right line on this issue to the satisfaction of all.

- In terms of the GMC meeting with doctors to discuss their case, there seems to be a possible conflict between doctors wanting to meet and discuss their case with the GMC; but strong evidence from the feedback received, that in the past their representation has actively discouraged doctors from engaging with the GMC in such a way.

2. Introduction, Objectives and Methodology

2.1 Introduction

In 2011, as part of a review the GMC's the Fitness to Practise Directorate highlighted a need to conduct research to better understand the experience of doctors who have been through fitness to practise (FTP) procedures. This research will be used to help inform the development of potential changes to the FTP procedures. It is proposed that the research be repeated periodically to track trends and identify areas for improvement and that additional, complementary research will also be conducted with complainants.

2.2 Objectives

The research explored perceptions of experiences throughout the FTP process, as well as broader issues of communication and general suggested improvements. The structure of both the quantitative questionnaire and qualitative topic guide were broadly similar, and asked for feedback on the following (where relevant):

- The initial letter informing the doctor of the complaint and the accompanying leaflet.
- Communication with employers/contractors about the complaint.
- The investigation process.
- Interim Orders Panel hearing.
- Case examiner decision and outcome.
- FTP Panel hearing.
- Communication during the process.
- Overall experience.

2.3 Methodology

The research focussed on doctors with a case closed during 2010.

A mixed methodology was used, with the following three stages:

Project component	Description
Cognitive pilot	Testing of the quantitative questionnaire with 3 doctors and 2 medically trained GMC staff
Research with doctors	Quantitative survey (postal and online) with 169 doctors 20 in depth interviews following up issues raised in quantitative survey
Research with doctors erased by an FTP panel	5 in depth telephone interviews, based on the online questionnaire, with doctors erased by an FTP panel

Cognitive pilot

In November 2011 the GMC wrote to 51 eligible doctors (i.e. those with a case closed during 2010 and without a subsequent open case) and invited them to participate in a cognitive pilot to help inform the design of the questionnaire for the quantitative survey. Doctors were invited to 'opt-in' to the pilot by contacting Community Research. Three doctors opted in. Given this low response, 2 GMC members of medically trained staff with knowledge of the FTP process also participated in the pilot to provide additional feedback.

These participants were interviewed by Community Research over the phone, with interviews lasting between 30 to 45 minutes. The interviewees were sent a copy of the draft questionnaire in advance of the interview and asked to review immediately prior to discussion.

Interviewees were asked about the following:

- What key changes they thought would improve the questionnaire.
- If anything was unclear/ambiguous/confusing.
- If anything was missing / any gaps.
- Views on the mix of question type, scales used and questionnaire length.

The results of the cognitive pilot were fed back to the GMC in the form of an amended and annotated questionnaire.

Research with doctors

Doctors with a case closed during 2010 were written to by Community Research (mailed by the GMC) and asked to participate in the research. A total of 2,363 doctors were contacted. The letter contained a URL directing doctors to the online survey, but it also allowed doctors to contact Community Research to request a paper questionnaire.

The questionnaire contained 'routing' meaning that doctors only completed the sections of the questionnaire relevant to them (in terms of the FTP processes that they had been through).

In total, 169 doctors completed the survey (a response rate of 7%). The survey was conducted from early June to mid-July 2012.

The last question of the survey asked respondents if they would be willing to participate in a further qualitative research phase, and if so, to leave their details. 113 of these doctors were willing to participate and provided the sample for the qualitative stage. A number of these doctors were then selected to participate in a telephone interview, at a time of their choosing, lasting up to 1 hour.

The 20 qualitative interviews were made up accordingly:

Doctor category	Interviews conducted
Those who have experienced a FTP panel	9*
Those who experienced the Interim Orders Panel process (but did not go on to a FTP Panel)	3*
Those whose case went to an Investigation Committee (but who did not go on to a FTP Panel)	3*
Cases where a warning was issued or where undertakings were suggested (and agreed or refused)	1*
Cases which were fully investigated and then subsequently closed	2
Cases where the GMC did not conduct a full investigation	2

*All survey respondents in this category who indicated a willingness to be contacted for the qualitative phase were contacted for a qualitative interview.

Research with doctors erased by a FTP panel

Doctors who had been erased from the register by a FTP panel were also written to by Community Research (again mailed by the GMC) and invited to participate in the research. 5 doctors agreed to participate.

They were interviewed by Community Research over the telephone and interviews lasted between 45 minutes and 1 hour. The interviews were based on the quantitative questionnaire, but were essentially qualitative in nature, enabling the doctors to talk through their specific issues and concerns in a more flexible and open way. This cohort was approached using this different methodology because of the additional sensitivity associated with such cases.

The interviews were conducted between 20th and 25th July 2012.

Notes on reading the report

It is worth noting that the doctors who participated in this research 'opted in' to the process and actively responded to communication about the research saying that they were willing to participate. We did not interview everyone who had been through the FTP process in 2010 and so we cannot say for certain that those interviewed are entirely representative of this broader population.

The vast majority of doctors who go through the FTP process have not chosen to do so (although some self-referrals do occur). The nature of the process generally means that a doctor has had a complaint made about their practice or a negative event has led the GMC to investigate the doctor. As such, it is to be expected that doctors will not view the experience positively. Whilst doctors were asked to be objective and to feed back on the process

itself rather than the details of their own case, it should be recognised that, for many, the process and the case will have been a distressing experience. Furthermore, the research focussed on suggestions for process improvement and as such actively sought doctors to be critical.

It is also important to note that both the quantitative and quantitative phases of the research asked participants their thoughts based on their recollection of what happened in their case and the process that they went through. They were not given information about the detail of what happens at each stage of the process (as shown throughout this report in text boxes, to aid the reader's understanding) and they were not asked to have any documentation to hand.

This report does not include findings from the cognitive pilot. These results were used to amend the questionnaire which was used as the basis of the second and third stages of the research.

The feedback from the interviews with doctors erased by a FTP panel has been incorporated amongst the qualitative feedback from doctors, within the main findings of this report.

The figures quoted in the tables and charts in this report are percentages unless otherwise stated. Base sizes on which percentages are calculated are provided at the bottom of the chart or table. Percentages may not sum to 100% in all instances on account of rounding.

Any differences cited in this report between respondent groups are statistically significant at the 95% confidence level. Other differences which are not statistically significant are not mentioned.

Also the results are subject to sampling error. Overall at their least accurate the results are accurate to +/- 6% at the 95% confidence level. This means that if 50% of the sample agreed with a specific question, the chances are that 19 times in 20 the true value (if the whole population had been interviewed) would be between 44% and 56%.

Throughout the report, doctors who took part in in-depth interviews are called 'participants' and those who completed the quantitative survey are called 'respondents' in order to differentiate between them.

3. Key Findings

3.1 The complaint or referral

Process
In each case that the GMC investigates, they write to the doctor and disclose the complaint or referral at an early stage. The letter asks the doctor to provide details of his or her employer/s or contracting bodies (records of individual doctors' employers are not maintained by the GMC), and invites the doctor to provide comment on the complaint or referral.

The GMC's triage process identifies those complaints or referrals that on the basis of the information provided would, if proved, require it to take action to protect patients. Only once this question has been settled does the GMC investigate the veracity of the complaint itself. In 2010 50% of complaints were closed immediately at this initial stage, a further 21% were referred back to employers to deal with and 29% were investigated.

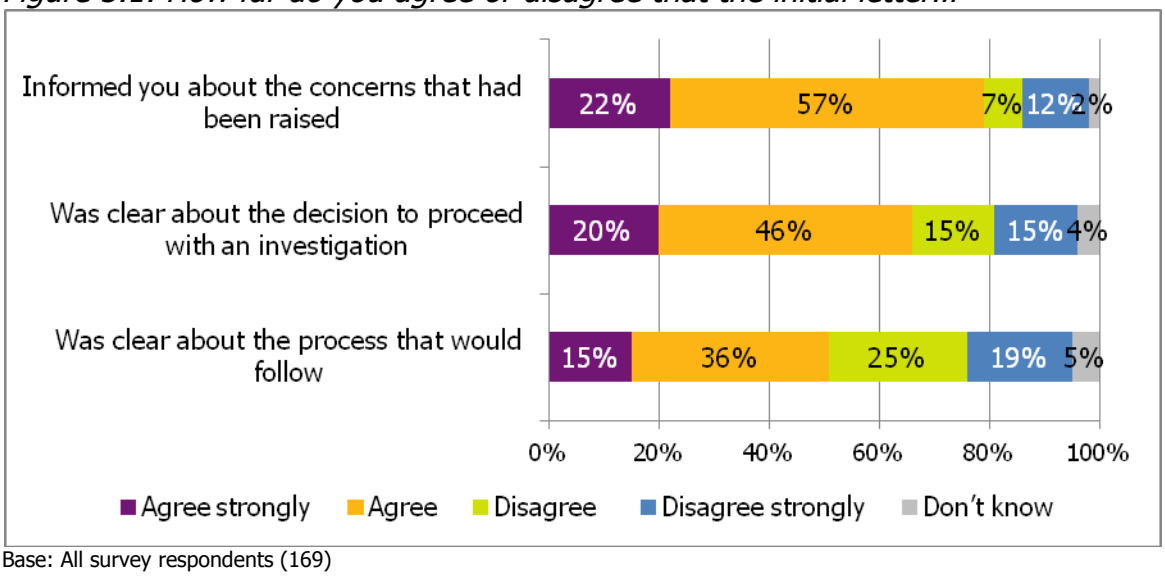
3.1.1 Clarity of the process and the decision to investigate

The survey began by asking respondents about the initial letter they received informing them of the complaint or referral.

Over three quarters (79%) of respondents agreed or agreed strongly that the initial letter informed them about the concerns that had been raised. Two thirds of respondents (66%) also agreed or agreed strongly that the letter was clear about the decision to proceed with an investigation; although there was a notable minority who disagreed or disagreed strongly with this (30%).

Opinion was almost equally divided about whether or not the letter was clear about the process that would follow; 51% of respondents agreed or agreed strongly and 44% disagreed or disagreed strongly that the letter was clear about the process that would follow.

Figure 3.1: How far do you agree or disagree that the initial letter…



Base: All survey respondents (169)

Respondents were then asked an open ended question (allowing them to write their own response) on how this initial stage of the process could be improved. The two most common responses, each with nearly one fifth of mentions (18%) were "keep me informed/ up to date/ copy me in to all correspondence" and "give more information on the different routes[1] and outcomes."

> *"A lot more information provided about the stages, and who would be dealing with the complaint at that stage."*
>
> *"Clearer understanding of the process/procedure would have helped. Including information on the stages/levels of investigation and action."*

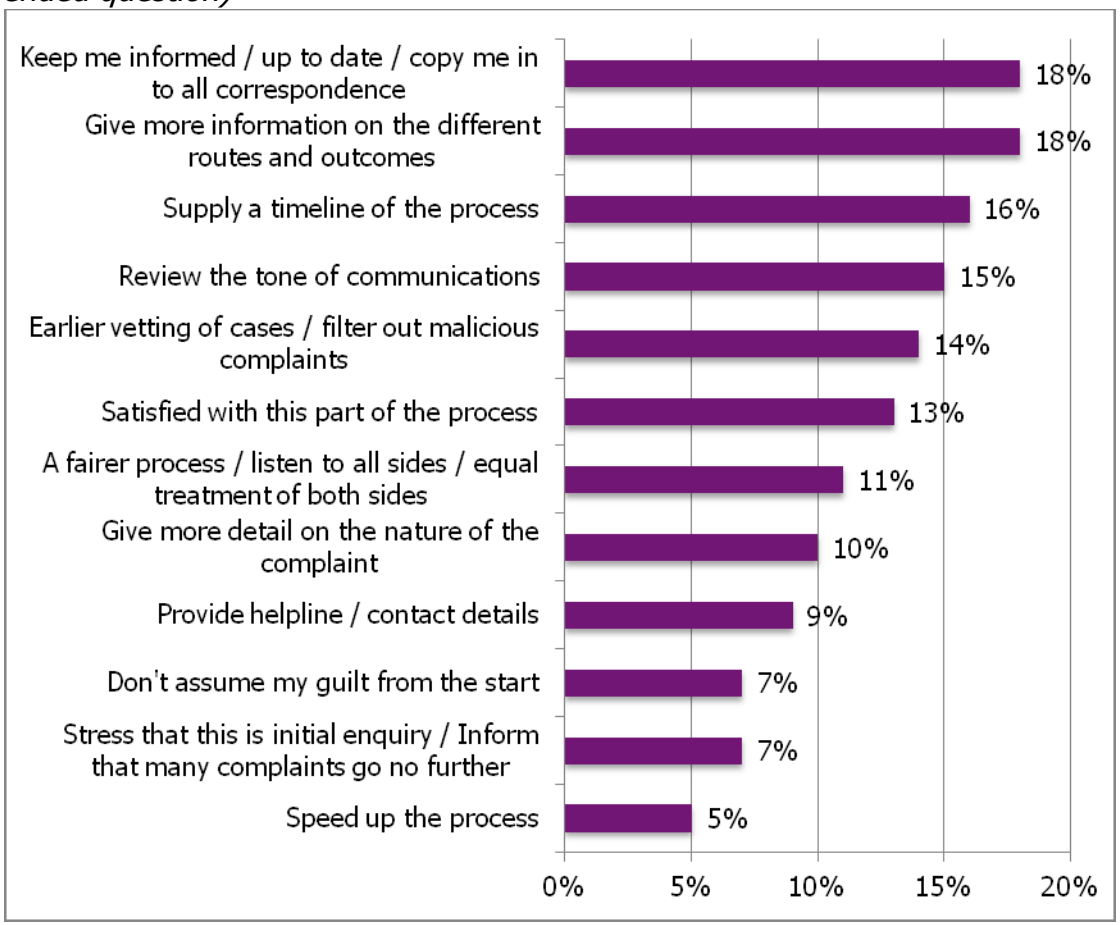
Other common responses at around one sixth of mentions included "supply a timeline of the process" (16%) and "review the tone of communications" (15%). Figure 3.2 provides shows the responses.

> *"Clearer about the process. Realistic about the timeframe. Clearer communications channels."*
>
> *"An initial letter, followed by a telephone call to reassure. The letter isn't very sensitively worded. Makes you feel guilty from the start."*

[1] The FTP process has various stages, as will be explored within later stages of this report. Doctors were asking here for greater clarity about the possible stages that might occur.

"A far less aggressive letter would be much better; one that did not make you feel like a criminal and that the GMC had decided against you already."

Figure 3.2: How could this initial stage of the process be improved (open ended question)



Base: All survey respondents (169)

Qualitative findings supported these open ended survey responses; doctors talked about wanting more information at the early stages of the process. They wanted to be better prepared, and would like to know what processes they might go through, how those processes work, who will be investigating and how. It was felt that a process map would be useful. They also wanted to know how long the entire process might take.

"It doesn't tell you how it's going to be investigated, who is going to investigate it, what the relative level of knowledge of the person who's going to be investigating it is and what it is that they're looking for. It just tells you there's going to be an investigation."

"They gave no indication as to what sort of timescales they'd be working to, so 18 months passed following that initial letter, maybe even up to two years, before it was finally dealt with. I

wasn't given an indication it would take that long, I wasn't given any indication as to what it was they were going to be doing, what their procedures were, what information they were looking for etc."

"I had to go and find the map and I found it on the GMC website and actually, having found the map, it still wasn't particularly reassuring because it wasn't a nice process but, having found the map, at least I knew where I stood."

When talking about communication at this early stage, doctors asked for more information about how the investigation would progress and the likely timescales involved.

"I think if you are going to send that letter out you need to make the decision within a month, you can't let it drift on for several months leaving people unsure as to what's going to happen."

In the qualitative interviews there was some discussion about the tone of this early communication, with doctors saying that the letter made them feel fearful and some said that the tone gave them the impression that the GMC was presuming their guilt. Some suggested there being something in the letter to reassure them, such as how many complaints are dropped.

"Obviously this is a terrifying moment. Perhaps [the letter needs] fuller reassurance that most cases go no further."

In the qualitative interviews there were also calls for more rigorous examination of the complaint at this early stage, both to vet unsubstantiated or vexatious complaints and to talk to the doctor and resolve issues that may be easily explained.

"The initial triage of it, that it seemed to automatically go down the full review rather than someone looking at it sensibly and saying 'well'. In medicine generally, we'd triage things that are obvious, there are things where they absolutely need to be investigated in complete thoroughness because someone's life is at risk as a result of it. I just wonder whether there's something, when they've initially seen the complaint, especially with the doctor's statement."

"We just assume that if anyone complains about a doctor to the GMC that automatically triggers off an investigation. Clearly it needs the GMC to come off sitting off the fence and say 'look, we've received this complaint and our initial concerns are x, y and z', a brief summary."

> *"The letters had this threatening tone and it seemed that, as soon as somebody complains to the GMC, they sort of swing into action and start looking for things then. It wasn't a question of 'has this patient's complaint any justification? Let's look through all that's gone before the Trust and get an expert to look at the answers'. This was 'oh, here's a chance to investigate a doctor, let's see what we can find'. That was the impression that I was given of the way the whole process went, which seems grossly unfair really."*

These comments suggest that doctors are not aware of the processes that have occurred before their initial letter was sent.

In the qualitative interviews a few participants commented that the GMC should look at the context and source of the complaint and whether the complainant have a particular bias or 'axe to grind.'

> *"I think they need to look at the context, rather than just seeing it as being a complaint they need to look at the context and I think this particularly applies, … perhaps across the piece, but it certainly applies to family, to expert witness work where there are clear reasons why people might want to complain."*

As shown in figure 3.1, survey responses showed the greatest level of disagreement with the statement that the initial letter was clear about the process that would follow. This was elaborated on in the qualitative interviews. A few participants indicated that they had been confused on receipt of the initial letter and the attached letter from the complainant. Although the initial letter states that the complaint or information enclosed raises concerns and requests certain actions from the doctor, these participants reported that they were unsure whether or not this was a complaint (especially if they did not read the complainant's letter as a complaint) and they were unsure what they should do about it. They thought the situation needed to be made clearer.

> *"So I got this letter and I didn't know, is it a complaint? Is it not a complaint? Is it making me aware? How do I respond? Where will this go to next? What will happen to my response? I didn't know whether they were just saying 'respond to this and we may well just drop the whole thing' or whether 'the process has now started. I think if they'd said in their letter 'we are treating this as a complaint, this complaint will be handed over to two case examiners who will assess it further along with your response, the possible next stage is.'"*

> *"It just said 'please find enclosed the letter', basically I think they were just saying here's a letter, a complaint, read the letter and I suppose what they implied was that if I read the letter I'd*

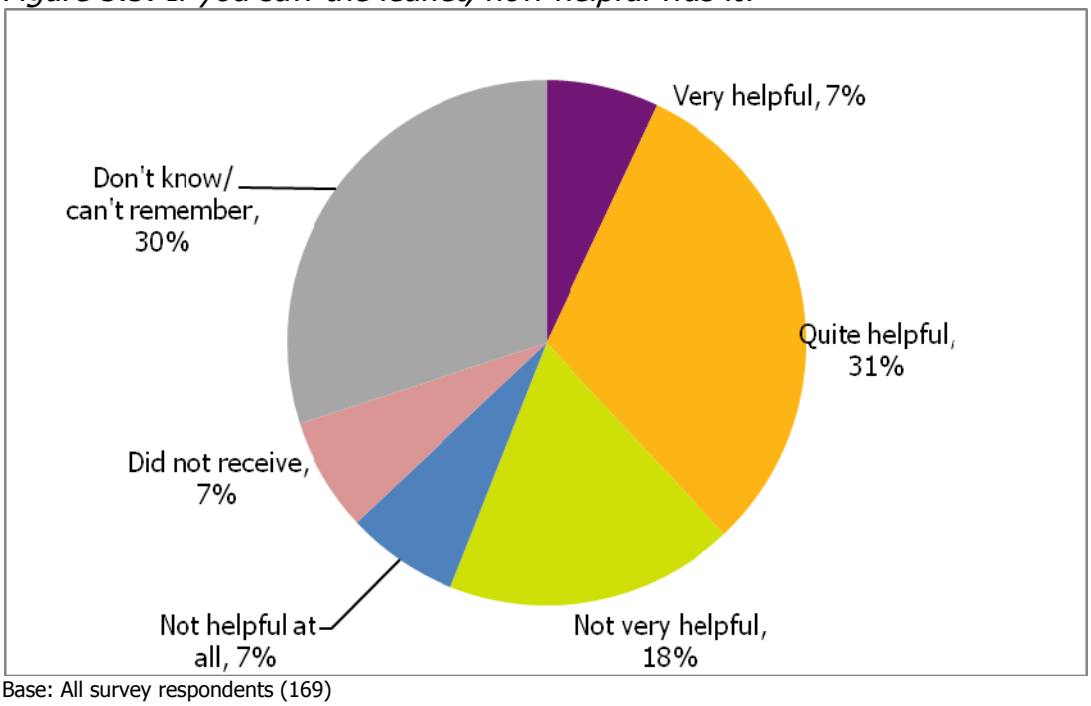
know what the complaint was about. But, as I said, I was barely able to understand the letter and certainly didn't understand what the specific complaint was about me."

