Public Confidence Thresholds Research – Rapid Literature Review

Research for the General Medical Council |June 2026

community research

Bringing the voices of communities into the heart of organisations

Contents

Please note: This report was originally submitted to the GMC in February 2025 in order to inform the development & implementation of the subsequent fieldwork

1. About the rapid literature review

The General Medical Council (GMC) commissioned this rapid evidence review to inform the design of a research study into public expectations of the Fitness to Practise process. The aim of this research is to better understand the public's views on where the GMC's thresholds should sit in public confidence cases, both in terms of their thoughts on hypothetical case examples, but also more broadly to understand why the public holds those views.

1.1 Purpose

This is not a full academic literature review, rather it is a rapid scan and summary of key relevant evidence. The purpose of the summary is to inform the design of the research project, specifically:

- The sample design (who we speak to);
- The methodology (the best way to identify and speak to them); and
- The content (what we speak to them about and how we elicit the information).

1.2 Approach

The GMC has identified some of sources reviewed here, although Community Research has supplemented these.

The approach to the review has been to scan the documents to identify points of interest, based on key questions agreed with the GMC in advance. This document summarises the key themes from the evidence reviewed, using this to make recommendations on the design of the research.

1.3 Key questions

The evidence has been reviewed with the following specific questions in mind:

- Which audiences are likely to have different experiences of or attitudes towards health services which may impact on confidence and should, therefore, be included in the research sample?
- What mitigating or aggravating factors are important influences of public confidence and should, therefore, be included in any hypothetical scenarios used during the research?

2. Public confidence

2.1 Current levels of public confidence

According to the British Social Attitudes 2023 survey[1], satisfaction with the NHS has dropped significantly since 2022, by 5 percentage points. Since 2020, satisfaction has seen an unprecedented drop of 29 percentage points. Dissatisfaction with the NHS is also at a record high, with 52% of respondents dissatisfied.

However, trust in the medical profession remains fairly stable. According to Ipsos's Veracity Index, the top five trusted professions in 2023 were nurses, airplane pilots, librarians, doctors and engineers. Trust in doctors was little changed on the previous year, with ratings similar by gender and income.

The GMC public confidence research[2] indicated that the general public have reasonably high levels of confidence in the medical profession. 87% of respondents agreed or agreed strongly that 'the majority of doctors can be trusted to do a good job', and 77% of respondents agreed or agreed strongly that they are 'confident in the UK's doctors'.

The GMC qualitative component of the research highlighted that individual cases of wrong doing were generally considered 'one-offs' had little impact on confidence in the wider medical profession. Any specific cases mentioned tended to be historic and overtly criminal, such as Shipman. Only three participants of 122 recalled the 'widely reported' Bawa-Garba case[3], though none remembered her name. Rather people recalled media stories of wider, generic system pressures in the NHS, and local cases of misdiagnosis.

Several national patient surveys ask service users whether they have confidence and trust in clinicians. The Nuffield Trust[4] has compared people's responses to understand how patient experience varies across NHS services (noting that differences in survey methodology and respondent demographics may impact findings). In 2020, 84% of Children and Young People's Survey respondents (parents with children aged 15 or under who had been admitted to hospital) said that they always had confidence and trust in the member of staff treating their child. 80% of the 2023 Adult Inpatient Survey respondents said that they always had confidence and trust in the doctor treating them.

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[1] Public Satisfaction With The NHS And Social Care In 2023 | BSA | The King's Fund
[2] GMC Promoting and maintaining public confidence (2019); Community Research promoting-and-maintaining-public-confidence- pdf-78744712.pdf
[3] https://www.judiciary.uk/wp-content/uploads/2018/08/bawa-garba-v-gmc-final-judgment.pdf
[4] Patient experience: do patients have confidence and trust in clinicians? | Nuffield Trust

77% of Maternity Services Survey respondents in 2024 reported that they 'definitely had' confidence and trust in the staff caring for them during their labour and birth. 67% of the 2024 Urgent and Emergency Care Survey respondents who had attended a type 1 department said that they 'definitely had' confidence and trust in the doctors and nurses examining and treating them. Lastly, 63% of 2024 GP Patient Survey respondents stated that they 'definitely had' confidence in the healthcare professional they saw or spoke to.