3.1.2 Perceptions of the leaflet and suggested improvements

Process
Enclosed with the initial letter, doctors receive a leaflet that is a guide to the GMC procedures, from the initial stage of considering an enquiry through all stages of the process, including hearings and appeals.

Respondents were asked about the leaflet that accompanied the initial letter. Nearly a third of respondents had no recollection of this leaflet (30%), with a few saying they had never received the leaflet (7%). However amongst those that did remember the most common response was that this leaflet was 'quite helpful' (31%), full responses are shown in Figure 3.3. The majority who could recall the leaflet found it quite or very helpful.

Figure 3.3: If you saw the leaflet, how helpful was it?



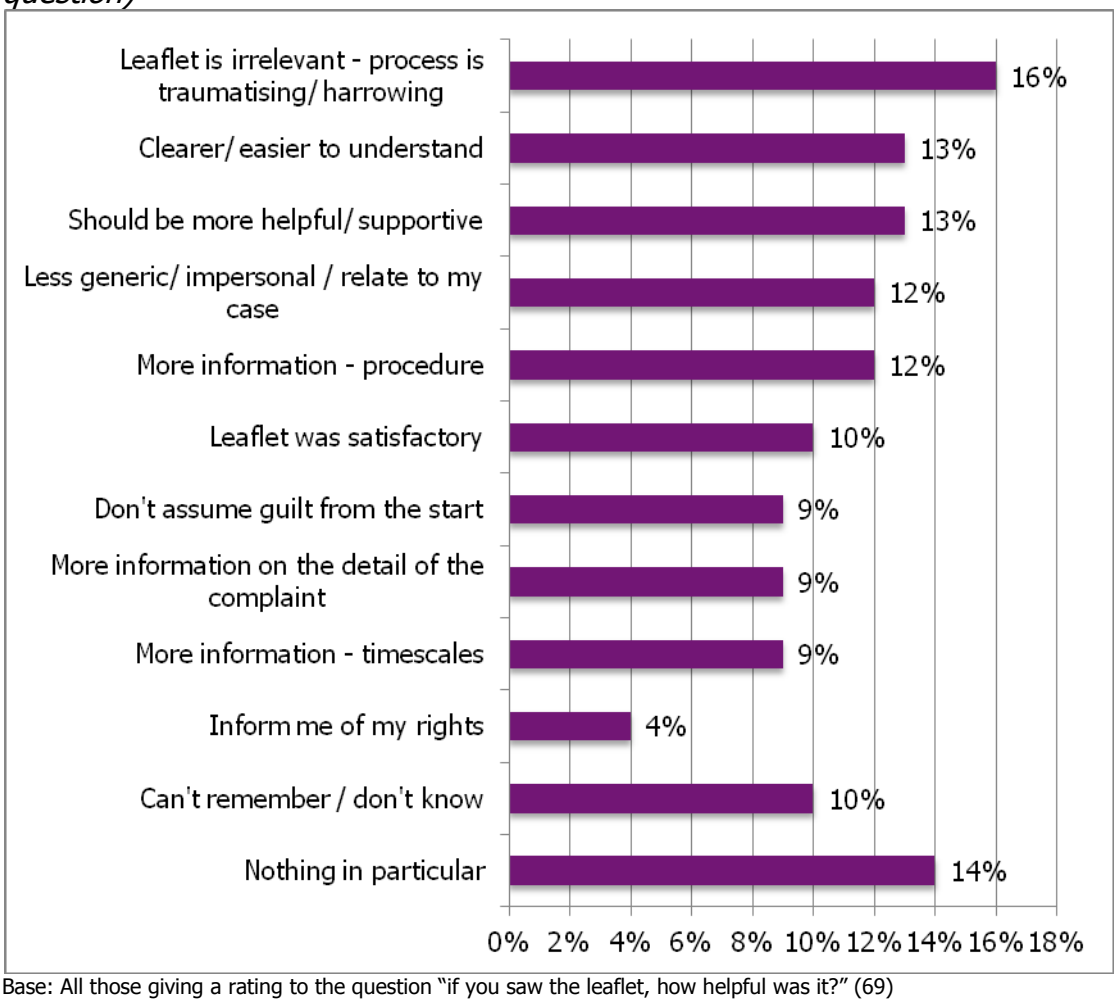
Base: All survey respondents (169)

Respondents who remembered the leaflet were asked about how this leaflet could be improved. There was not much consensus of response to this open ended question.

Other suggestions included making the leaflet "clearer and easier to understand" (13%) and "more helpful/supportive" (13%). One source of suggested support was an explanation of the number of complaints made to the GMC and their outcomes, in order to provide context or acknowledgement that complaints can be vexatious.

"It is very dry and unsympathetic. It is pro-complainant anti-doctor. It needs to be more reassuring for the majority of excellent clinicians who have been reported. Acknowledgment must be made that vindictive patients will make groundless accusations."

Figure 3.4: How could the information leaflet be improved (open ended question)



Base: All those giving a rating to the question "if you saw the leaflet, how helpful was it?" (69)

In the qualitative interviews, those that didn't find the leaflet helpful were mainly critical because they wanted more personalised information, telling them what processes they are likely to go through; what their role / involvement / rights are at each stage of the process; and how long it is likely to take. There was also a sense that the enormity of the situation and the stress that a GMC investigation causes, cannot be tackled or mitigated by a leaflet – hence the most common response in Figure 3.3 above with nearly one in six (16%) saying "the leaflet is irrelevant – the process is traumatising/harrowing."

"At this stage the reaction is going to be distress at receiving a complaint, so it's difficult to provide information that will be reassuring."

There was also comment that the stress of receiving the letter can make it difficult for any information, however useful, to 'sink in'.

> *"The initial shock removes the ability to think clearly. Information and instructions (in the leaflet) need to have complete clarity."*

There were suggestions that the leaflet could have more advice or FAQ's on issues such as the doctor's rights and getting representation.

> *"I was sent a leaflet which explains the process but it doesn't advise what to do and, of course, what is best practice. For example, this is the first stage, that's how we file the complaint. And perhaps you're not obliged to involve anyone else but it would be a good idea to involve someone else like, for example, your Medical Defence organisation."*

> *"The advice that I would give to colleagues now which I think it would be helpful to be reflected some way in the literature and advice provided by the GMC which, I think it does say we advise you to consult your solicitor or whatever, but I think it should be more explicit that the GMC uses an adversarial process and you need to defend yourself."*

3.2 Communication with employer(s) or contractor(s) of services

3.2.1 Ratings of aspects of communication

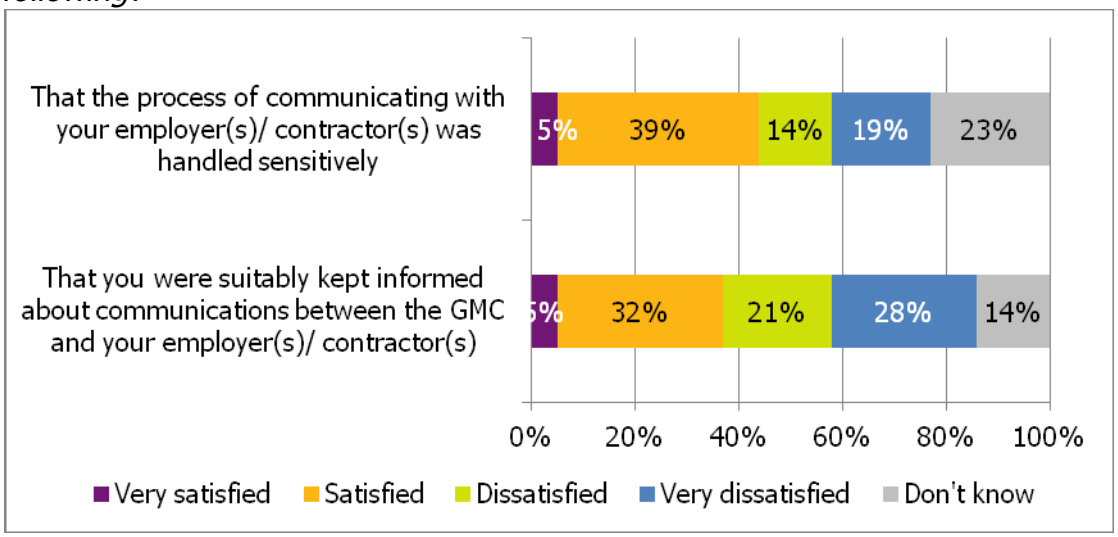
The process
In order to investigate a complaint or referral, the GMC contacts doctors' employers at an early stage and asks for their feedback about the complaint and the doctor's fitness to practise. The initial letter specifically asks the doctor for their employer details because the GMC does not maintain records of individual doctors' employment. This informs the doctor that once they have returned the form providing their employment details, the complaint or referral will be sent to the employer or contracting body for comment. This exchange also ensures that the GMC will have a complete overview of the doctor's practice and that any information held by the GMC is available to those responsible for local clinical governance.

All respondents who were employed or working under contract at the time of the complaint were asked about how satisfied or dissatisfied they were that the process of the GMC communicating with their employer(s) or contractor(s) was handled sensitively. Views were mixed with 44% satisfied or very satisfied, but a third dissatisfied or very dissatisfied (33%) and a quarter said that they didn't know (23%). The qualitative interviews showed

that a number of doctors did not remember anything about providing employer details and communication with their employer, which would explain this high 'don't know' response in the survey.

The survey showed greater dissatisfaction about how they were kept informed about communications between the GMC and their employer/contractor; almost half of the respondents stated that they were dissatisfied or very dissatisfied (49%). Responses are shown in Figure 3.5.

Figure 3.5: How satisfied or dissatisfied were you with the following?



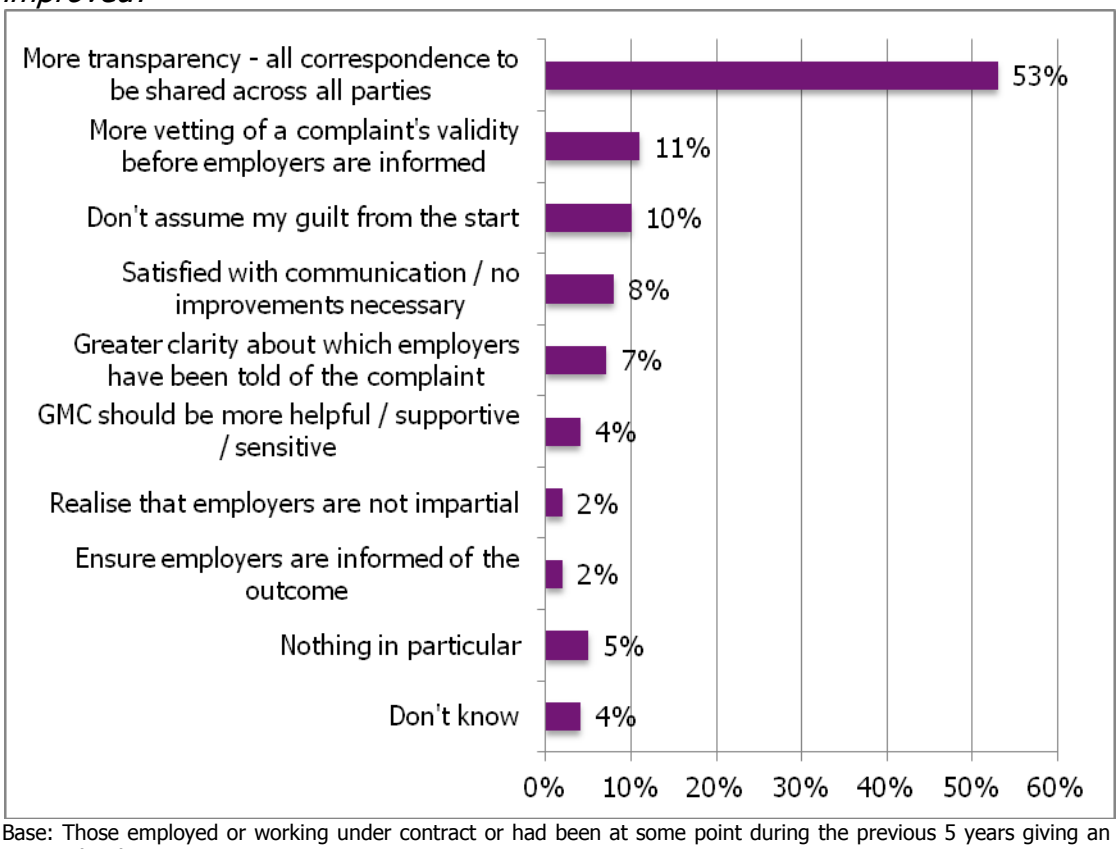
Base: Those employed or working under contract or had been at some point during the previous 5 years (145)

3.2.2 Suggested improvements

There was considerable consensus among respondents about how communication with employers should be improved. In response to an open ended question about how this part of the process could be improved, over half (53%) said that there should be more transparency and that all correspondence should be shared across all parties. The next response, with far fewer mentions (just over 1 in 10) was more vetting of a complaint's validity before employers are informed (11%). Figure 3.6 shows the responses.

> *"All communications between the two parties must be copied to the accused doctors, for reasons of transparency."*
>
> *"Any correspondence between my contractor and the GMC should have been copied to me which I am sure wasn't the case."*
>
> *"Finding out whether there was any truth in the allegations before informing other agencies."*

Figure 3.6: How could this part of the process (communication with your employer or contractor) be improved?



Base: Those employed or working under contract or had been at some point during the previous 5 years giving an answer (121)

In the qualitative interviews, doctors stated that they wanted to know exactly what their employer was being told and the level of detail being given. Some suggested being copied in to all correspondence. There were some instances where doctors had been surprised by what their employer knew (in terms of the level of detail) and had therefore felt unprepared when a discussion with their employer about the complaint arose.

> *"I would have liked to know what they were going to ask (the employer). It would have been nice to have known that they were going to ask …., just as a matter of courtesy really."*

> *"There was clearly communication which I hadn't been copied in to…it was quite a surprise when we kind of met in a corridor about something else, he started a conversation about a level a detail which I hadn't expected. Which I think was slightly uncomfortable in that I was obviously feeling a bit raw about it and it was suddenly coming up in a situation where I wasn't expecting it to come up."*

One participant commented that he had been allowed to see the correspondence between his employer (a Primary Care Trust) and the GMC and by doing so, this helped to reduce his stress.

> *"I didn't know what the PCT had written, I had no idea, and it was only on me phoning up and literally, not pleading, but sort of just telling the gentleman at the Directorate that I really was struggling with this, that he faxed through the relevant documentation. So, I was then able to see what the various responses were, what the letters were and, bizarrely, just having sight of them sort of took me out of the dark a little bit and made it a less distressing experience."*

In the qualitative interviews a few doctors were concerned that complaints may be vexatious, or might be a simple misunderstanding and their disclosure to the employer before an outcome had been decided could damage employer relations or disadvantage the doctor in some way (e.g. if being considered for promotion). There was also one example where the doctor claimed that the employer had been written to and the information about the complaint was incorrect.

> *"I'd only just started my new job and a letter came without my knowledge, without my lawyer's knowledge to my employers saying, quite wrongly, that I was accused of financial fraud. Thankfully, my employer really couldn't believe this and showed me the letter. Now, if I had not had the support of my employer like that, that would have gone behind my back, I wouldn't have known about it, it was completely wrong. And so it is profoundly damaging to one's reputation, completely wrong, and I have yet to receive an apology"*

> *"GMC writes to the employer…, have you any concerns about this doctor? The problem there is that if they have concerns they should have acted upon them, but the concern I have is that weak employers think 'ah right, well, we can get at this doctor because we don't like him'."*

Whilst in reality the GMC does write to employers requesting information about the doctor's fitness to practise; in the qualitative interviews a few doctors raised concerns about a lack of communication between the GMC and the employer regarding the outcomes of any employer investigations. There was a perception that the GMC were insufficiently informed about investigations already undertaken by the employer.

> *"There wasn't any communication between the Trust and the GMC, that I was aware of, because surely if I had been, the Trust would have said actually we've been through all this with a fine tooth comb and found that actually this patient is one of*

those peculiar people who just likes to complain and got very angry over things that he didn't understand."

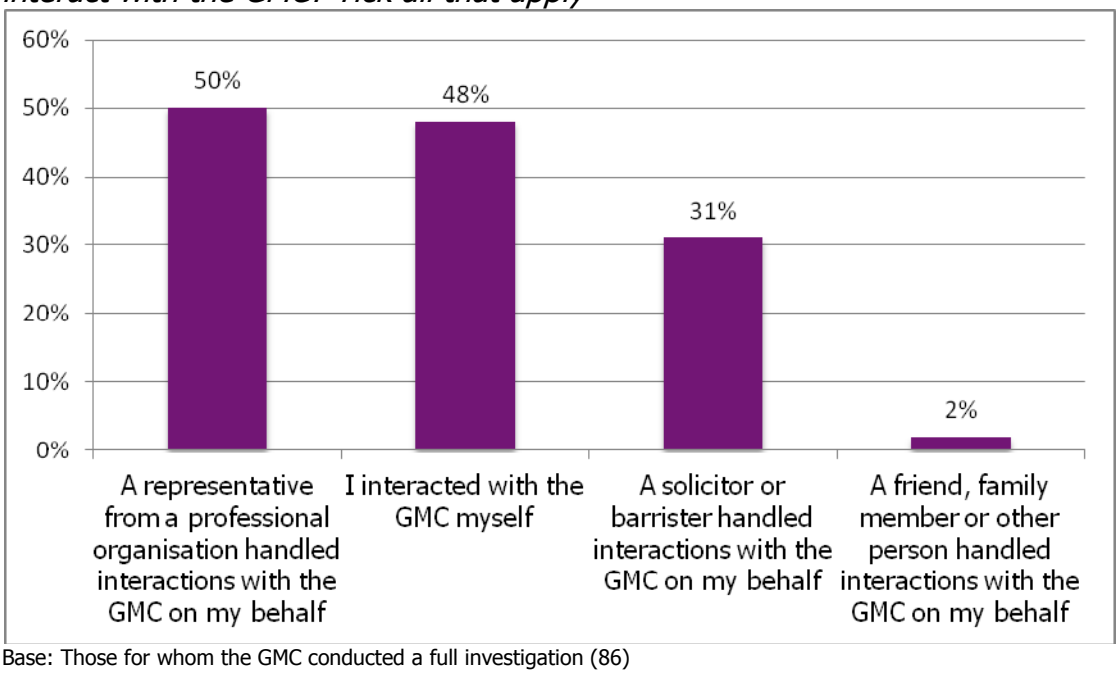
The qualitative interviews also highlighted some discrepancies in the way that respondents may have completed this section of the quantitative questionnaire; the doctors whose complaints were initiated by their employer (i.e. their employer was the complainant) appear to have answered this section slightly differently.

3.3 The investigation process

3.3.1 Representation

Respondents were asked how they generally interacted with the GMC during the investigation of their case. Multiple responses were possible. As Figure 3.7 shows, half of respondents (50%) said that a representative from a professional organisation handled interactions with the GMC on their behalf and nearly half (48%) said that they interacted with the GMC themselves. Nearly a third (31%) said that a solicitor or barrister handled interactions with the GMC on their behalf.

Figure 3.7: During the investigation of your case how did you generally interact with the GMC? Tick all that apply



Base: Those for whom the GMC conducted a full investigation (86)

The qualitative interviews suggested some confusion about the need for representation. For most, the receipt of the initial GMC letter triggered a call to a representative body. However some doctors failed to appreciate the possible magnitude of the FTP process; they believed an investigation would conclude their innocence and so did not think to involve representation at early stages.