2.2 Factors influencing public confidence

Use of services and age

The GMC public confidence research[2] further suggests that the level of confidence in the wider medical profession may be driven by individuals' experience of care i.e. that 'heavy' users of care may have different views to those who use care less frequently.

This was also found in analysis conducted by the Kings Fund in 2015[5]. People who have had recent contact with NHS services (defined as personal contact with inpatient or outpatient services in the past 12 months) were more likely to trust NHS doctors and nurses 'just about always' than those who had not (20 per cent compared to 11 per cent for doctors, and 25 per cent compared to 13 per cent for nurses).

The report comments that "this difference may reflect genuine relationships of trust built between individuals and the doctors and nurses who care for them, but also perhaps a degree of gratitude for the care that individuals have received. The difference may also be partially driven by negative media reporting having a greater influence over the views of those with no recent personal contact. Trust also appears to be related to age: older respondents were more likely to trust doctors and nurses 'just about always' than younger respondents. This is perhaps partly because older groups were more likely to have had recent contact with health services, or it may reflect generational differences in attitudes and expectations regarding 'professional' status."

Ethnicity

Minority ethnic groups[6] are disproportionately represented in the low income population (BAME groups make up 23% of the UK population in poverty, compared with 13% of the UK population overall). There is much evidence[7] that wider determinants of health, such as poverty, have an impact on health outcomes.

[5] https://www.kingsfund.org.uk/blog/2015/12/public-trust-doctors-nurses
[6] Greater London Authority response to 'Ethnic disparities and inequality in the UK: call for evidence' | London City Hall
[7] Health inequalities, Deaton Review

The Kings Fund[8] has reported on health inequalities between ethnic minority and white groups, and between different ethnic minority groups. It found that the picture is complex, both between different ethnic groups and across different conditions. However it found that before the Covid-19 pandemic, life expectancy at birth was higher among ethnic minority groups than the white and Mixed groups:

- people from the White Gypsy or Irish Traveller, Bangladeshi and Pakistani communities have the poorest health outcomes across a range of indicators. They are also most likely to report having a long-term condition and poor health.
- rates of infant and maternal mortality, cardiovascular disease (CVD) and diabetes are higher among Black and South Asian groups than white groups
- mortality from cancer, and dementia and Alzheimer's disease is highest among white groups.

The report also found that "among ethnic minority groups structural racism can reinforce inequalities, for example, in housing, employment and the criminal justice system, which in turn can have a negative impact on health. Racism and discrimination can also have a negative impact on the physical and mental health of people from ethnic minority groups".

The Race and Health Observatory[9] reported that the health of ethnic minority people has been negatively impacted by 'a lack of appropriate treatment for health problems by the NHS; poor quality or discriminatory treatment from healthcare staff; a lack of high quality ethnic monitoring data recorded in NHS systems; lack of appropriate interpreting services for people who do not speak English confidently and delays in, or avoidance of, seeking help for health problems due to fear of racist treatment from NHS healthcare professionals.' Their review looked at specific areas of healthcare and found differential outcomes/experiences for Black people in relation to mental health services. They also explored maternity services and highlighted "the intersection of additional aspects of social disadvantage with minoritised ethnic identities that can further compromise women's access to, and positive experiences of, maternity care. Groups of women of particular concern include Roma, Gypsy and Traveller women, those seeking asylum or recent refugee status, those with mental health conditions, teenage women and young mothers".

There is less evidence on how these differential experiences and outcomes impact on trust and confidence in doctors.