> *"I made the mistake at the time of deciding to initially act in my own defence. I felt 'I'm completely not guilty here and that I'll conduct my own defence'. And I believe that I conducted it competently, but I worry that the GMC treats people that defend themselves with greater aggression because it has less to fear than someone that is supported by lawyers."*

3.3.2 Rating of aspects of the process

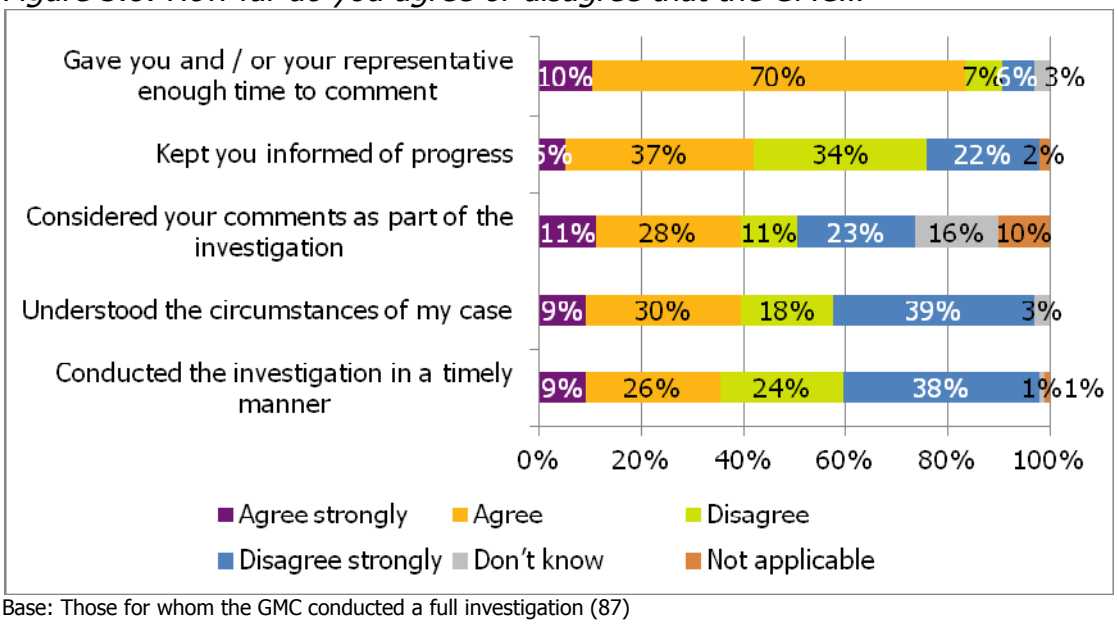
All respondents for whom the GMC had conducted a full investigation were asked to rate five different aspects of the investigation process. The aspect rated most highly was 'gave you and/or your representative enough time to comment', with 70% of respondents agreeing and 10% of respondents agreeing strongly with this statement.

Other aspects of the investigation process received a more mixed response. Just over half of respondents (56%) disagreed or disagreed strongly that they were 'kept informed of progress' whilst just under half, 42% agreed or agreed strongly.

Nearly 4 in 10 respondents (39%) agreed or agreed strongly that 'their comments were considered as part of the investigation', however just over a third disagreed (34%) with a quarter (23%) disagreeing strongly. There was also a comparatively high 'don't know' response to this question (at 1 in 5 or 16%); qualitative investigation suggested that this is because they felt they had no clear way to know for certain, whether or not the GMC had genuinely considered their comments.

When asked whether they agreed or disagreed that the GMC understood the circumstances of their case, nearly 4 in 10 respondents (39%) disagreed strongly. Similarly, responding to the statement 'conducted the investigation in a timely manner' a similar number of respondents (38%) disagree strongly. The full responses to these questions are shown in Figure 3.8.

Figure 3.8: How far do you agree or disagree that the GMC…



Base: Those for whom the GMC conducted a full investigation (87)

In qualitative interviews, participants had some strong criticisms of the investigation process. Some doctors whose cases were concluded with no finding after an FTP hearing, thought that better investigation may have prevented the need for a hearing. Criticism in the qualitative interviews also focussed on a perceived lack of understanding throughout the investigation, with non-medical case examiners or unsuitable medical experts/assessors seen as not understanding the issues at hand. In particular, there is a perception that assessors lack understanding of private practice.

> *"He (the assessor) didn't understand the nuances of the relevant sub speciality and he didn't... I don't think he grasped what the patient was complaining about."*

Some respondents raised questions as to whether the GMC had sufficient assessors to ensure the appropriate breadth as well as depth of knowledge. One participant commented about the barriers to becoming an assessor, with

the hours required by the GMC not being consistent with the hours allowed for professional leave by the NHS; this was thought to limit the numbers of assessors and limit the most capable or experienced doctors or consultants becoming assessors.

> *"They obviously have a need to employ a lot more investigators within multiple subspecialties."*

> *"There doesn't appear to be any national agreement via the NHS that time off to be a GMC assessor, it can be added to the category of professional leave and extra days awarded so they'll... so it's almost impossible for anybody to become a GMC assessor who's a busy, working NHS consultant."*

Other criticisms about the investigation process in the qualitative interviews, were around a perceived lack of 'common sense'. Some talked about procedures being followed which didn't fully address the accusations at hand and there was a sense that the investigation process is 'tick box' or inflexible.

> *"I got no impression that at any stage did the GMC seek this man's medical records. Because the basis of the diagnosis wasn't just on what he did at the interview or what he told me, it was all on the basis of copious medical records that I'd got. So, there was no sense that the GMC were actually investigating it in a way that would have addressed the issue he had."*

Participants saw the process of investigating the doctor's practice as a whole, not just the individual complaint or concern, as unfair and criticised the 'creep in the scope' of the investigation, beyond the allegations. This indicates that the doctors do not understand GMC's statutory obligations when examining complaints to examine the doctor's entire practice and not to limit its investigations. This sense that there is 'creep in scope' feeds an overall sense of mistrust in the GMC.

> *"It wasn't a question of 'has this patient's complaint any justification, let's look through all that's gone before the Trust and get an expert to look at the answers'. This was 'oh, here's a chance to investigate a doctor, let's see what we can find'. That was the impression that I was given of the way the whole process went, which seems grossly unfair really."*

> *"What they actually picked up on was some vagaries in the consent form, which was entirely outside the circumstances of the case."*

In the qualitative interviews doctors were frustrated by the inability to talk to case examiners and explain their case. They expressed the desire to have a chance to put their side of the story across and answer questions that the

GMC have as soon as possible. Some used the analogy of a police investigation, where the accused would be interviewed by the police and have a chance, verbally, to explain or defend themselves and thereby influence the focus of the investigation. The same is expected of a GMC investigation. The current system of letters is thought to be inadequate and, instead, a conversation is needed to paint a complete picture and ensure that the case examiners have an adequate/appropriate understanding of the issues.

> *"Much of this could have been avoided if competent, respectable people had met with me and listened to my concerns but because it's all done through writing… at no point did the investigator feel it necessary to question me, it's all done in writing. Even the police, when they question a suspect, they don't say 'right, we want your lawyer to write to us', there has to be some sort of cross examination because only at that verbal level do you get a sense of the complaint."*

> *"I would have thought, and I may be crying for the moon, but in my particular case if an intelligent, open minded, knowledgeable medical person in the GMC had said 'can you come down and we'll have a preliminary discussion about it' and I'd been able to present my rebuttals and explain the background and potential ulterior motive, especially present my rebuttals to a medical person… I mean, all the subsequent things they investigated me for drew blanks, and therefore, if it was my rebuttals that had explained the situation to them they would have, I can imagine, closed the case without even an interim orders panel. Its more investigatory rather than an adversarial approach."*

In the qualitative interviews there was also considerable dissatisfaction with the length of the investigation process and a perceived lack of communication whilst the process was on-going. This 'being kept in the dark' is felt to considerably add to the stress caused by the investigation and leads some doctors to question how active their investigation really is. Participants talked about regularly having to chase their lawyers, defence union or the GMC directly to find out about the status of their case. Participants would have liked regular communication from the GMC to explain the status of their case and any indication of timelines, if possible.

> *"The investigation should have been done within a month. They waited for six months then another six months then another six months, what for? Well, they say they are doing investigation but I didn't see any investigation. They didn't tell me what investigation they had done in six months."*

> *"All I got in that period was, or my solicitor got, the holding emails. They didn't say what they were looking for, the information they were seeking."*

In the qualitative interviews those that had agreed or agreed strongly in the survey that the GMC "gave you and/or your representative enough time to comment", nevertheless bemoaned the protracted nature of the overall investigation, and stated that the length of the overall process was, in fact, a cause of dissatisfaction, even though it did mean that there was plenty of time to comment.

Some doctors erased by an FTP Panel mentioned lengthy delays in their investigation as a result of waiting for information from witnesses or complainants, which was not forthcoming. It was felt that there should be some sort of time restriction on the submission of information from witnesses or complainants (including PCTs). Some participants felt that if complainants were not forthcoming with their information, this could indicate a lack of concern on their part or a change of heart about pursuing a complaint, meaning the investigation should be reconsidered.

> *"There was a three year delay in dealing with my case. I think the main reason was that the doctor who complained, they sent him all the forms to be... he had to make it more formal, and he just never did it and only after another two years did they say 'look, what are you doing'. So it was really dragged out."*

> *"September 2008 we should have had a hearing but then the last moment PCT sent some more information, which they had it all this time and suddenly they decide the last moment, within a month of the Hearing, they send more information. So my case had to be postponed six months again, no PCT was questioned why they did not send all the papers in the right way. So I was waiting from end of December 2006 to September 2008 to have the Hearing which was postponed to July 2009."*

A common concern amongst doctors erased by an FTP Panel was that the GMC did not make sufficient effort to understand the doctor and how they work. Doctors commented that the GMC had not spoken to them and a few doctors commented that the GMC had not been to visit them in their place of work, which they felt would have greatly helped the GMC understand them and the issues of their case.

> *"They never spoke to me in person, they never visited my surgery, they never came to see what I do. They've never been to visit me at all just to see for themselves, they just took it on somebody else's opinion."*

> *"None of the GMC panel ever went to our Practice to see how we were working."*

In some cases the investigation was thought to rest on a 'he said, she said' situation, with a perception that the GMC made insufficient efforts to delve deeper into the issues.

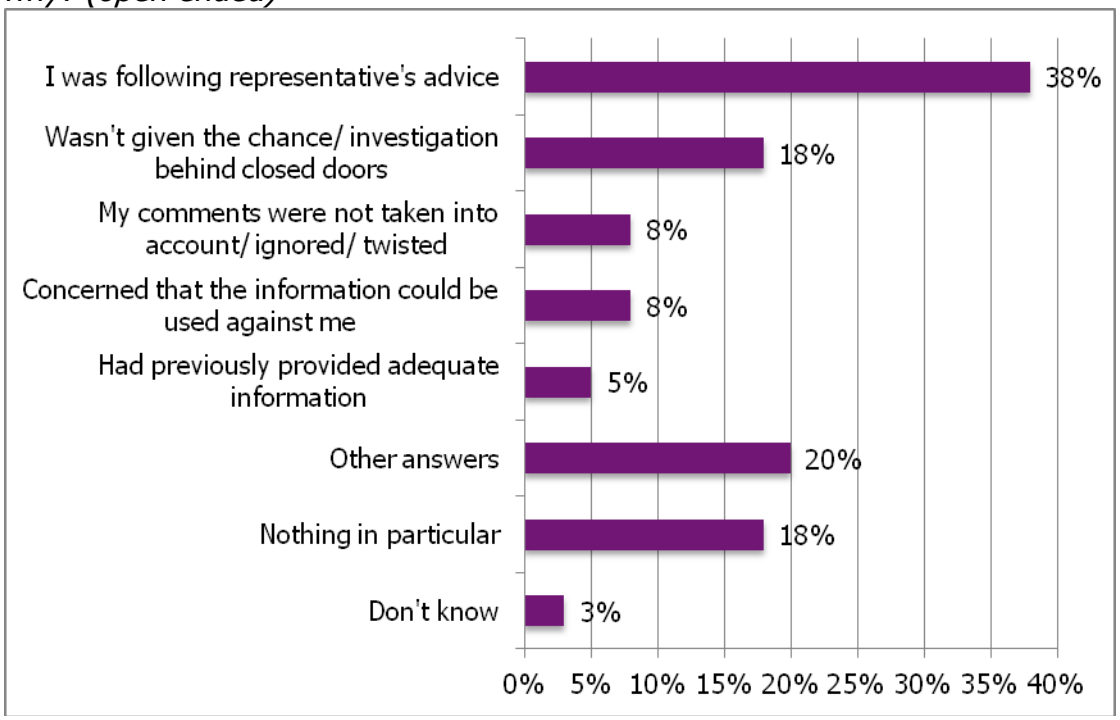
3.3.3 Reasons for not commenting

Process
Doctors are asked directly for comment at the outset of the investigation in the initial letter they receive, and are again asked at the end of the investigation. Doctors may also provide comment at any point during the investigation.

In the survey, respondents were asked, if they didn't comment on their case, to explain why

The most common response, with over a third of responses (38%), was that they were following their representative's advice. The next most common response at nearly 1 in 5 (18%) was that they were not given the chance to do so, or that the investigation was conducted behind closed doors. Responses are shown in Figure 3.9.

Figure 3.9: If you did not comment on your case, can you please explain why? (open ended)



Base: All those giving an answer (40)

The qualitative interviews highlighted a number of cases where the doctors had been told by their defence unions or representatives not to speak to the GMC. They had been told that they were risking widening the scope of the investigation and that the GMC could 'twist things' and use the doctor's evidence against them.

"The advice I had from the barrister was to make no comments to the GMC as they tend to go on a fishing exercise to look for faults and try to twist anything said against the doctor."

"I was told not to (comment) by my solicitor, and I think that comes back to an even more important point, is that what the lawyers are telling us as doctors is that we don't engage with this process because we are in fear, and I use that word advisedly, we are in fear of the GMC misusing that sort of interaction to their own ends. And, if you say something which is seen as being defensive or argumentative or taking issue with what they're doing, then they will haul you up on the basis you lack insight. This word 'insight' is used repeatedly by the GMC for people who try and defend themselves, 'people lack insight because they're trying to defend themselves'. So one is in the position where you're being advised, all the time, not to say anything, not to engage with the GMC, not to comment, not to do anything because the GMC will use it."

The qualitative interviews also highlighted some confusion over the term 'comment'. It appears that doctors may have thought that they hadn't had the chance to comment, but their representation had commented on their behalf and not made it clear that the doctor could comment themselves, if they so wished.

In a few qualitative interviews there was call for more opportunities to comment during the process. One participant had wanted to be able to comment on the assessor's report, before a decision had been made by the case examiners, but thought that he was not allowed to do so. Another participant had wanted to be able to respond to initial conclusions the case examiners had made. These participants had not understood that they could comment at any point in the process and this should therefore be more clearly emphasised by the GMC in future .

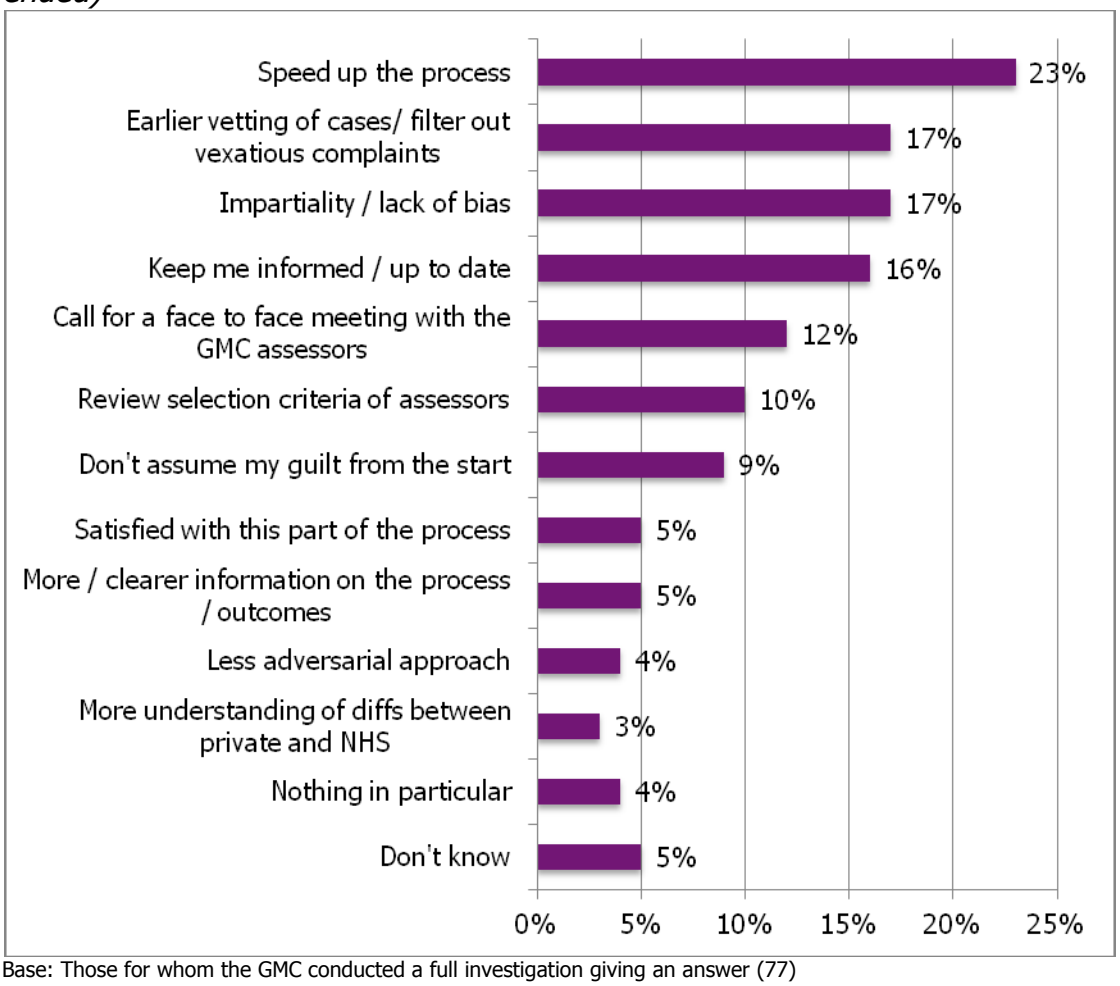
"I got a letter from the GMC stating that they weren't going to take it further if I accepted a warning on the basis of their assessor's report, without giving me the opportunity to comment on the assessor's report."

3.3.4 Suggested improvements

In the survey, respondents for whom the GMC had conducted a full investigation were asked how the investigation and opportunity to comment part of the process could be improved. The most common response to this open ended question, with a quarter of responses (23%) was to 'speed up the process'. Other common responses included 'earlier vetting of cases/filter out vexatious complaints' (17%), 'impartiality/lack of bias' (17%) and 'keep me informed/up to date' (16%). Responses are shown in Figure 3.10.

As was found in the qualitative discussions, a face to face meeting with the GMC is also called for, by 12% of respondents. 10% call for a review of the selection criteria of assessors and discussion in the qualitative interviews suggest that this means selecting assessors with more suitable skills and knowledge (see section 3.3.2).

Figure 3.10: How could this part of the process (the investigation and opportunity to comment) be improved? (open ended)



Base: Those for whom the GMC conducted a full investigation giving an answer (77)

3.4 Interim Orders Panel hearing

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

Under statute, an IOP can only impose temporary restrictions or suspension of a doctor's registration for a maximum of 6 months. If the GMC feels the order should stay in place for longer because the investigation has not yet concluded it is required to reapply to an IOP every 6 months and after 18 months must apply to the High Court for an extension. This is to protect doctors by ensuring temporary orders are reviewed periodically to check they are still needed.

Only 7 survey respondents had been through an Interim Orders Panel (IOP) hearing, therefore results to the questions on this part of the process have not been shown in charts. Six of the 7 respondents had a solicitor or barrister representing them and one didn't attend and didn't have representation.

Results suggest that in the main, respondents clearly understood the purpose of the IOP hearings and they are thought to be run effectively, with both sides given sufficient opportunity to present their case and the Panel attentive and professional.

There is broad agreement that the decision of the IOP hearing is clearly stated and explained. The main frustration seems to be around the fact that IOP hearings by their nature are not fact finding, a finding that was mirrored in the qualitative interviews. A couple of participants also thought the Panel were heavy handed or that an IOP was not necessary in their case.

> *"Yes, they were very sympathetic and like I say they were happy for me to work and they seemed to look at the evidence in a sensible manner. A lot of the conditions, well, all the conditions they put on me were actually to protect me so I felt they were quite fair."*

> *"The fact that the IOP is not a fact finding body and the fact that the doctor is not allowed to defend himself is rather surreal."*

"They assume that they're working on the fact that the accusations are taken as proven which, to a certain extent, I can see in terms of serious cases involving child molestation and murder and that sort of thing, and I suppose the GMC will be saying that they have to protect the public or, more importantly, to be seen to be protecting the public; but in did strike me that there's very few other situations where you're guilty until proven otherwise."

"The IOP said 'we are not doing any investigation, we are not looking into evidence, this is just a kind of a feeling, a broad brush feeling, and we're suspending you'. And because the PCT had suspended me they felt that was the right thing to do."

The doctors who had been erased by an FTP Panel had often had multiple IOP hearings, as the outcome was reviewed every six months. These were a cause of on-going stress for doctors. These doctors are not clear why their investigation was taking so long and so why there is a need for these multiple IOP hearings.

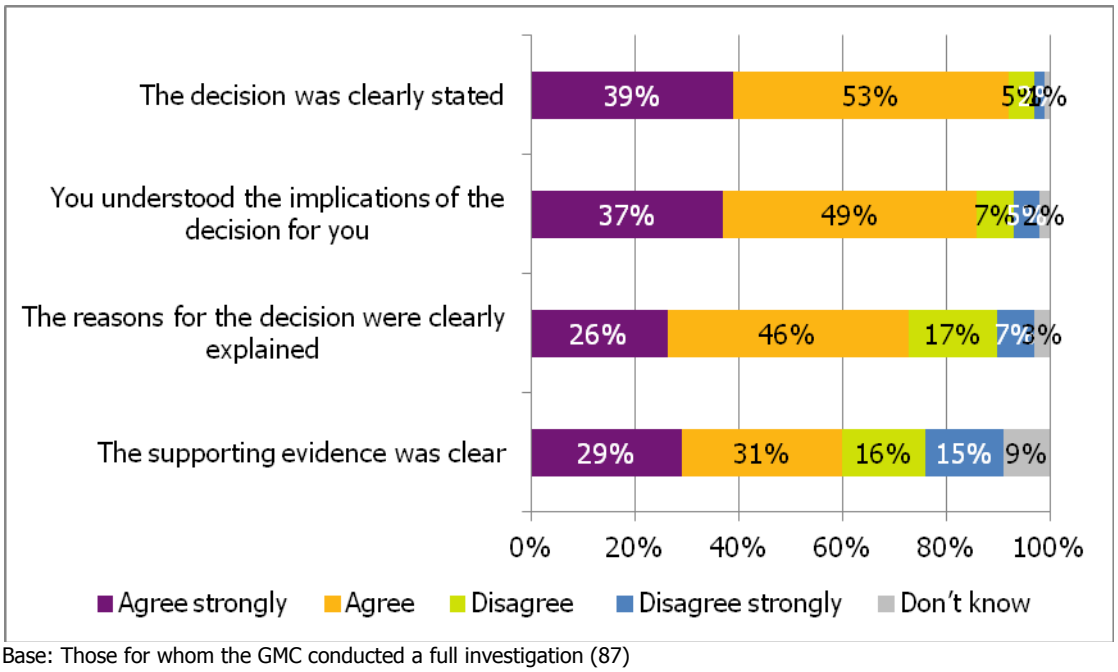
3.5 Case examiner decision and outcomes

3.5.1 Clarity of the process and the rationale for the outcome

In the survey, all those for whom the GMC conducted a full investigation were asked to rate a number of aspects related to the case examiner decision and outcomes. The results (in Figure 3.11) show that respondents, in the main, believe the GMC to be clear during this stage of the process. More than 9 out of 10 respondents who had been through a full investigation (92%) agreed or agreed strongly that the decision of the case examiner was clearly stated (4 in 10 or 39% agreed strongly). Nearly 9 out of 10 respondents who had been through a full investigation (86%) agreed or agreed strongly that they understood the implications of the decision for them (nearly 4 in 10 or 37% agree strongly).

Nearly three quarters of respondents (72%) agreed or agreed strongly that 'the reasons for the decision were clearly explained' and 6 out of 10 respondents (60%) agree or agree strongly that 'the supporting evidence was clear'.

Figure 3.11: How far do you agree with the following statements?



Base: Those for whom the GMC conducted a full investigation (87)

In the qualitative interviews, however, participants were often critical about the case examiner decision, but their criticisms were not about the clarity of the decision and its explanation, rather their criticism focussed on two main aspects. Firstly, that the GMC had not considered their comments and rebuttals; they would have liked to see evidence that their point of view had been considered, even if the case examiners show that they had dismissed or disregarded the comments and why. Secondly, that the GMC had not sufficiently understood the case; there was comment that the allegations and/or evidence provided indicated a lack of understanding of the case and the issues involved.

> *"At each point that I heard from the GMC, I wrote back clearly indicating all these errors in the statements…Neither did they acknowledge them nor did they.. they did not rebut them. You would have thought that, apart from anything else, if I'm making all sorts of rebuttals they should then do a further rebuttal of the rebuttal if it was necessary."*

> *"There was generally a complete ignorance of the framework that I'd been accused of tampering with and I didn't feel the GMC has anybody who understood really the ramifications of what I'd done and I just felt that some of the questions and some of the way they were investigating, it just wasn't very helpful to either them or me and that was quite frustrating."*

> *"The decision making was opaque and that the reasoning just didn't make logical sense, no proper explanation was given as to why my account was discounted."*

3.5.2 Response to 'Meeting with Doctors' initiative

The 'Meeting with Doctors' pilot was explained and discussed in the qualitative interviews. The following paragraph describing the initiative was read to participants whose case had progressed to a full investigation and they were asked what they thought of the initiative and whether they thought it would have helped them.

> *From September the GMC will be piloting a **'Meeting with Doctors'** scheme whereby the GMC will meet with the doctor at the end of the investigation. This will provide an opportunity for the GMC to explain its initial view on what action is necessary based on the investigation. If there is disagreement over this to discuss what supporting evidence the doctor could provide to impact upon this decision. It is intended that following the meeting the doctor would have an opportunity to accept a sanction as an alternative to a hearing in more cases than at present.*

The initiative received a very positive response from most participants. Doctors really welcomed the idea of an opportunity to talk face to face with the GMC and have a discussion and they liked the concept of being able to discuss what additional evidence they could provide to impact the decision.

> *"I think it's a brilliant idea because in this situation I would have been able to say exactly what I said to you now."*

> *"If I had a chance to let me put it in a different way, if I had a chance to explain my side of the story in a more, let's say informal way, so in a meeting with the people who are going to make a decision, perhaps the thing would have been much, much different."*

> *"Yes, I think at that stage it would have been a possibility of some dialogue about the lack of logic in the beginning, from my perspective the lack of logic underpinning the decision that was made and then there'd be the potential then for that to be clarified and I think it would have been around additional information."*

However, doctors said that they thought that this discussion should happen at the start of the process, rather than at the end (or both at the beginning and end of the process); this is something that participants had spontaneously mentioned throughout the interviews.

> *"It would be useful, I would have thought, if there was some way in which there could be an interaction, right at the outset, so that everybody could understand what the issue is and what*

problem is being investigated and how it should be investigated rather than this sort of going into this black hole for two years."

Some doctors thought it was important that they bring representation to such a meeting in case they should 'incriminate' themselves.

"I think it could be a very intimidating process for a doctor to go through, I think it could be extremely stressful, so I think that if they were allowed to bring some sort of representative…Just being dazzled by this process and just not being able to think clearly or articulate your own thoughts clearly or ask the questions that need to be asked. So I think, yes, it's got the potential to be good, but if the doctor was allowed to bring some representation with them."

And there was also concern that their medical defence team might advise against this discussion.

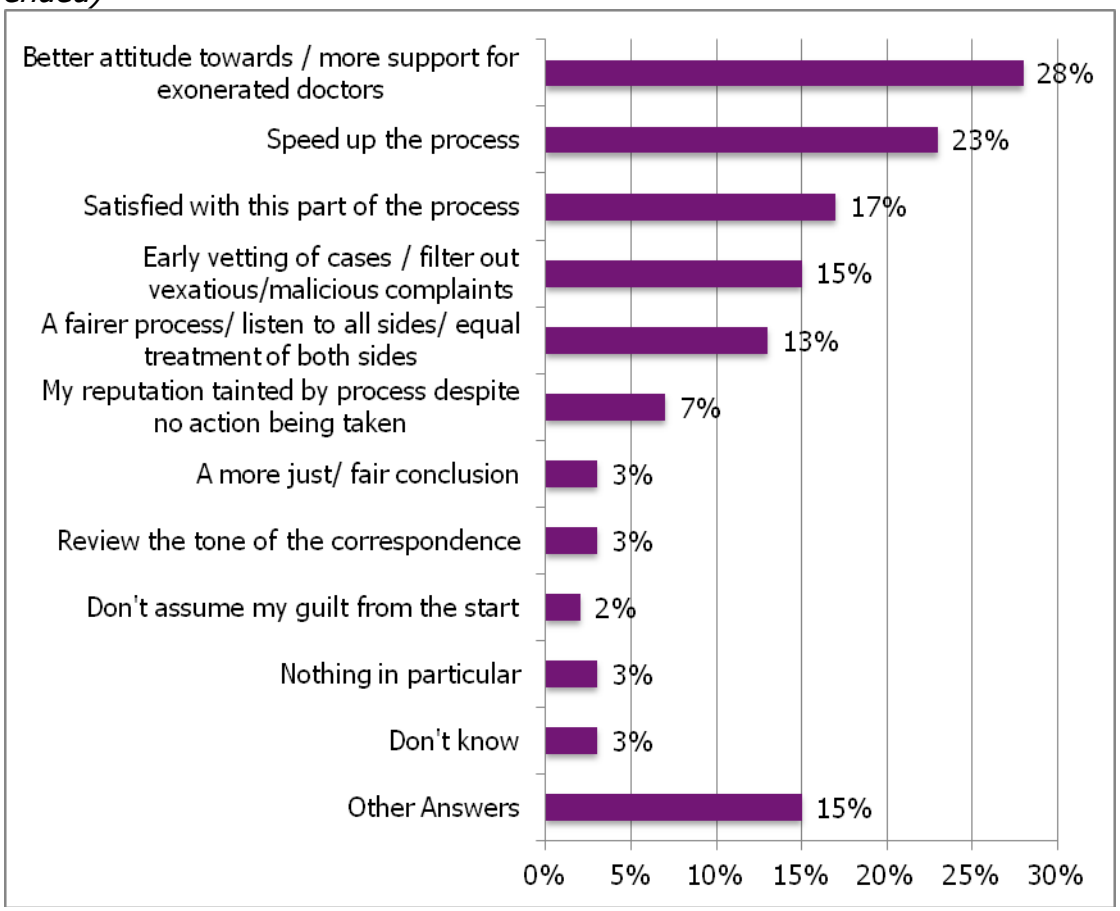
"It's very difficult because obviously my first reaction, instinct, was to defend myself because I knew that I didn't do anything to deserve this, right. And I wanted to pick up the phone and to speak to the case worker dealing with my case but they (medical defence) said 'no, don't do that'."

3.5.3 Suggested improvements

All respondents whose case was closed, a warning issued or undertakings discussed were asked how this part of the process could be improved. The most common response with nearly 3 in 10 of responses (28%) was to have a better attitude towards exonerated doctors or give more support to exonerated doctors. The next more common response, at nearly one quarter (23%) was to speed up the process. A further 1 in 6 respondents (17%) said that they were satisfied with this part of the process. Figure 3.12 shows the results for these questions.

Figure 3.12: How could the process of either closing your case, issuing a warning or discussing undertakings be improved? (open

ended)



Base: Those where the case was closed, a warning issued or undertakings discussed (60)

3.6 Investigation Committee

Process
At the end of the investigation the case examiners can ask the doctor to accept a warning. If the doctor refuses the warning, a Committee called the Investigation Committee, is asked to meet and consider the evidence and decide whether the warning should be issued. Doctors can attend, although oral testimony is not usually heard.

In the survey, those who went through the Investigation Committee process were asked for their suggestions for improving this part of the process. Only 5 respondents went through the Investigation Committee process and amongst these 5 there is no common comment about improving the process – most were satisfied.

Individual comments included a complaint about the length of time taken to schedule the hearing; a lack of understanding about what refusing a warning would mean (i.e. going to an Investigation Committee) and the stress caused by going to the hearing.

3.7 Fitness to Practise Panel (FTP) hearing

Process
Fitness to practise panels hear evidence and decide whether a doctor's fitness to practise is impaired, and if so, what sanctions should be imposed. The panel hearings are held in public, except where they are considering confidential information relating to a doctor's health or they are considering making an interim order. The panel includes medical and non-medical people appointed to hear the case. Panellists are independent from the GMC and are appointed through open competition against agreed competencies. A legal assessor provides legal advice to the panel. One or more specialist advisers may also be present, to advise the panel on medical issues regarding a doctor's health or performance. Expert opinion is provided by expert witnesses and panel members are trained in listening to evidence and making considered judgements.

The GMC, which brings the case against the doctor and is usually represented by a barrister, and the doctor, who may also bring representation are both invited to attend. Both parties may call and cross-examine witnesses. The panel may also put questions to the witness. Once the panel has heard evidence, it must decide if the facts have been found proved, whether on the basis of the facts found proved the doctor's fitness to practise is impaired and if so, whether any action should be taken to restrict or remove a doctor's registration.

3.7.1 Representation

In the survey, only 14 respondents had been subject to a full FTP Panel hearing. Of these 14 respondents

- 11 attended all of the hearing and 3 did not attend at all.
- 1 represented him/herself, and 12 had representation from a solicitor, barrister or professional organisation.

Qualitative interviews suggest that at least one respondent answered incorrectly and did not have an FTP hearing, having said that they did.

In the qualitative interviews, when asked about representation, the doctors who had been through a FTP hearing said that they would not have considered representing themselves since the hearing was akin to a court and consequently they would need representation. They all had been represented through the process by a defence organisation, which had appointed legal counsel.

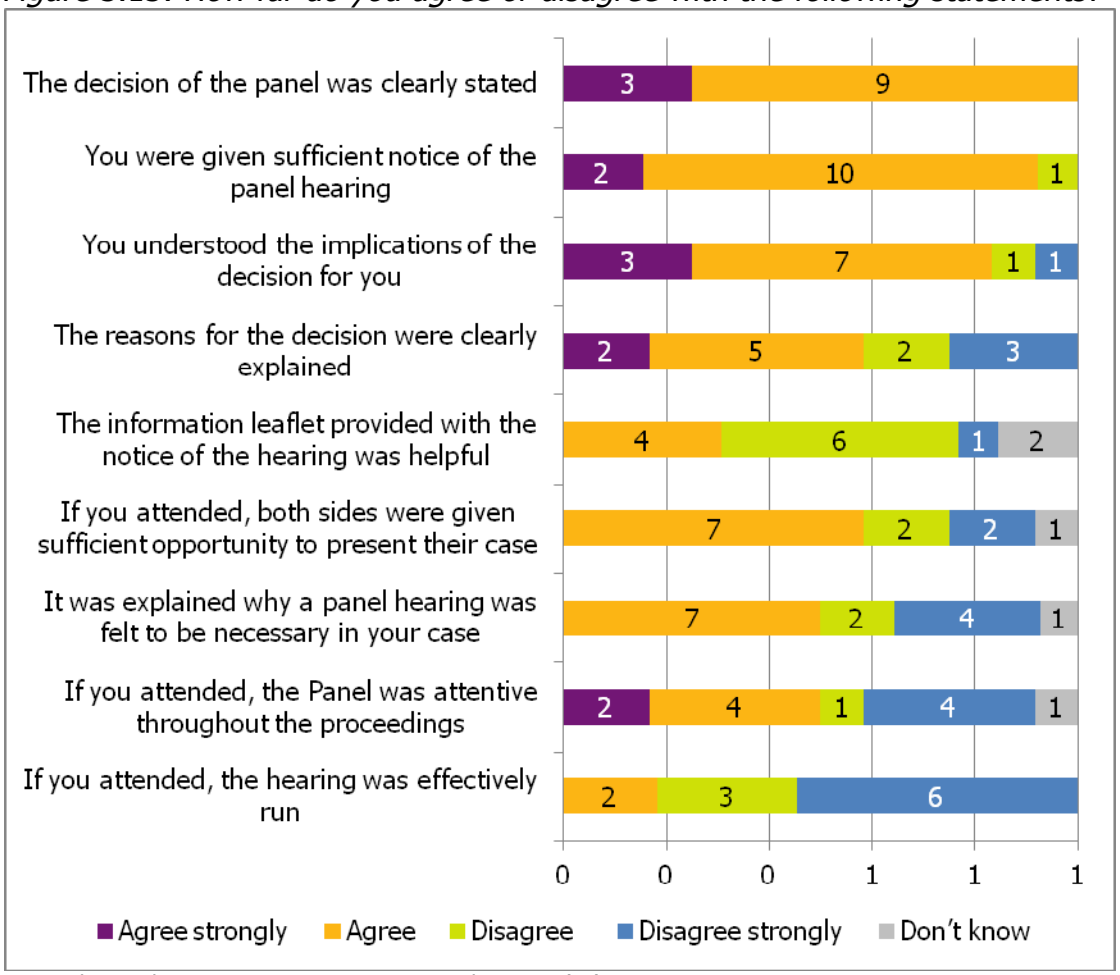
3.7.2 Rating of aspects of the process

Whilst only 14 respondents who had been through an FTP hearing responded in the survey, their responses are shown in Figure 3.13, the chart shows raw

numbers, rather than percentages. Results should be treated as indicative only, since the number of responses is so small.

The aspects of the panel hearing which had the highest levels of positive response related to the lead up to the hearing (being given sufficient notice) and the outcome of the hearing (decision being clearly stated, understanding the implications of the decision, the reasons for the decision clearly explained). The aspects which score less well, are around the running of the hearing and the conduct of the Panel.

Figure 3.13: How far do you agree or disagree with the following statements?



Base: Those subject to a Fitness to Practise Panel Hearing (14)

The qualitative interviews suggested considerable dissatisfaction with FTP Panel hearings and there were common concerns between the survey findings and the subsequent qualitative interviews as well as with the doctors who had been erased by a fitness to practise panel who were only interviewed by telephone.

Some participants had been surprised by the adversarial nature of the hearing and had found the process and the prosecution unexpectedly aggressive.

> *"I guess the way it was an adversarial process was the bit that was the real surprise. I guess I'd expected something that was more, that wasn't such a legal process, it was more of an examination and debate of the evidence using, what I would call common sense."*

Delays at the outset

A few doctors talked about their frustration at the process at the start of FTP hearings, with much discussion between lawyers to agree the wording of charges. It is thought that this is something that could be done before the hearing.

> *"It's the delays that are frustrating. I've waited a year for all this and the first two hours, our lawyers were effectively bargaining with each other, and why on earth that couldn't have happened before hand, I just don't know."*

> *"The idea of spending well over a day deciding on the exact wording of something that you're then going to deny seemed bizarre. And I guess if I'd felt I was guilty or the charges were legitimate, I think in that I would have probably have felt at least I'm getting a fair trial, my barrister's getting every chance to defend me but it just seemed to defy common sense."*

Dissatisfaction with the Chair

There were a number of concerns about the conduct of the Chair during hearings. Some concerns were around the Chair's perceived ineffectiveness at running the hearing. This included reports of allowing the inclusion of information or areas of questioning that participants thought irrelevant to the accusations at hand, or focussing on less relevant/important information to the detriment of the main issues at hand.