[8] The Health Of People From Ethnic Minority Groups In England | The King's Fund
[9] Ethnic Inequalities in Healthcare: A Rapid Evidence Review - NHS – Race and Health Observatory

Some differences have been noted in terms of satisfaction with GP services by ethnicity[10], with patients from the Pakistani and Bangladeshi ethnic groups least likely to report a positive overall experience (and also least likely to have a positive experience making a GP appointment). Black African patients were the most likely out of all ethnic groups to report a positive overall experience with their GP services

Mistrust was noted between the patient and the healthcare professional, as well as mistrust of an overall 'system'. A literature review of the experiences of the Black community of primary care[11] found that "some of the African Caribbean community … take a very rational view that mental health services are punitive, treated differently because of their ethnicity, lack of cultural connection or sensitivity".

There is some evidence in relation to a lack of trust affecting levels of Covid-19 vaccination levels amongst ethnic minority groups[12], with some positing that 'NHS resources were viewed as an extension of the Government, meaning they lacked credibility among people who felt disenfranchised by the state'.

There might be differences amongst people who have more recently migrated to the UK as we have found amongst some communities there is a higher level of deference to authority figures[13].

Other audiences of possible interest

There are other audiences who may have different views on the topics in question as a result of their background, lifestyle, health or social inequality and/or discrimination. For example:

- Members of the LGBT community can have a higher prevalence of unhealthy lifestyle behaviours, higher incidence of mental health issues and experience prejudice[14].
- Carers can have extensive contact with health services as a result of their caring responsibilities but also experience isolation and poor health outcomes themselves[15].

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[10] Patient satisfaction with GP services - GOV.UK Ethnicity facts and figures
[11] Views and experiences of primary care among Black communities in the United Kingdom: a qualitative systematic review Full article: Views and experiences of primary care among Black communities in the United Kingdom: a qualitative systematic review
[12] Rebuilding trust in medicine among ethnic minority communities
[13] For example, in work amongst recent migrants for Thames Water, we found people were unlikely to question authorities (https://www.thameswater.co.uk/media-library/home/about-us/performance/customer-research-library/vulnerability-deep-dive-march-2023.pdf).
[14] LGBT in Britain - Health (2018) | Stonewall; LGBT_evidence_review_NIESR_FINALPDF.pdf
[15] soc23-health-report_web.pdf

- People with learning disabilities[16] can experience poorer health outcomes and experience prejudice.

2.3 What public confidence means in this respect

A point of note is the reference in the final judgement of the Bawa-Garba case[3] to public confidence relating to "fully informed and reasonable member of the public" and of "ordinary, intelligent citizens who appreciate the seriousness of the sanction, as well as other issues involved in the case".

A report from the PSA[17] on how public confidence is maintained when fitness to practise decisions are made, noted divergence in the referencing of public confidence in different regulatory frameworks and a certain 'lack of reasoning' and the use of 'standard text' in tribunal decisions to indicate that public confidence had been considered.

The GDC/NMC report[18] on the concept of seriousness explored the notion of public confidence. Regulators were interviewed and asked how they apply the concept of maintaining public confidence in a profession in their decision-making. Participants offered differing interpretations of its meaning. Some saw it as ensuring that allowing a registrant found to have committed misconduct to continue to practise unrestricted would not impact on members of the public's willingness to seek treatment from healthcare professionals. Others positioned themselves as the prospective patient when talking about applying this concept. One suggested that such a threshold was too high, and that consideration of how to maintain public confidence should be a broader judgement about professionalism and registrants' adherence to professional standards.

Some participants also highlighted the importance of regulation being seen to be done in terms of maintaining public confidence, with media coverage mentioned i.e. a test being how would it be seen by the public if details of the case were published in the Daily Mail. However, participants also cautioned against using the anticipated tone of future media coverage as a barometer of public opinion, or a marker for how public confidence in healthcare professionals might be affected by FtP cases.