> *"There were not any allegations made against me with regards to keeping proper notes, consent, there were no allegation as such and to the questions the members of the panel made about the notes, about the consent, I got the impression that they were more interested in things which were not in the allegations themselves. If you're going to judge someone, whoever it is puts the allegation forward, everything else is irrelevant but, in my case, I felt that it was not."*

There were complaints about the perceived ineffective time management of the Chair, allowing for numerous recesses or adjournments. This was reported as frustrating for participants who wanted the Panel to be concluded as quickly as possible and there is an expectation amongst some that a hearing would run similar to a '9-5' normal working day. It was also reported as being difficult for doctors who have travelled and who were spending numerous nights away from home, something which they feel adds to the

stress of the ordeal. A few doctors were cynical about these delays, saying that the Panel members, including the Chair, are paid 'per session' and so it is in their interests financially to protract the time that the hearing runs.

> *"A huge amount of time was wasted by legal and expert witnesses waiting for bundles, papers, computer links etc., vastly inflating the costs of panels."*

> *"The prosecution cynically took so long with their submission, with such multiple repetition that the entire 14 weeks scheduled for the case was used for their case. We then suffered numerous delays, with the hearing eventually taking nearly X years"*

> *"There were far too many adjournments and delays. They make excuses for adjourning to an afternoon session then they (the panel) can claim a full payment for that session so it's run extremely inefficiently."*

> *"There are five people there, five members of the panel who don't have any reason to stop that proceeding at that time. It means that if these people don't work for five days they won't get paid for five days. That is something which has been explained to me by my barrister, she said 'they have allocated five days for this hearing, don't expect the hearing to last less than five days'. And the way it works is that they get paid for the time they spend there so obviously they have every reason to prolong the session, even if they have opportunity to stop it earlier, if they feel that something is not right they will go to the last day, as happened with my case."*

Other criticisms of the Chair were around his/her lacking authority. This ties in to the inclusion of inappropriate areas of questioning/information above, but also includes perceived poor moderation of the prosecution, where appropriate, for example when overly aggressive in their behaviour towards the accused.

> *"What he didn't do, which is what a judge would have done in that circumstance, was to curb some of the excesses of the prosecuting council and my legal team used to come out incandescent on occasions because he didn't have the experience to do that and the prosecuting QC took every advantage."*

> *"The prosecuting barrister had such vile language, as if, 'you are rubbish' and I wasn't rubbish."*

There were a couple of complaints regarding the Chair not being fair to both sides or dominating or influencing the panellists, particularly lay panel members, which is thought to be inappropriate.

> *"I didn't feel that the Chair of the panel was, from my point of view or from my legal representation point of view, fair and balanced and willing to listen to both sides of the argument, that's certainly the impression we came away with. The kind of questioning and the way she would turn things round and the written parts, that when I received them were, I wouldn't go as far as to say biased but certainly they didn't appear to have a balanced and fair view of the evidence that was presented really."*

> *"And also the difficulty was the other two panel members, the other lay person was fairly quiet and very rarely spoke, and the doctor, as I say, he was elderly, retired, he appeared to be completely ineffectual. He did ask some questions but he was completely dominated by the Chair and the other woman on the panel. Well, that's certainly the impression."*

> *"The Chairman is the law, they influence the two lay members, the lay members have no voice of their own. They started showing some sympathy towards me but the chairman has extreme powers, he just bullies the panel and the two doctor members, and one doctor was very forceful in his opinion and he guided, he influenced the two lay members. So really, the lay members just get influenced very easily and they don't feel that they can stick up for their own independent thinking. It's a sham."*

Dissatisfaction with the Panel

In the qualitative interviews, doctors expressed dissatisfaction with what they perceived as the panel's insufficient understanding of the issues. This includes both lay panel members and non-lay panel members (with expertise sometimes perceived to be far removed from the issues at hand). There was complaint that considerable time was spent explaining issues, rather than tackling the accusations and the doctor's guilt.

> *"A totally inappropriate panel member for an academic case, there wasn't one academic amongst them. So, again, you had the feeling of an organisation that was setting things up to get the result it wanted."*

> *"In my case, it was a surgical procedure, a complication as a result of a surgical procedure. If a Psychiatrist judges me, a Psychiatrist in my opinion has nothing to do with medicine. How can you ask someone to judge someone else if they're not*

familiar with the speciality?.... you have a medical degree but that doesn't give you any kind of familiarity with what we're talking about."

There was also complaint that the panel members were not attentive and a number of participants mentioned panel members falling asleep during their hearings.

> *"It ended up as quite an ordeal for all concerned. One of the panel members was not infrequently asleep during the proceedings, which did not give me reassurance."*
>
> *"One of the panellists could be seen dozing fairly frequently, which is not reassuring when it is your livelihood and family home at stake."*
>
> *"I said 'look, they are sleeping'. It was after lunch and I had to give my version of events, my testimony after lunch, and I said to my barrister afterwards 'did you see that two of them were sleeping' and she said 'I saw it and I was raising my voice to wake them up'. I can't believe that."*

Dissatisfaction with expert witnesses

A number of participants had concerns about the expert witnesses used in their FTP hearings. They were thought to have been inappropriate in terms of their expertise and have insufficient understanding of the issues.

> *"I think the difficulty is, the GMC did appoint a CWOF expert, a GP expert but, to be honest, I didn't feel that he had a hands on, realistic idea of what they were, he wasn't a GP in the true sense of the word and that was quite frustrating for us because, certainly during the FTP panel, a lot of my evidence I was trying to explain to the panel what CWOF was and what it was there for and what it did, which just to me seems… because I meant the trouble is there were two lay people and then there was a retired psychiatrist, which obviously none of them had any idea about general practice."*
>
> *"He was a knee surgeon who did not work in the NHS and who claimed he'd been trained in shoulder surgery but, in fact, had undertaken no work in shoulder surgery, I think, for the whole of his consultant life. I was annoyed, I was going to complain about him to the GMC but my MDU barrister said it's not worth the effort, the GMC won't take any notice because they're short of assessors."*

Practical arrangements

There were a number of concerns about the practical arrangements surrounding the hearing. These included the cost incurred (travel, subsistence, accommodation) which were considerable for some participants, who did not receive compensation afterwards. There was also the cost of the time taken away from work (which can mean less pay) and away from family.

> *"I felt aggrieved that, if it had been an adversarial process in a Court of Law, then I would have recourse to seek damages. I was lucky in that my Trust gave me special leave to attend and they also paid my expenses, they paid my train fare and for me to stay in a hotel. If they hadn't I would have had to take unpaid leave for the whole period and paid my own expenses which don't seem fair…. having been found not guilty, there was none of the benefits that would go with that in a Court of law."*

One participant complained that they were not entitled to apply for professional advancement during the process and this, coupled with the protracted timeframe of their case (6 years), meant considerable financial loss, which they would never recover. They also pointed out that the lower salary, meant smaller pension contributions and therefore a smaller pension pot. Their perception was that the process is punitive from the start, when the doctor may be entirely innocent.

> *"When you are under GMC investigation or charge, you are not allowed to apply for your professional advancement, so your career increment stops, so for my family the financial impact was massive. I was unable, I think, for a total of about six years to apply for that and having to pay to live in London for months at a time. The whole thing cost our family well in excess of £100,000, we nearly had to move out of our house at one stage."*

<u>*No apology/debrief at end of process*</u>

For some of the doctors who were cleared at their hearing, there is dissatisfaction that at the end of the process there is no letter of apology or recognition of the upheaval and stress caused by the process. Some feel the need for some sort of debrief after the process and find it strange that at the end of the hearing, they simply leave and don't hear about it again.

> *"We shook hands with the barrister and said 'I can go home now, can I'? and he said 'yes, yes it's finished, I'm off to my next case'. There was no kind of aftercare or acknowledgement of the situation or explanation of what was going to happen so I just went home. There was then a letter some time later from the GMC with the transcript of what the person had said but the nature of the letter I found actually quite offensive, It was saying that the case has been dropped... the panel did not find against you, however, the case will remain open for six months*

and, if the GMC wishes to take further action or whatever, it will. And that was the nature of the wording."

"I guess on a personal level I felt aggrieved that there was no acknowledgement from the GMC that they had made a mistake, no acknowledgement of the professional and personal implications, the damage that it did to myself, my family, my work, the effect it had on my patients, all that kind of thing, there was just no acknowledgement of that."

Difficult to appeal

Process
A doctor can appeal direct to the High Court of Justice (the Court of Sessions in Scotland or High Court of Justice in Northern Ireland) any decision of a fitness to practise panel to restrict or remove their registration. A doctor can challenge a warning issued by a fitness to practise panel by making an application for judicial review.

A couple of participants discussed the difficulties they perceived in appealing an FTP hearing decision. Some individuals perceived judicial review, one possible recourse of appeal, as problematic, primarily because the cost is prohibitively expensive.

"Just to clear my name I wanted to appeal. The lawyer said to me 'if you appeal, first of all you're not going to have the case opened again, a judge will have a look and decide, they'll have a judicial review as to whether the panel took the right decision, not took the right decision, but the panel have the right to take this decision. So, not only the principle of the charge itself but based on whether the panel could have thought it was normal, it was legal, to take this kind of decision. She said 'if your insurance company pays that's fair enough, that's fine, you can take a chance, but if your insurance company does not pay you have to pay out of your own pocket £100,000'. £100,000 is quite a lot of money for a judicial review and, to be honest, even if I had that amount of money I would not have spent it just to clear my name, it's an awful lot of money."

3.7.3 Suggested improvements

In both the survey and the qualitative interviews some participants found it hard to move beyond discussing the issues they faced, to focus on how the FTP hearings might be improved.

The few improvements that were commonly suggested included:

- **Improving the atmosphere of the hearing**: making them less combative or aggressive.

- Ensuring hearings are run more efficiently, by:
  - Reducing the time taken, including more preparation in advance (agreeing the charges, discussions between counsel), and fewer adjournments.
  - More effective Chair selection, perhaps using a QC, to ensure the Chair would effectively curb the 'excesses' of the prosecution and ensure that relevant information is presented efficiently.
  - Better use of experts: selecting more appropriate expert witnesses.
  - Changes to the panel composition. Whilst there was no consensus here, there was one mention of removing lay panel members. Others suggested increasing the number of medical panel members, as well as including suitable medical expertise on the Panel.
  - **Better closure for doctors after the hearing**: Some want a letter of apology, or at least a letter recognising the trauma of the process for doctors, others wanted some kind of face to face debrief.

> *"It should be less threatening and intimidating."*
>
> *"They should be more medical members in the composition of the panels."*
>
> *"Panel members should stay awake."*
>
> *"The barristers could get their acts together beforehand as the start time was held up with their discussions. Again a lot of hanging about. I also feel the whole gladiatorial combative style is too legalistic it is not a court of law."*
>
> *"Some respect and dignity."*
>
> *"I think then that, when people are cleared or when they're overturned, then the very least the GMC should... you should get a letter from the president of the GMC. The fact that you did… it finishes, you just walk out of the building, nobody says a word to you and you don't hear from them afterwards. I mean, it just leaves a nasty taste."*
>
> *"They obviously have a need to employ a lot more investigators within multiple subspecialties and there needs to be some national agreement whereby GMC assessors have time away from their normal working practice which is under some national agreement because otherwise you're going to then be left with semi-retired or private people who are trying to earn some extra money by being GMC assessors as opposed to your hardworking NHS consultant who is strictly limited in the amount time that he can take off."*

There were also a couple of individual suggested improvements:

- **Better sanctions guidance**: one participant received a sanction of suspension but noted that the time taken from his IOP, where he was suspended, to his FTP hearing where he was given a suspension of the same length. He thought that he had therefore carried out his sanction, but in actuality he couldn't work for another lengthy period; he thought that the GMC should work in the same as a criminal court here, where he would have been considered to already have 'done his time.'

> *"In terms of the sentence that I ultimately got…; in my opinion, having already had a [lengthy] suspension, then had that been a criminal court I would have been free to walk whereas the FTP sentence was in addition to what had happened before."*

- **Improving the process for returning to the GMC register**: one doctor complained that the date he was given where he would be returned to the register was inaccurate as he was not returned until midnight on that day, but the GMC took his subs from the start of that day and he was particularly frustrated because he was due to start work that day.

> *"The panel said I would be allowed back on one date and in fact it's not until midnight on that date. To my mind it's just stupid, it's either one or the other. In addition to that, they actually took my money for the day that I... for the GMC registration, I know it's only a quid but there is a principal to it. I was supposed to be starting work that day. So actually it not only screwed me up but it also screwed up the Practice I was going to work with."*

Perceptions of FTP Panel hearings amongst doctors erased by an FTP Panel

This group tended to have many complaints about their Fitness to Practise hearings, reflected in the comments above. Whilst they all attended the beginning of their hearing, three out of the five doctors felt unable to stay until the end of the hearing. This was either because they found the process too emotionally stressful to endure, or because they felt that the decision had already been made (against them) and they were powerless to change the outcome.

> *"I went to all of it but I didn't go on the last day because they destroyed me physically, mentally and emotionally and I do take offence to that."*

> *"I attended the first half …but I realised 'what am I doing here, what am I doing here, this is just a farce, it's just a kangaroo court'."*

There were complaints by these doctors about the time limitations on the hearings, which a couple of doctors felt were profoundly unfair; they thought time limitations were not appropriate in a hearing of this significance.

> *"My doctor, my specialist doctor, because they ran out of time, they never listened to him. The GMC paid him thousands of pounds for attending and preparing the case, my own specialist, he had to write his report but they didn't give him a chance to speak because they ran out of time. Which was bizarre."*

Some doctors said that they thought that in their case the GMC was siding with the PCT, who had already made a ruling which was not in their favour. The doctors felt that the PCT were 'out to get them' and the GMC were siding with them.

> *"They will take side of the biggest institutions and big people, why should they take my side, they will take the PCT side because they want business from PCT. If they admonish PCT, the PCTs won't refer their cases to them and they won't be in business. So they will take the PCT side."*

One doctor complained that the GMC had an agenda in his case, in terms of the way in which he practised and therefore wanted to 'strike him off' without adequately understanding how he practised and his specific circumstances and outcomes.

> *"I doubt that they would have wanted to do anything for me; it was their clear intention to get rid of a number of us who were practising [in this way]. I certainly wasn't the only one."*

There was a feeling amongst these doctors that they were powerless and that the GMC can 'nail anybody' if they decide to. There was a perception that the GMC can make accusations which are very difficult to defend against with certain proof.

> *"You can't win. They said 'we think you're dishonest' so you're dishonest because it was my word against the Receptionist and they went to her side but there was no evidence of any dishonesty. In the olden days you had to have criminal level of proof, but they've changed it since the Shipman thing… Dishonesty and insight are two big words they can hang any doctor on. 'You overdosed him and you say you didn't but we think you did' and when there is no evidence how can you hang somebody, but that's the law. So these two things they can just hang you for it, they are a law unto themselves because they can decide."*

There was a common complaint of being made to feel like criminals, not just during the hearing, but afterwards, for example with information being circulated in newspapers. The stress of this was reported as not just affecting the doctors, but also their spouses and families.

> *"They treat us as if we are vicious criminals and my advice to them is only that one day they will have to answer to that, but not to me. I think that is vicious and criminal in itself."*

> *"We had to deal with that then as well (press coverage) and I just thought that's so underhanded and nasty and why did they have to be like that. I'm not a person whose heart it is to hurt people."*

A couple of these doctors felt excluded in the hearing by the legal jargon. They did not understand fully what was happening and their legal representation was not good at explaining this to them.

> *"You know, we are ordinary doctors with ordinary English speaking, we are not lawyers and legal jargon to be used which is so confusing. There's no plain English and it's too difficult for people to understand."*

For all these doctors, there was a strong feeling that the punishment did not fit the crime. They commented that no patients had died in their care and there was no sexual misconduct; these were perceived as the only types of reasons for which doctors should get 'struck off'. In some cases, complaints had not come from patients, but from other health care professionals; doctors felt that if their patients were happy, then they should not be struck off. Furthermore, the doctors felt that they were in the profession to do good and help people. They felt that they did not deserve the treatment which they had received.

> *"I didn't kill anyone, I didn't rape anybody or any kind of... you know, you normally think of a doctor who's struck off as someone who's killed people or who's sexually assaulted people or who's tried to falsify their Will into their name and stuff like that."*

> *"They should know that human beings and doctors are basically good people, this is the presumption you should start with. Our job is to look after patients sensitively but when we are confronted nobody is sensitive about that. When you go to the case they have no sensitivity at all and we are supposed to be sensitive people."*

> *"No patient died, no patient complained, this Hearing was because of the PCT."*

Dissatisfaction with defence and legal representation

A common theme throughout the interviews with doctors who had been erased by a FTP panel was their profound dissatisfaction with their legal representation. In one case the doctor's insurance company had refused to provide representation altogether at his FTP hearing and the doctor had felt overwhelmed and unprepared to navigate his own defence; whilst repeatedly contacting the GMC for guidance, this was not forthcoming.

> *"I had a solicitor and a barrister in the first IOP hearing and in the second and in the third one I didn't have anyone because my defence refused to provide me help and they didn't give me any reason why. So I had to do it on my own. I asked the GMC to give me time or tell me how to give my evidence to the GMC. I wrote to the case examiners again and again and also I wrote to the opposite solicitor also to say please tell me, because I was going on my own."*

Common complaints about legal representation included their poor communication. Lawyers were not good at passing on information about the doctors' cases and were poor at explaining the process and the implications of certain issues.

> *"I had the [defence organisation] person but the solicitor was very laid back. I think they may have a cost implication, I suppose, so I wrote to the GMC myself."*

There was another complaint about incorrect advice from their legal representation. This was in terms of how they did (or didn't) comment on their case. One doctor was told that he could choose voluntary erasure, but this was incorrect advice and he was subsequently erased by a FTP panel with the fallout that ensued and he had wanted to avoid (mainly information in the press).

> *"They can't just accept that the advice that the doctors are getting from their legal team is good advice, if there's some way round that. They should have told my legal advice immediately 'actually you cannot apply for voluntary erasure'."*

3.7.4 Response to establishment of the Medical Practitioners Tribunal Service (MPTS)

In the qualitative interviews, there was an explanation and discussion about the recently established Medical Practitioners Tribunal Service with all doctors who had had FTP Panel hearings. The paragraph below about the MPTS was read to participants describing the MPTS, what it was set up to do and who it will be accountable to.

> *You may or may not be aware of the recent establishment of the **Medical Practitioners Tribunal Service or MPTS.** Doctors involved in Interim Orders Panel and Fitness to Practise hearings will now be referred to a new tribunal service set up as part of government led reforms. The establishment of the MPTS is part of GMC's wider programme of reform of medical adjudication.*
>
> *It was set up to:*
> - *provide better separation between the GMC's complaints and investigation functions and adjudication, and*
> - *to take over responsibility for the day to day management of hearings, panellists and their decisions.*
>
> *The MPTS, while part of the GMC, is run separately and is accountable directly to Parliament. It is run by an independently appointed chair. The MPTS will run all panel hearings for the medical profession in the UK and make decisions on what action is needed to protect patients.*

Participants broadly welcomed the development. They agreed with the need to separate investigation and adjudication and in light of their concerns about FTP Panel hearings, there was hope that some of these may be addressed.

> *"In principle I agree with that, it's something that in my opinion which was very unacceptable, to have the GMC conducting the investigation and to do the adjudication as well."*

A few expressed concern about independence, given that it is still part of the GMC. Whilst accountability to Parliament is intended to provide assurance of the impartiality of the MPTS, one participant was concerned about political interference.

> *"Yes, potentially that could be a step forward. I mean, it would be interesting to see how it actually works on the ground but, certainly, the headline is better than what's going on at the moment."*

"The fact that if politicians have a particular axe to grind under a certain circumstance it will have an effect on the outcome of the hearing. There's been several very political cases recently, again, I've seen other sort of major issues that there's been a lot of political comment on in advance of GMC hearings, which I'd had concern about politicians making decisions or making statements and accusations in advance of a hearing."

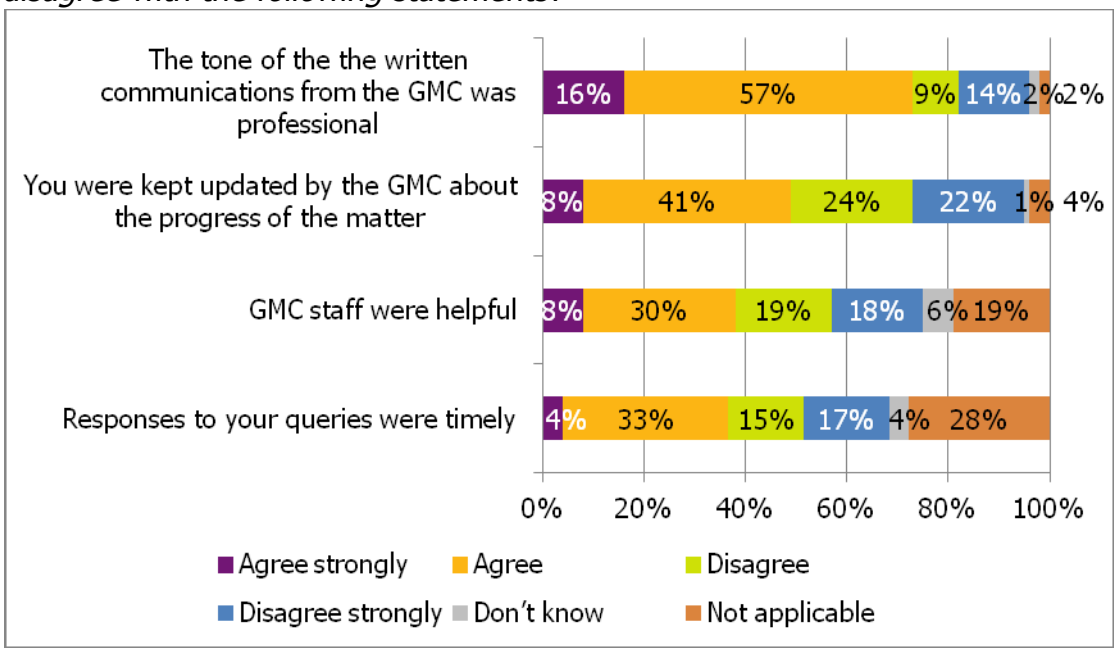
3.8 Communication during the process

3.8.1 Rating of aspects of communication

In the survey, all respondents were asked to rate different aspects of the GMC's communication. The highest scoring aspect, with nearly three quarters of respondents agreeing (73%) was that the 'tone of the written communications from the GMC was professional'.

However for the other 3 aspects rated, there was a much more mixed response (see Figure 3.14). Just under half (49%) agreed or strongly agreed that they were 'kept updated by the GMC about progress'; just over a third (38%) agreed or strongly agreed that 'the GMC staff were helpful', with one quarter disagreeing or disagreeing strongly (24%); and just over a third (37%) agreed or strongly agreed that 'responses to your queries were timely' (however there was a large don't know response of 28%, perhaps suggesting that they didn't direct queries to the GMC).

Figure 3.14: Thinking about the entire process, how far do you agree or disagree with the following statements?



Base: All survey respondents (169)

In the qualitative research, communication problems were a recurrent theme. Participants often expressed feeling they had been 'kept in the dark' during

much of the process. They reported being unsure what, if anything, was happening with their case and when their case might be resolved. One doctor who had been erased by an FTP Panel, took the lack of communication from the GMC as an indication that his investigation had been dropped.

> *"I wasn't getting communication from them. What I actually thought was they'd actually gone into it and seen that it's a load of rubbish and that they'd forgotten about it, that's what I thought."*

For many, they felt dependent on their representation to keep them up to date. In some cases participants had been told by their representation to expect communication from the GMC to be infrequent.

> *"I did get, or my solicitor got, an email from the GMC saying that they were still looking into it and that was basically it, just a sort of holding email, I think, saying 'we're still researching,' you'll have to wait. That would occasionally come back every six months or so, occasionally I would write to my solicitor and say 'what's going on?' and he'd say 'we don't know'."*

There was also one doctor who had been erased by an FTP Panel, who had not understood initially that the GMC were communicating with his lawyer and he felt that the GMC should have written to both him and his lawyer, rather than assuming that his lawyer would pass the information on.

> *"I hadn't heard anything from the GMC from September 2008 when they told me they were now looking into the case. I didn't hear anything for months and months and months and I rang my solicitor in May 2009 to say 'have you heard from the GMC what was happening', he said 'yes, I've been receiving letters and things'. I said 'why don't you tell me what's going on'. This legal profession is a law unto themselves, the GMC really should have written to me, giving a copy of what was sent to the solicitor."*

In the qualitative interviews there was mention of concern if they chased the GMC too frequently for the status of their complaint, that this action might prejudice the process in some way.

> *"Having to chase it up via my Defence Organisation and you're feeling that if you're chasing it up it will prejudice the complaint, so it was slow."*

Whilst there was broad agreement that the tone of letters was professional, in the qualitative interviews there were other criticisms about tone. A common complaint was the communications implying guilt, even at the point of case

dismissal. For example one participant mentioned that their final communication said *"on this occasion, there is no case to answer".*

> *"The communications are… they are just done in a very aggressive way, there is the assumption of guilt. Everybody I've ever spoken to who's had anything from the GMC comments on the brutality of it."*

> *"The general tone was 'you're in trouble.' It was along the lines of 'you're in trouble and you've got to get yourself out of it', rather than 'we need to investigate this'. I think the slant could have been different."*

There were also a number of concerns about unclear language or jargon being used in GMC communications.

There were a few complaints about unhelpful GMC staff, with individual examples including:

- Giving vague answers to questions.
- Reassuring doctors, leading them to believe that they would have a more positive outcome than they ultimately did.
- Giving incorrect information.

> *"They (GMC staff) were just vague really, just sort of vague. I thought things would be done a lot quicker and when I was trying to give hints to sort of say, 'is it going to be pre or post summer?', they said don't worry about summer holidays, it's going to carry on for ages. The implication was that this is normal that things should take ages."*

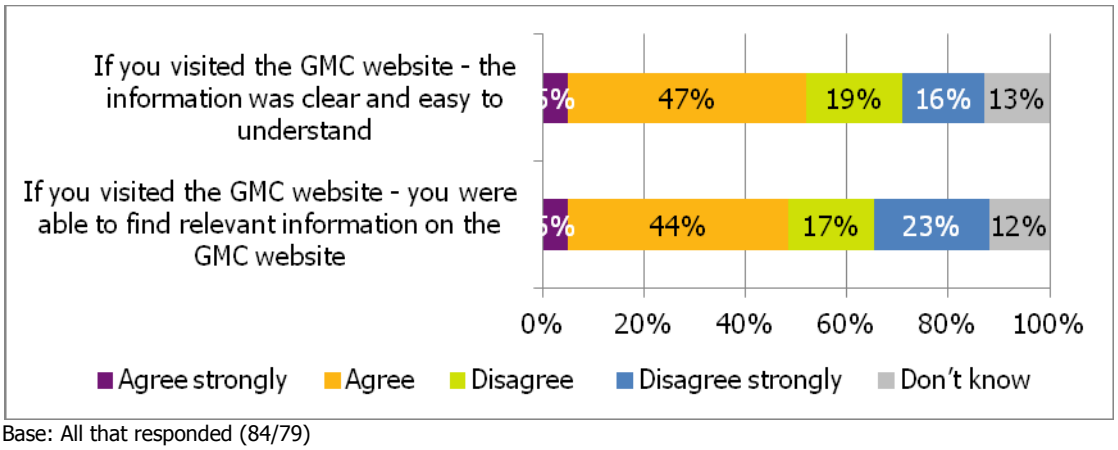
> *"I called the GMC the next day to say 'I've received this letter, I don't know what to do, please give me some indication of what I'm supposed to do' and, instead of someone being open with me and telling me I have to contact the Medical Defence Union, I have to get a lawyer, they said 'oh doctor, that's alright, don't worry, some doctors don't even bother to reply these days', which is not very helpful and it was not helpful in my case."*

The website

In the survey, respondents were asked about the website, if they had used it (Figure 3.15). Just over half (52%) agreed or strongly agreed that the information on the website was clear and easy to understand and just under half (49%) agreed or strongly agreed that they were able to find relevant information on the GMC website.

Figure 3.15: Thinking about the entire process, how far do you agree or disagree with the following

statements?



Base: All that responded (84/79)

The few qualitative participants who had used the website, had used it to find out more about the processes they might go through and to try and find out about similar cases to theirs, in order to know what to expect. One participant had been directed to specific pages on the website, by their lawyer. They commented that finding this information was difficult and navigation of the website was not easy, overall.

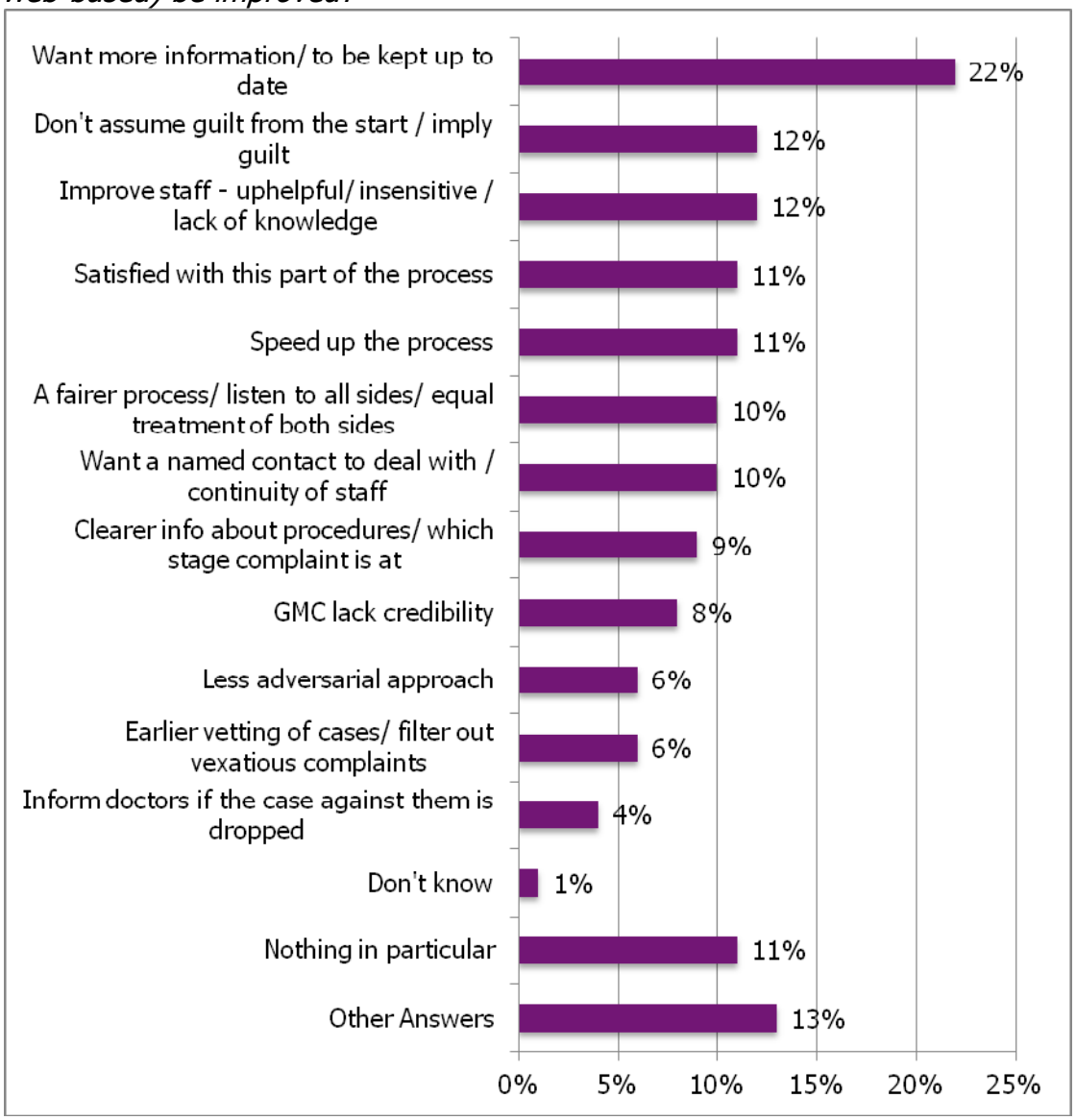
> *"I tried to have a little look on the website to try and find out what exactly happens as well and there wasn't really anything to say what the process was. It was quite hard to find anything out apart from, I think there was one thing about what someone had been through before or something on a forum or something like that."*

> *"I think on that website it should maybe go through the process and say the kind of variables and timelines depending on certain levels of cases, saying that in certain cases they finish within two or three weeks, certain cases this is the sort of process that happens, this is the variation in terms of how long it takes and saying if you're kind of worried about this stage you can ring up. It just wasn't helpful like that."*

3.8.2 Suggested improvements

When asked in the survey how the GMC's communication could be improved, nearly a quarter of responses to this open ended question related to requirements for more information or being kept up to date. The full responses are shown in Figure 3.16.

Figure 3.16: How could the GMC's communication (written, telephone and web-based) be improved?



Base: All that responded (139)

In the qualitative interviews, participants called for much more frequent contact from the GMC explaining the status of cases. They wanted to know what is happening, and if there were delays or the process was taking a long time, why this was. They would also like to know what sort of timeframe to expect for the resolution of cases.

There were also recommendations about tone, being less threatening or not implying guilt. The tone was even described by one participant as 'brutal'.

> *"Can I suggest that someone reads letters before they are sent out from the viewpoint of a potential recipient? They are legendarily brutal."*

Doctors responded positively when told in the qualitative interviews about new guidelines to ensure written communications are more accessible, personal and jargon free.

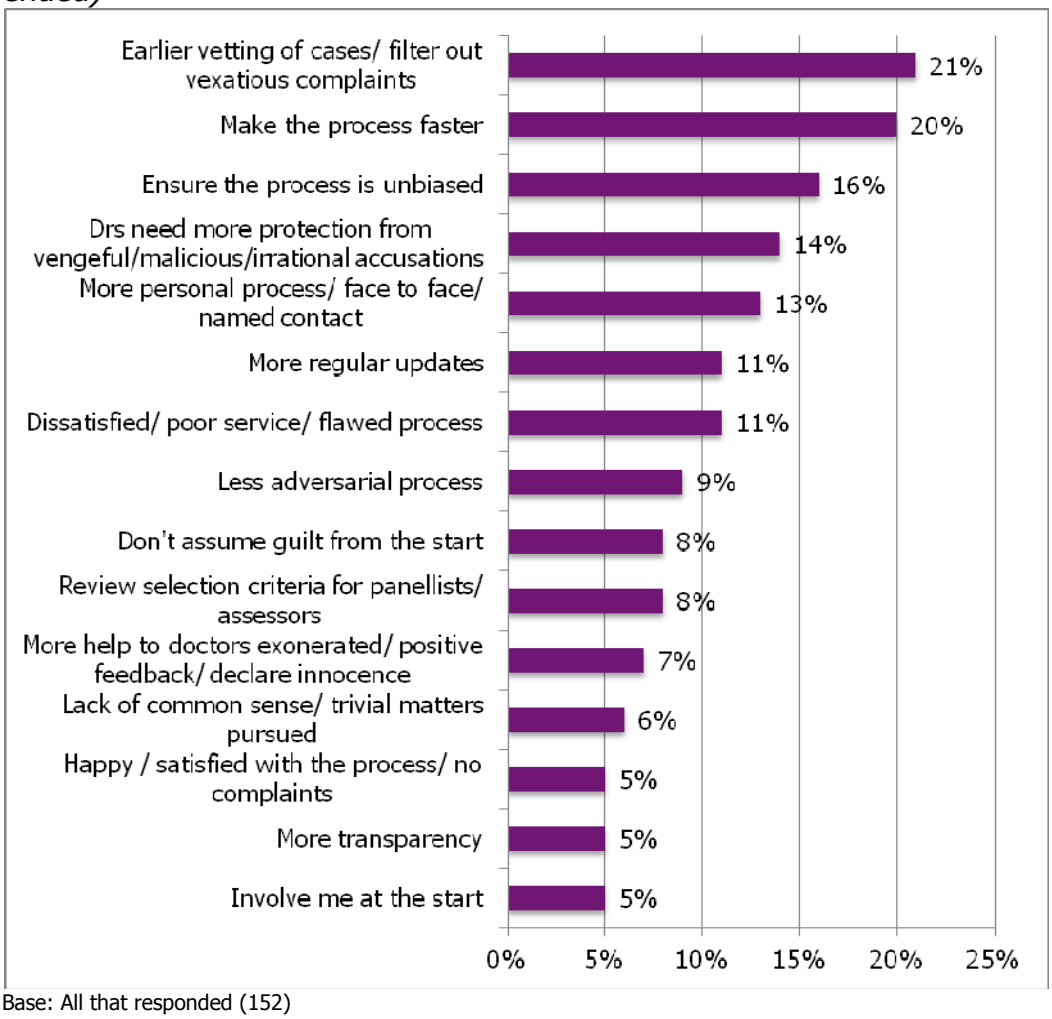
> *"More personal, less jargon. Perhaps less threatening might be another (suggestion) because that's the underlying tone."*

3.9 Overall experience

3.9.1 Single most important thing to improve

When asked, in an open-ended question 'what is the most important thing that the GMC should do to improve the Fitness to Practise procedure for doctors?', the most common responses with around 1 in 5 of all responses were around earlier vetting of cases or filtering vexatious complaints (21%) and making the process faster (20%). 1 in 6 responses related to ensuring the process is unbiased (16%) and just under 1 in 6 responses mentioned providing protection from vengeful, malicious or irrational accusations (14%). The full responses are shown in Figure 3.17.

Figure 3.17: What is the most important thing that the GMC should do to improve the Fitness to Practise procedure for doctors? (open ended)



Base: All that responded (152)

In the qualitative interviews there was a common call for better vetting or 'triage' on receipt of the complaint to filter vexatious complaints or resolve issues that may be easily explained. It was thought that a time investment here, would reduce the number of complaints going through a more thorough investigation process, only to be 'thrown out' later on.

> *"To have an independent doctor who initially looks at the complaint. Then has a telephone conversation with you to discuss, looks at notes etc. then goes on to make the decision whether to take it further or not would be helpful. A better clinical triage."*

Doctors also did not understand why their processes took so long and thought it was important that the process is quicker. For a few, they found the extended process so stressful that this in itself impaired their fitness to practise (sleepless nights, etc.) and they thought fast resolution was important for ensuring good patient care.

> *"I think they need to have a better sense of urgency in terms of getting cases finished, if they need more people to do it they need to do that. They need to see the impact of doctors having to work while they've got this on their mind."*

They also called for better explanation of possible timescales and, if possible, commitment from the GMC that each process should take a specified amount of time.

> *"Maybe even mark them in complexity, say 'actually at this stage probably you're going to take this month', so that it gives people an idea at the beginning rather than 'ah well, we aim to finish it within six months' so you don't really know."*

For some, there was repeated complaint that the GMC was 'out to get them' or biased against them. The tone of the letters, which were felt to imply guilt, reinforced this perception, as does perceived inadequacy of investigation. This perhaps explains why there are calls in the survey to 'ensure the process is unbiased.'

> *"It suddenly felt to me clear that the, and particularly in the FTP panel, that the GMC were trying to get me accused, they were trying to prove that I wasn't fit to practise."*

3.9.2 Response to the Doctor Support Service initiative

In the qualitative research, The Doctor Support Service pilot was explained and discussed with those who touch on the issue of doctor support. It was broadly welcomed; participants liked the idea of confidential, independent emotional support and this initiative recognises the emotional toll that Fitness

to Practise procedures can take on doctors. Some participants said that it can be hard to talk about and ask for emotional support, but they thought it is something that would have helped them. A few said that they received help from other sources locally, or via their defence body or employer. A few also said that they wouldn't need this service because of these local services, or the support that they had received from their employer and/or family.

> *"Absolutely it would have been helpful to me because at that stage I was so desperate, I didn't know anyone who went through that process and obviously there was no one with experience to help me through that. By that time I had my solicitor who was okay, he was supporting me, but obviously it's a different thing to have a professional, it's a different thing to have emotional support and I felt that it was really very, very important to have someone, not only during but afterwards as well because that's the time I was more in need for support."*

> *"I found it extremely helpful talking to [a medical defence organisation]. My first point of contact was actually a medical person, obviously you have medical advisors, who then handed me over to a solicitor who was extremely helpful and who said to me 'we're not just here to give you legal advice, if you just want to phone up and talk you can'. Now, I didn't avail myself of that fully but on the occasions that I didn't have to have dialogues we talked around the issues and the impact it was having and just being able to articulate that was quite helpful."*

Despite the service being described as confidential, the issue of confidentiality is clearly key with one participant questioning whether disclosure of their emotional state may result in their fitness to practise being called into question. And another participant questioned if non BMA members would have access to this service.