Some participants noted the idea of 'the well-informed' or 'reasonable-minded' member of the public as an abstract figure in considering whether public confidence would be undermined if a registrant was allowed to continue practising without restriction, but noted that this is difficult to apply meaningfully.

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[16] transforming-commissioning-services.pdf; http://www.bris.ac.uk/media-library/sites/cipold/migrated/documents/finalreportexecsum.pdf

[17] PSA How is public confidence maintained when fitness to practise decisions are made? (2019) Report (for web)

[18] GDC/NMC Concept of Seriousness report 2022; University of Plymouth The concept of seriousness in fitness to practise – a cross-regulatory research

In another study, Promoting public confidence in the medical profession: Learning from the case of Dr Bawa-Garba[19], the authors argue that "the use of the rhetoric of public confidence in the regulation of the medical profession has been characterised by an unsatisfactory lack of transparency, excessive deference by the courts to regulatory tribunals and that research is increasingly signalling that instinctual 'expert' judgements on the issue of 'what the public think' may be unreliable'". They call for a "recalibration of the approach to assessing public confidence issues, with more emphasis on research into public confidence, could lead to different outcomes and may in time address long-held concerns that regulatory action too often extends into conduct beyond the clinical sphere…Devaney and Holm[20], for example, have argued that professional regulation is still based on 'the profession's values' and not to any 'appreciable extent on what the public upon reflection might think about doctors' private actions in their private lives'".

The report is largely focussed on clinical aspects but it does also state that regulators can feel pressure to mark the seriousness of certain types of non-clinical cases, including proven dishonesty and sexual misconduct. They state that in these cases remediation is of 'subdued significance' when it comes to deciding the appropriate sanction.

They conclude by calling for further research in this area given that "instinctual judgements are no longer satisfactory and that the deployment of public confidence justifications needs further contextualisation, for example, a grounding in research on public opinion and patient perspectives".

Deliberations in relation to public confidence have been at the heart of the 2024 fitness to practise case[21] in relation to Dr Benn's environmental protests. The Tribunal determined that Dr Benn's fitness to practise was impaired by reason of misconduct. It concluded "that, given the repeated breaches of the law in contravention of GMP, the Tribunal's findings as to why this amounts to misconduct, and the high likelihood of recurrence, public confidence in the profession and its system of regulation would be undermined if a finding of impairment were not made". The Tribunal was of the view that the overwhelming majority of the public would not condone breaking the law in the repeated way in which Dr Benn did, especially given the impact, on the final occasion, to the wider public resources

[19] case-sharma-2020-promoting-public-confidence-in-the-medical-profession-learning-from-the-case-of-dr-bawa-garba.pdf
[20] S. Devaney and S. Holm, 'The Transmutation of Deference in Medicine: An Ethico Legal Perspective', Medical Law Review 26(2) (2018)
[21] Dr Sarah BENN Apr 24 - MPTS

involved. This has been challenged during the December 2024 appeal process (with reference to the 2019 GMC public confidence research[2]).

3. Considerations for the research sample

3.1 The brief requirements

The research brief states that the sample should "be 'broadly representative' of national population demographics, specifically with respect to protected characteristics as defined across England, Scotland, Wales and Northern Ireland but also including socio-economic disadvantage". It should include proportionate representation across the four countries of the UK, urban and rural residents and a range of patient experience, in terms of frequency and depth of engagement with healthcare services including primary, tertiary and secondary care.

It also states that the following should be excluded - current and retired doctors, PAs and AAs, other healthcare professionals (current and retired), employees of healthcare regulators, patients with experiences of GMC's FtP procedures as a complainant or have been closely associated with a complaint through friends or family and individuals under the age of 18.

3.2 Overall approach to this project

The agreed approach is as follows:

- Qualitative research with just over 80 participants. This will be in the form of:
  - a brief online forum which provides information and gives scope for initial individual feedback.
  - followed by a series of face to face and live online sessions with general public/patients and specific targeted audiences to allow for detailed discussion and debate.
- A nationally representative quantitative survey with 2,000 responses

3.3 Sampling approach adopted by other studies

Samples used in other relevant qualitative research projects are as follows:

GMC public confidence research (Community Research)[2]

In addition to seeking the view of a cross section of the public through 8 groups segmented by lifestage, frequency of health service use and SEG, there were specific focus groups conducted with:

- Minority ethnic groups who were considered to have poorer health outcomes than the general population (separate groups with Pakistani, Bangladeshi and Black Caribbean audiences).
- Individuals living with long term health conditions.
- Individuals with extensive, informal, caring responsibilities.
- Individuals who have previously raised a complaint about a medical professional.

GMC standards research (NatCen)[22]

The research aimed to include harder to reach groups of people – those who may be less likely to engage in the wider consultation with the public being carried out by the GMC. The populations of interest included in this research were:

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

GOC standards research (Shift Insight)[23]

- 6 focus groups broadly representative by key demographics, split by age bands, with a total of 45 respondents.
- 10 interviews conducted with vulnerable service users, defined as those who have domiciliary care.

PSA research into dishonest behaviour (Policis)[24]

- 4 extended focus groups with participants from a mix of lifestages, socio economic groups and frequency of use of health services.
- 8 depth interviews with residents of nursing homes or those living at home and dependent on care.

GMC research to inform Good Medical Practice (ICE)[25]

ICE engaged with 159 members of the public and patients from across all four UK countries and targeted people from several specific groups including people from a minority ethnic heritage; with different religious beliefs; for whom English is not their first language; with a disability/long-term health condition; with impaired mental capacity; with a learning disability; who are deaf; Ex-offenders; Homeless people; Domestic abuse survivors; Parents and pregnant women; Care leavers; Young and adult carers; Asylum seekers and refugees; Roma and Irish Travellers; LGBTQ+ and transgender people.

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[22] GMC The standards expected of doctors (2012); NatCen The standards expected of doctors

[23] GOC Research into public perceptions of standards 2023; Shift Insight PowerPoint Presentation

[24] PSA research into perceptions of dishonesty 2016; Policis https://www.professionalstandards.org.uk/docs/default-source/publications/research-paper/dishonest-behaviour-by-hcp-research.pdf?sfvrsn=cff17120_34

[25] GMC Research to inform Good Medical Practice 2022; ICE Creates Exploring patient and public views to inform the Good medical practice review - GMC

HCPC research on Indicative Sanctions Policy (Gfk)[26]

The sample was made up of eight mini-group discussions and eight in-depth interviews.

- Groups were stratified by age, socio-economic group and presence of dependent children, with some people who have used services recently and carers.
- Depths were conducted with those aged 75+ with a health condition, those with sensory impairments and those with mental health conditions

3.4 Learnings from other research studies

There are some learnings from other relevant research studies that help inform decisions about sampling for this project.

The PSA research[24] on dishonesty found little difference in perceptions amongst those from different socio-economic groups and educational attainment but much more strength of feeling amongst those using the services more frequently. It also identified some gender and generational differences, particularly involving cases which focussed on professional boundaries or which contained a sexual element.

In the GMC qualitative research[2] on public confidence, retired participants in lower socio-economic groups and Bangladeshi women, were more likely to unquestioningly trust their doctors. Participants who had previously made a complaint against a healthcare professional and those who had witnessed 'blunders' and errors were less forgiving from the start and expected stronger regulatory action in cases of clinical errors. Those working in professional occupations who were accustomed to regulation also sometimes had a different starting point for discussions. In the quantitative research, older people displayed higher levels of confidence. The survey results also highlighted significant differences in terms of awareness of the GMC by age (older respondents were more likely to be aware) socio-economic group (those from the highest socio-economic backgrounds were more likely to be aware); and ethnic origin (White British people more likely to be aware of the GMC than those from BAME and White Other backgrounds).