> *"That would be a very good thing. You feel very alone. The other worry you have is that, if you admit to having psycho emotional stress, that in itself may impact on your fitness to practice."*

One participant also commented that, although they felt such a service could be helpful, he would have been unlikely to take it up because he was in denial about the FTP case and would not like to 'show weakness' by admitting that he needed help.

It was also suggested that those who have been through the FTP process and have been cleared still need help returning to 'normal' practice as they have been through a traumatic experience and it may change how they practise in future (i.e. they practise more defensively). It was felt that this service should

be extended to doctors who have been through the process (or if it is available, this fact be promoted).

4. Conclusions

The vast majority of doctors who go through the FTP process have not chosen to do so (although some self-referrals do occur). The nature of the process generally means that a doctor has had a complaint made about their practice or a negative event has led the GMC to investigate the doctor. As such, it is unlikely doctors will view the experience positively. Whilst doctors were asked to be objective and to feed back on the process itself rather than the details of their own case, it should be recognised that, for many, the process and the case will have been a distressing experience. Furthermore, the research focussed on suggestions for process improvement and as such actively sought doctors to be critical. It is unsurprising therefore that the research revealed many concerns about the process and that there was considerable strength of feeling about some aspects of the process. Despite this, there were also some positive messages regarding the process, particularly in terms of the clarity of GMC communications.

4.1 Survey findings

Initial letter and leaflet.

The initial communications from the GMC following the complaint received mixed feedback. On the positive side, over three quarters of doctors 79% agreed that the initial letter informed them of the concerns that had been raised. However, views were more evenly split about whether the letter is clear about the process that would follow (51% agreed and 44% disagreed). The most common suggested improvements about this early stage included "give me more information on the different routes and outcomes" and "keep me informed/ up to date/ copy me in to all correspondence" (with 18% of individuals reporting this in each case). Whilst almost a third of doctors couldn't recall the leaflet, the majority of those who could recall it found it 'quite helpful' or 'very helpful'.

Communication with employer

Respondents were divided on perceptions of the GMC's communication with their employer and there appeared to be some uncertainty about these communications. Almost half (49%) expressed dissatisfaction with regard to how well they were kept informed about communications between the GMC and their employer. Responses suggest that whilst doctors are told that their employer will be communicated with, they don't know exactly what is being disclosed in this communication. The most common suggested improvement to the GMC's communication with employers is more transparency and the sharing of correspondence across all parties (53% offered this response to the open ended question regarding improvements).

The investigation process

In terms of the investigation process itself, there was considerable agreement that the GMC gave doctors and their representatives enough time to comment (80%). Other aspects of the investigation process received a more mixed response, with opinion divided on whether or not they were 'kept informed of progress' and whether or not 'their comments were considered as part of the investigation'. Almost two thirds (62%) disagreed that the investigation was conducted in a timely manner and the most common suggested improvement was to speed up the process (23% gave this response to the open ended question regarding improvements).

Case examiner decision

The vast majority (92%) of those who had been through a full investigation agreed that the case examiner decision was clearly stated and 86% agreed that they understood its implications. The most common suggested improvements to this element of the process included having a better attitude towards / or more support of 'exonerated' doctors (28% gave this response to the open ended question asking for suggested improvements) and to speed up the process (23%).

Communications

Almost three quarters of doctors (73%) agreed or agreed strongly that the tone of the written communications from the GMC is professional. However, opinion was more divided about whether or not they were kept updated by the GMC about the progress of their case (49% agreed and 46% disagreed). The most common suggested improvement in relation to communications was to be given "more information / be kept up to date" (22% provided this response to the open ended question asking for suggested improvements to communications).

Single most important thing to improve

When asked, in an open-ended question 'what is the most important thing that the GMC should do to improve the Fitness to Practise procedure for doctors?', the most common responses with around 1 in 5 of all responses related to earlier vetting of cases or filtering vexatious complaints (21%) and making the process faster (20%).

4.2 In depth qualitative feedback

The findings from the qualitative interviews initially appear to be more negative than the findings from the quantitative survey; however this does not necessarily indicate that the two are misaligned. During the qualitative interviews, discussions focussed on the reasons behind answers given in the quantitative survey and it was often the case that more negative perceptions were revealed than had immediately been apparent from the bald quantitative responses. For example, in the survey, a clear majority of respondents agreed that they had sufficient time to comment, but when asked about this in the qualitative phase, they talked about the entire process being much too long,

which was frequently a cause of considerable dissatisfaction, even though this, in turn, meant that they had had plenty of time to make comments.

The qualitative sample, although 'self-selecting' in the sense that they put their names forward for the qualitative phase, was nevertheless broad. Over two thirds (67%) of all those taking part in the survey volunteered to be interviewed in the qualitative phase with actual participants selected at random.

Common Concerns

The responses of qualitative interviewees were remarkably consistent regardless of the parts of the process they had been through, suggesting common concerns across all those who had experienced the process. This commonality was also reflected in the survey, where analysis showed there to be no significant differences in the answers of respondents who had been through the different parts of the process.

The common concerns were as follows:

- A perceived lack of clarity within the process and insufficient information, particularly with regard to progress in their case:
  - Doctors reported not knowing what was happening with their case, how and by whom the investigation was conducted, and crucially how long it would take.
  - Communication was seen as infrequent and at certain times during the process, vague.
  - Doctors reported this perceived information shortfall as causing considerable stress.
    - The perceived adversarial nature of the investigation and the sense that there is a 'guilty until proven innocent' attitude from the GMC:
  - Doctors expected their investigation to be a fact finding mission, but felt the tone of communications conveyed a sense that the GMC starts from a point of presumed guilt, looking for evidence to back this up.
- The protracted nature of the process:
  - Many doctors were surprised and extremely dissatisfied with the length of the FTP process.
  - Doctors tended not to expect a lengthy process and felt that this was not clearly explained at the outset.
  - Furthermore, they reported that they did not know what was happening and why their process was taking so long.
- Perceived insufficient scrutiny of the complaint at the start (and whether it necessitates investigation at all):

- Doctors said that complaints should be better 'triaged' when received as many felt the complaint about them should not have been progressed. They frequently asked for better vetting on receipt of the complaint to filter vexatious complaints or resolve issues that may be easily explained.
- Doctors called for this more thorough scrutiny at the outset and felt this could reduce the number of cases that would go to a full investigation.
- Doctors wished to see vexatious complaints in particular being better vetted and disregarded.

- Inflexibility of the process (not allowing discussion between doctor and GMC from the outset):
  - Doctors reported being frustrated at the inflexibility of the process and were concerned that the GMC is not always investigating the elements of the complaint that the doctors felt should be the focus.
  - Doctors called for a discussion with the GMC at the outset, to allow them to put their side of the story across. There was a perception that this opportunity may have made a considerable difference to the subsequent course of the investigation.

- Doctors often perceived there to be a lack of understanding by case examiners, and sometimes assessors, about the nature of the complaint and surrounding issues:
  - Doctors expressed concern about what they saw as a lack of understanding of case-relevant issues, by non-medically trained case examiners.
  - Doctors also made complaints about unsuitable assessors.

    - Amongst the small number of respondents who had experienced a Fitness to Practise panel hearing, key suggestions for improvement included:
  - Improving the atmosphere of the hearing.
  - Ensuring hearings are run more efficiently.
  - Changes to the panel composition.
  - Improvement to the process of closure for doctors after the hearing.

At a broader level, the research highlighted fundamental issues of mistrust. There was a feeling amongst doctors who had been through the fitness to practise process that the GMC does not trust them and in turn these doctors do not trust the GMC – some believing that the GMC is 'out to get them.' The fact that the GMC investigates the doctor's practice as a whole, not just the individual complaint or concern, was seen as unfair and doctors criticised the 'creep in the scope' of the investigation, beyond the allegations. This indicates that doctors tend not to understand GMC's statutory obligations as a public protection body when examining complaints to examine the doctor's entire practice and not to limit its investigations. This sense that there is 'creep in scope' feeds the overall sense of mistrust in the GMC.

4.3 Key Challenges for the GMC

The research highlights a number challenges for the GMC in seeking to improve the FTP experience, but two in particular will present a challenge because the responses from doctors are to an extent contradictory and therefore difficult to resolve:

- In terms of communication: some doctors wanted early reassurances from the GMC's staff that the chances are good that everything will turn out well in their case. However, others bemoaned being given false hope by having received such reassurances. It will be very difficult for the GMC to tread the right line on this issue to the satisfaction of all.

- In terms of the GMC meeting with doctors to discuss their case: there seems to be a possible conflict between doctors wanting to meet and discuss their case with the GMC, but strong evidence the feedback we received that, in the past, their representation actively discourages doctors from engaging with the GMC in such a way.

5. Appendices

5.1 Respondent Profile

Figure 5.1: Where did you earn your Primary Medical Qualification?

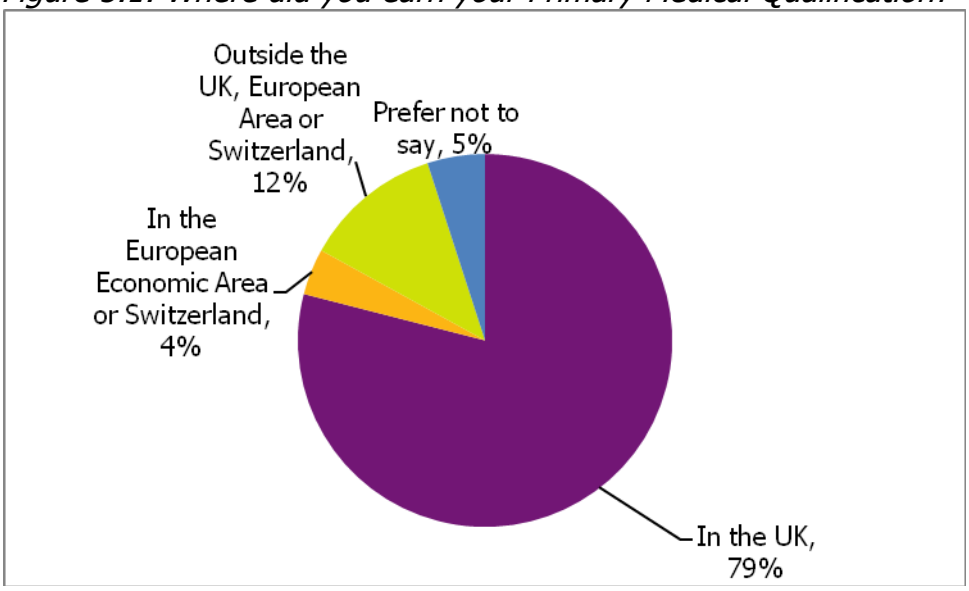


Figure 5.2: What is your gender?

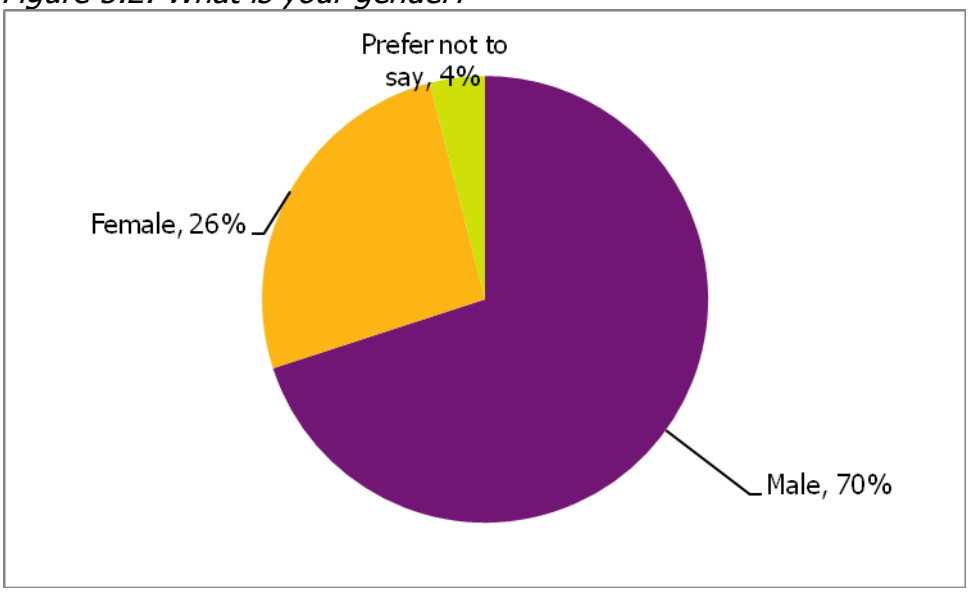


Figure 5.3: What is your age?

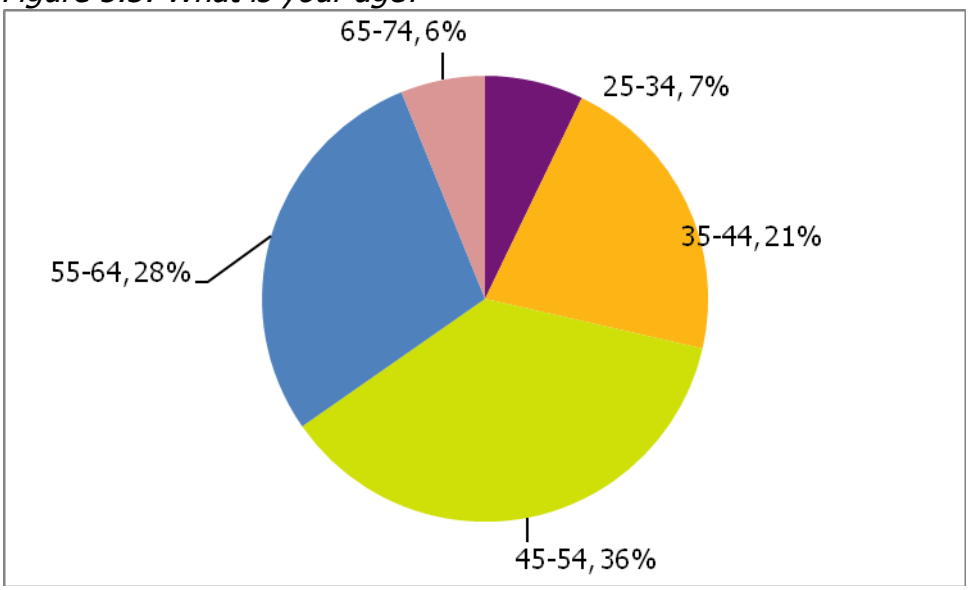
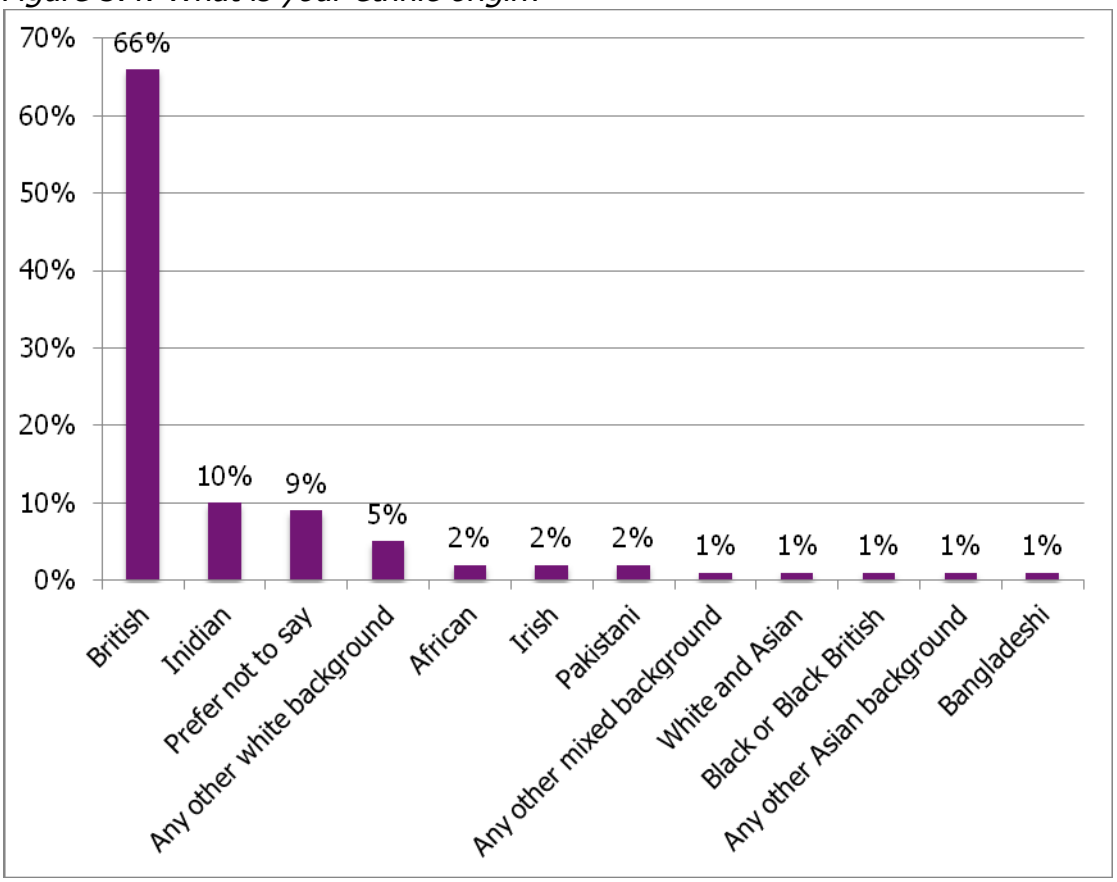


Figure 5.4: What is your ethnic origin?



5.2 Research instruments

5.2.1 Questionnaire

About this questionnaire:

- This questionnaire is intended to gather information to help the GMC improve its process for handling complaints about doctors and we very much appreciate your participation.
- If you have any questions about the survey, please contact Community Research by e-mail at: gmc@communityresearch.co.uk

Instructions for completing this questionnaire:

- The questionnaire should be completed by the named recipient only.
- INSTRUCTIONS YOU SHOULD FOLLOW ARE IN CAPITALS. Please provide your answer to each question by ticking the box or writing in.
- Answer all the questions in the order they appear unless directed otherwise.
- Not all sections of the questionnaire will be relevant to your own experience. Instructions IN CAPITALS will ensure that you answer all the questions relevant to you.

This questionnaire should take around 10-25 minutes to complete depending on your experience of the GMC procedures. Thank you in advance for your time.

SECTION 1 – THE COMPLAINT OR REFERRAL

At the start of the process, the GMC would have sent you a letter acknowledging or informing you of the complaint or referral, the next steps for the inquiry and further information about the GMC processes.

1) How far do you agree or disagree that this initial letter:

TICK ONE BOX ONLY PER LINE	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
Informed you about the concerns that had been raised	❑	❑	❑	❑	❑
Was clear about the decision to proceed with an investigation	❑	❑	❑	❑	❑
Was clear about the process that would follow	❑	❑	❑	❑	❑

2) How could this initial stage of the process be improved?
PLEASE WRITE IN:

3) You should have received a leaflet along with this initial communication from the GMC. If you saw the leaflet, how helpful was it?

Very helpful	❑	PLEASE CONTINUE TO Q4
Quite helpful	❑	
Not very helpful	❑	
Not helpful at all	❑	
Don't know/ can't remember	❑	PLEASE MISS OUT Q4 AND GO TO Q5
Did not receive	❑	

4) How could the information leaflet be improved?
PLEASE WRITE IN:

SECTION 2 – COMMUNICATION WITH YOUR EMPLOYERS(S) / CONTRACTOR(S) OF SERVICES

1. At the time of the initial complaint or referral, which of the following was true?

You were employed (or working under contract) or had been at some point during the previous 5 years	❑ ⟶	PLEASE CONTINUE TO Q6
You had NOT been employed or working under contract for five or more years, (either because you had been self-employed and working completely independently and/or you were unemployed)	❑ ⟶	PLEASE MISS OUT Q6 and Q7 AND GO STRAIGHT TO Q8

Once details of your employment situation had been received by the GMC, the GMC would then have written to your employer or contractor of services to inform them of the complaint (or to acknowledge receipt if it had been originally referred by the employer or contractor).

2. How satisfied or dissatisfied were you with the following?

TICK ONE BOX ONLY PER LINE	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied	Don't know
That the process of communicating with your employer(s) / contractor(s) was handled sensitively	❑	❑	❑	❑	❑
That you were suitably kept informed about communications between the GMC and your employer(s) /	❑	❑	❑	❑	❑

contractor(s)					

3. How could this part of the process (communication with your employer or contractor) be improved?
   PLEASE WRITE IN:

4. Did the GMC conduct a full investigation of the complaint?

Yes	❑ →	PLEASE CONTINUE TO Q9
No	❑ →	PLEASE MISS OUT Q9-Q25 AND GO STRAIGHT TO Q26

SECTION 3 – THE INVESTIGATION PROCESS

This section of the questionnaire focuses on the investigation part of the process.

5. During the investigation of your case how did you generally interact with the GMC?
TICK ALL THAT APPLY

I interacted with the GMC myself	❑
A solicitor or barrister handled interactions with the GMC on my behalf	❑
A representative from a professional organisation handled interactions with the GMC on my behalf	❑
A friend, family member or other person handled interactions with the GMC on my behalf	❑

During the investigation process, a doctor can comment at any stage, however, the GMC would have specifically invited comment from you about the concerns that had been raised at the outset and towards the end of the investigation.

6. How far do you agree or disagree that the GMC:

TICK ONE BOX ONLY PER LINE	Strongly agree	Agree	Disagree	Strongly disagree	Don't know	Not Applicable
Conducted the investigation in a timely manner	❑	❑	❑	❑	❑	❑
Understood the circumstances of the case	❑	❑	❑	❑	❑	❑
Kept you informed of progress	❑	❑	❑	❑	❑	❑
Gave you and/or your representative enough time to comment	❑	❑	❑	❑	❑	❑
Considered	❑	❑	❑	❑	❑	❑

your comments as part of the investigation						

7. If you did not comment on your case can you please explain why?
   PLEASE WRITE IN:

8. How could this part of the process (the investigation and opportunity for comment) be improved?
   PLEASE WRITE IN:

SECTION 4 – INTERIM ORDERS PANEL HEARING

If the GMC considers that a doctor could be an immediate risk to patients or themselves it can take immediate action by suspending their registration or by restricting their practice. This is done through holding an Interim Orders Panel hearing. Please note that this is different from a Fitness to Practise Panel hearing, which may have been held towards the end of your case.

5) Was an Interim Orders Panel hearing held at any point in your case and did you attend?

Yes, a hearing was held and you attended	❑	PLEASE ANSWER Q14 - 16
Yes, a hearing was held but you did not attend	❑	
No, a hearing was not held in your case	❑	PLEASE MISS OUT Q14-Q16 AND GO STRAIGHT TO Q17
Don't know	❑	

9. Who represented you at the Interim Orders Panel hearing?
TICK ALL THAT APPLY

A solicitor or barrister	❑
A representative from a professional organisation	❑
A friend, family member, or other person	❑
You represented yourself	❑
No one	❑
Don't remember	❑

10. How far do you agree or disagree with the following statements:

TICK ONE BOX ONLY PER LINE	Strongly agree	Agree	Disagree	Strongly disagree	Don't know	Not applicable
You understood the purpose of the Interim Orders Panel hearing	❑	❑	❑	❑	❑	❑
If you attended, the hearing was effectively run	❑	❑	❑	❑	❑	❑
If you attended, both sides were given sufficient opportunity to present their case	❑	❑	❑	❑	❑	❑
If you attended, the Panel was attentive throughout the proceedings	❑	❑	❑	❑	❑	❑
The decision of the panel was clearly stated	❑	❑	❑	❑	❑	❑
The reasons for the decision were clearly explained	❑	❑	❑	❑	❑	❑
You understood the implications of the decision for you	❑	❑	❑	❑	❑	❑

11. How could this part of the process (Interim Orders Panel) be improved?
PLEASE WRITE IN:

SECTION 5 – CASE EXAMINER DECISION AND OUTCOME OF YOUR CASE

At the end of the investigation, a decision is made by two GMC staff called case examiners. The GMC would have written to you with their decision.

12. How far do you agree or disagree with the following statements?

TICK ONE BOX ONLY PER LINE	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
The decision was clearly stated	❑	❑	❑	❑	❑
The reasons for the decision were clearly explained	❑	❑	❑	❑	❑
The supporting evidence was clear	❑	❑	❑	❑	❑
You understood the implications of the decision for you	❑	❑	❑	❑	❑

13. What was the case examiners' decision in your case?
TICK ONE BOX ONLY

Your case was closed with or without advice	❑	PLEASE ANSWER Q19 AND THEN MOVE STRAIGHT TO Q26
A warning was issued	❑	
Undertakings were suggested and agreed	❑	
A warning was refused and an Investigation Committee held	❑ →	PLEASE MISS OUT Q19 AND THEN GO STRAIGHT TO Q20
Undertakings were suggested and refused	❑ →	PLEASE ANSWER Q19 AND THEN GO STRAIGHT TO Q22
The case was sent to a Fitness to Practise Panel hearing	❑ →	PLEASE MISS OUT Q19 -

		Q21 AND GO STRAIGHT TO Q22

14. How could the process of either closing your case, issuing a warning or discussing undertakings be improved?

    PLEASE WRITE IN:

15. How could the Investigation Committee process be improved?

    PLEASE WRITE IN:

16. What was the decision of the Investigation Committee?
TICK ONE BOX ONLY

Your case was closed	❑	PLEASE MISS OUT Q22-25 AND GO STRAIGHT TO Q26
A warning was issued	❑	
Your case was sent to a Fitness to Practise Panel Hearing	❑ →	PLEASE CONTINUE TO Q22

SECTION 6 – FITNESS TO PRACTISE PANEL HEARING

At a Fitness to Practise hearing a panel hears all the evidence and then decides if and what action is necessary regarding the doctor's registration.

6) Did you attend your Fitness to Practise Panel hearing?

Yes all of it	❑
Yes, some of it	❑
No not at all	❑
Don't know	❑

17. Who represented you at the Fitness to Practise panel hearing?
TICK ALL THAT APPLY

A solicitor or barrister	❑
A representative from a professional organisation	❑
A friend, family member, or other person	❑
You represented yourself	❑
No one	❑
Don't remember	❑

18. How far do you agree or disagree with the following statements:

TICK ONE BOX ONLY PER LINE	Strongly agree	Agree	Disagree	Strongly disagree	Don't know	Not applicable
It was explained why a panel hearing was felt to be necessary in your case	❑	❑	❑	❑	❑	❑
The information leaflet provided with the notice of hearing was helpful	❑	❑	❑	❑	❑	❑
You were given sufficient notice of the panel hearing	❑	❑	❑	❑	❑	❑
If you attended the hearing was effectively run	❑	❑	❑	❑	❑	❑
If you attended, both sides were given sufficient opportunity to present their case	❑	❑	❑	❑	❑	❑
If you attended, the Panel was attentive throughout the proceedings	❑	❑	❑	❑	❑	❑
The decision of the panel was clearly stated	❑	❑	❑	❑	❑	❑
The reasons for the decision were clearly explained	❑	❑	❑	❑	❑	❑
You understood the implications of the decision for you	❑	❑	❑	❑	❑	❑

7) How could this part of the process (Fitness to Practise Panel) be improved?

PLEASE WRITE IN:

SECTION 7 – COMMUNICATION DURING THE PROCESS

19. Thinking about the entire process, how far do you agree or disagree with the following statements?

TICK ONE BOX ONLY PER LINE	Strongly agree	Agree	Disagree	Strongly disagree	Don't know	Not applicable
You were kept updated by the GMC about the progress of the matter		❑	❑	❑	❑	❑
The tone of the written communications from the GMC was professional	❑	❑	❑	❑	❑	❑
GMC staff were helpful	❑	❑	❑	❑	❑	❑
Responses to your queries were timely	❑	❑	❑	❑	❑	❑
If you visited the GMC website, you were able to find relevant information on the GMC website	❑	❑	❑	❑	❑	❑
If you visited the GMC website , the information was clear and easy to understand	❑	❑	❑	❑	❑	❑

20. How could the GMC's communication (written, telephone and web-based) be improved?
PLEASE WRITE IN:

SECTION 8 – OVERALL EXPERIENCE

21. What is the most important thing that the GMC should do to improve the Fitness to Practise procedure for doctors?
PLEASE WRITE IN:

22. Please provide any additional comments you may have.
PLEASE WRITE IN:

SECTION 9 – ABOUT YOU

This section is optional and any responses you give will be **completely confidential** - you will not be individually identified to the GMC. It would however be very helpful to know a little bit about you. Collecting this information will help the GMC to understand how its process for handling complaints about doctors may affect different groups of people. PLEASE TICK ONE BOX ONLY ON EACH OF THE FOLLOWING QUESTIONS.

23. Where did you earn your Primary Medical Qualification?

In the UK	❑
In the European Economic Area or Switzerland	❑
Outside the UK, European Area or Switzerland	❑
Prefer not to say	❑

24. What is your gender?

Male	❑
Female	❑
Prefer not to say	❑

25. What is your age?

Under 24	❑
25 – 34	❑
35 – 44	❑
45 – 54	❑
55 – 64	❑
65 – 74	❑
75 +	❑
Prefer not to say	❑

8) What is your ethnic origin?

Asian or Asian British	··Bangladeshi	❑
	··Indian	❑
	··Pakistani	❑
	··Any other Asian background, please specify,	❑
Black of Black British	··Black or Black British	❑
	··African	❑
	··Caribbean	❑
	··Any other Black background:	❑
Chinese or any other ethnic group	··Chinese	❑
	··Any other background, please specify	❑
Mixed	··White and Asian	❑
	··White and Black African	❑
	··White and Black Caribbean	❑
	··Any other mixed background:	❑
White	··British	❑
	··Irish	❑
	··Any other white background:	❑
Prefer not to say		❑

Thank you very much for your time. Your response has been very helpful.

Further Interview Request

As part of this research project Community Research will be conducting some more detailed interviews with a selection of doctors over the telephone. The interview would be arranged at a time to suit you. Your answers would remain confidential. Would you be happy for Community Research to contact you about an interview?

Yes	❑
No	❑

If you're interested in taking part in the interviews, please provide your contact details below and tick the box or boxes that apply:

Full Name:	_____
Email address:	_____
Landline telephone number:	_____
Mobile telephone number:	_____

Depending on the level of response it may not be possible to conduct a telephone interview with all doctors that agree to take part although we will try to do so with as many as possible. If we are able to include you we will be in contact with you to arrange the interview. If you do not hear from us this means that unfortunately we have been unable to include you. Thank you for your understanding.

5.2.2 Qualitative discussion guide

GMC FTP Survey: Depth interview draft discussion guide

27th July 2012

Approach

The interview will be conducted over the telephone with a selection of 30 doctors who have opted in to be recontacted as part of the quantitative survey. We will use their responses to the postal or online questionnaire as the basis for questioning.

The discussion guide will be tailored to each respondent and will focus on the aspects of the process or experience that are relevant to the individual (and are identified as most important to them from their responses to the quantitative survey).

NOTE:
This is a semi-structured guide, as such these questions are designed more as prompts than to be read out verbatim. The conversation will be guided by individual responses to the survey, it is therefore likely that the conversation will differ for each participant

Exploration of the following key themes:

- What went well?
- What aspects of the process or communications were they least happy with?
- What improvements or changes could be made to the process to improve doctors' experiences in the future?
- What is their response to a number of key initiatives being piloted by the GMC (for example, 'Meeting with Doctors' pilot and the new Support for Doctors service)

6. Introduction

The interviewer will:

- Provide brief details of the aims and objectives of the research
- Reiterate that we will not be covering the detail of the case as such but are interested in their views of the process
- Remind the interviewee about the quantitative survey that they have already completed
- Reassure about confidentiality of responses
- Request that the interview can be taped recorded

NOTE TO INTERVIEWER:
FOR EACH SECTION, FOCUS ON THE AREAS OF GREATEST AND LOWEST SATISFACTION , PAYING PARTICULAR ATTENTION TO HOW THE PROCESS COULD BE IMPROVED, AND CRUCIALLY, WHAT THIS MIGHT LOOK LIKE IN PRACTICE (SO FOR EXAMPLE, IF THEY ARE ASKING FOR GREATER TRANSPARENCY – WHAT SPECIFICALLY DO THEY WANT TRANSPARENCY IN?)

7. The complaint or referral

At the start of the process, the GMC would have sent you a letter acknowledging or informing you of the complaint or referral, the next steps for the inquiry and further information about GMC processes…

- In your questionnaire response, you indicated that you were particularly satisfied/ dissatisfied with xx aspects of the process. Why did you select those ratings for the process? Probe.

- You said that the process could be improved by xxx. Probe for further information on the suggested improvement (and focus on how this could be achieved).

- Is there anything else that would help improve things?

8. Communication with your employer(s) and contractor(s) of services

At the start of the process, the GMC would have sent you a letter acknowledging or informing you of the complaint or referral, the next steps for the inquiry and further information about GMC processes…

- In your questionnaire response, you indicated that you were particularly satisfied/ dissatisfied with xx aspects of the communication with your employer/ contractor(s). Why did you give those ratings for this part of the process?

- Do you have any views on how employers are informed about the complaint?

- You said that the process could be improved by xxx. Probe for further information on the suggested improvement. (and focus on how this could be achieved)

- Is there anything else that would help improve things?

9. The investigation process

Thinking now about the investigation process…

- You indicated that you interacted with the GMC yourself/others acted for you during the investigation. Why did/didn't you have representation? What were the factors in this decision?

- In your questionnaire response, you indicated that you were particularly satisfied/ dissatisfied with xx aspects of the investigation process. Why did you give those ratings for the process?

- Probe on reasons for not commenting on case (if appropriate.)

- You said that the process could be improved by xxx. Probe for further information on the suggested improvement (and focus on how this could be achieved).

- Is there anything else that would help improve things?

10. Interim Orders Panel hearing

On the questionnaire you indicated that an Interim Orders Panel hearing was held in your case…

- (If appropriate), you indicated on the questionnaire that a IOP hearing was held but you did not attend. Why did you elect not to attend?

- You indicated that you represented yourself/others acted for you during the IOP hearing. Why did/didn't you have representation? What were the factors in this decision?

- In your questionnaire response, you indicated that you were particularly satisfied/dissatisfied with xx aspects of the IOP hearing. Why did you give the select those ratings for the process?

- You said that the process could be improved by xxx. Probe for further information on the suggested improvement (and focus on how this could be achieved).

- Is there anything else that would help improve things?

11. Case examiner decision and outcome

At the end of the process, a decision is made by two GMC staff called case examiners. The GMC would have written to you with their decision…

- In your questionnaire response, you indicated that you were particularly satisfied/ dissatisfied with xx aspects of this process. Why did you give the select those ratings for the process?

- You said that the process could be improved by xxx. Probe for further information on the suggested improvement (and focus on how this could be achieved).

- Is there anything else that would help improve things?

IF THE DISCUSSION MOVES ONTO THE ISSUE OF RESOLVING CASES EARLIER, OR IF THERE IS ANY DISCUSSION OVER THE EXPLANATION OR NATURE OF THE CASE EXAMINER DECISION, PLEASE MENTION THE FOLLOWING:

*From September the GMC will be piloting a **'Meeting with Doctors'** scheme whereby the GMC will meet with the doctor at the end of the investigation. This will provide an opportunity for the GMC to explain its initial view on what action is necessary based on the investigation. If there is disagreement over this to discuss what supporting evidence the doctor could provide to impact upon this decision. It is intended that following the meeting the doctor would have an opportunity to accept a sanction as an alternative to a hearing in more cases than at present.*

- Would you have found this helpful in your case?

- Do you think that this would improve the experience of doctors generally going through the process? Probe why/why not?

- Do you have any comments/ suggestions for the scheme?

12. Fitness to Practise Panel hearing

On the questionnaire you indicated that Fitness to Practise Panel hearing was held in your case…

- You indicated on the questionnaire that a FTP hearing was held but you did not attend. Why did you elect not to attend?

- You indicated that you represented yourself/others acted for you during the FTP hearing. Why did/didn't you have representation? What were the factors in this decision?
-
- In your questionnaire response, you indicated that you were particularly satisfied/ dissatisfied with xx aspects of the FTP hearing. Why did you give the select those ratings for the process?
-
- You said that the process could be improved by xxx. Probe for further information on the suggested improvement (and focus on how this could be achieved).
-
- Is there anything you would like to say about the hearing in general? (POSSIBLE PROBES - BE CAREFUL NOT TO LEAD THIS: practical arrangements, the panel, decision making)
- Is there anything else that would help improve things?

FOR DISCUSSION WITH ALL WHO HAVE BEEN THROUGH FTP HEARING:

*You may or may not be aware that the GMC has recently established the **Medical Practitioners Tribunal Service or MPTS.** Doctors involved in Interim Orders Panel and Fitness to Practise hearings will now be referred to a new tribunal service set up as part of government led reforms. The establishment of the MPTS is part of the GMC's wider programme of reform of medical adjudication.*

It was set up to:

- *provide better separation between the GMC's complaints and investigation functions and adjudication, and*
- *to take over responsibility for the day to day management of hearings, panellists and their decisions.*

The MPTS while part of the GMC is run separately and is accountable directly to Parliament. It is run by an independently appointed chair The MPTS will run all panel hearings for the medical profession in the UK and make decisions on what action is needed to protect patients.

- Do you think this change (and the separation of investigation and adjudication) represents an improvement?
- Why/why not?

13. Communication during the process

Thinking about communication during the entire process…

- In your questionnaire response, you indicated that you were particularly satisfied/ dissatisfied with xx aspects of communication. Why did you give the select those ratings?

- Do you think the tone of the communications generally is appropriate?

IF RESPONSE IS NEGATIVE:

The GMC has recently developed new guidelines to inform its writing style. The guidance is designed to change the tone of its communication so that it's more accessible personal and free of jargon. In light of this the GMC is reviewing the tone and style of its written correspondence with doctors involved in a fitness to practise case.

- Does this sound like it will address any concerns you had over tone?
- How else do you think the tone of GMC communications could be improved? (assuming they have said that the tone isn't appropriate). ASK FOR SPECIFICS

- Probe for any views on the quality/quantity of information on the website.

- You said that the process could be improved by xxx. Probe for further information on the suggested improvement (and how this could be achieved).

- Is there anything else that would help improve things?

14. Suggested improvements

Thinking about the whole experience, I want to focus now on the single thing that would improve the process for other doctors experiencing it in future…

N.B. ALWAYS TO BE ASKED:

1. You said that the single most important improvement to the overall process would be xxx. Probe for further information on the suggested improvement. Why do you say this? How could this be achieved?

- Is there anything else that would help improve things?

IF THE DISCUSSION HAS TOUCHED ON THE ISSUE OF DOCTOR SUPPORT, DISCUSS THE FOLLOWING:

*The GMC is currently piloting **'The Doctor Support Service'.** They have commissioned BMA 'Doctors for Doctors' to provide dedicated confidential emotional support to any doctor involved in a Fitness to Practise case who would like it. The service is open to any doctor who needs it and is free of charge. The service does not offer medical or legal advice but provides the following:*

- *Doctors can call the service for emotional support and advice from a fellow doctor who is completely independent of the GMC.*
- *If the case ends up at a hearing, the doctor can ask someone from the service to go with them to the first two days of this (or any other two days by agreement between them).*
- *After a case has closed, the doctor can also talk to their supporter about how they feel about the outcome.*
- *The dedicated telephone line is open from 9am to 5pm, Monday to Friday.*
- *The support service is completely independent of the GMC.*

- Would you have found this helpful in your case?
- Would you have felt comfortable talking to someone from this scheme?

- Do you think that this would improve the experience of doctors generally going through the process? Probe why/why not?
- Do you have any comments/ suggestions for the scheme?

15. Final thoughts

- Is there anything else you feel we should have covered?
- Are there any aspects of the process that worked well and you feel should not change?
- Overall, what aspects of the process were you most dissatisfied with? Why?

Thank for their time.