The GOC research[23] on standards showed some differences in online expectations by age group (which is important given social media activity is likely to be a focus for this research). Younger respondents expressed how their expectations around the online conduct of optical professionals were largely the same regardless of whether it was in a personal or professional capacity – particularly due to how easy it might be to link them and the idea that 'the internet is forever'. However, some middle-

[26] HCPC research into Indicative Sanctions Policy 2018; GfK The Indicative Sanctions Policy - the Public's View | The HCPC

aged and older respondents were less concerned about online conduct on personal accounts, feeling that professionals should be able to post what they liked.

The GMC research on standards[22] findings are useful when considering sample in relation to discussions around personal beliefs. Doctors being able to maintain a divide between the personal and the professional areas of their lives was a key issue that arose when discussing how personal beliefs could be managed in the workplace. Participants who felt that a doctor should not be made to go against their personal beliefs or morals were particularly found within the non-English language interviews, the Gypsy and Traveller group, the refugee and asylum seeker group, the unemployed group in Northern Ireland and the BME group. The study also identified some generational differences - older people were more relaxed about a conflict of interest scenario (a registrant suggesting a care home that they have shares) than younger people.

The HCPC research[26] on indicative sanctions found that personal experience and values played a role in shaping any reaction to fitness to practise cases and the sanctions imposed. These differences in outlook did not tend to result in major differences in opinion throughout the research, but were reflected in situations where some participants were slightly more or less lenient towards cases. Across the research, very few differences emerged based on demographic profile of the participant.

The ICE research[25] explored the views of those with protected characteristics on GMC on different aspects of GMC guidance. However, the research focussed on these audiences as opposed to a more generalised sample so it's difficult to make any inferences about differences by demographics.

3.5 Recommended approach to sample

Overall approach

In the qualitative work we need to strike a balance between understanding the responses of the general public and including people with protected characteristics. We also need to bear in mind that we are working within budgetary constraints. It is our belief, therefore, that this research should focus primarily on a general sample of the public (that is as broadly representative as possible), along with some fieldwork that focuses specifically on people whose needs and experiences mean they might have a different perspective. However, we will need to be selective, prioritising those we believe have experiences that are more widely represented, rather than people who are highly vulnerable or communities who are known to face greater health inequalities and discrimination in healthcare. We need to take care not to group together people who fall under a particular protected characteristic – for example, there are widely varying needs and perspectives amongst disabled people; LGBT people; and people from minoritised ethnic groups. We would, therefore, need to

conduct multiple groups or depths with people who have common experiences or identities in order to cover off the diversity of perspectives – something which is beyond this more generalised piece of work.

Sample composition

The online forum approach will allow some analysis of feedback by key demographics. In terms of the approach to the sample for the in-person and live online groups, consideration needs to be given to the optimal group composition so that different views of different audiences can be explored and allowing sufficient homogeneity so that participants feel comfortable giving their opinions.

As the evidence shows that personal experiences affect people's trust in doctors, we propose boosting the numbers of people defined as 'heavy' or frequent users of health services amongst the older groups (aged 70+). We could also hold separate online group discussions amongst people with disabilities and long-term conditions (both physical and mental), those with recent experience of maternity services and with unpaid carers – both because they could have different views and to facilitate their involvement given inability or unwillingness to take part in an in-person session.

A possibility is conducting specific session with people who have complained about a health professional, as their views could be affected by their experience. However, there may be more of an argument for this in relation to views of clinical fitness to practise cases. On reviewing the data from 2019 research[2], we note that over 100 survey respondents had experience of making a complaint, and we were therefore able to analyse their responses separately. It could be possible in this study to rely on the quantitative data to understand the impact of negative experiences of doctors on people's views on confidence thresholds.

We propose that sampling also takes into consideration demographic factors that influence trust in doctors (and professionals/ authority figures more widely). Based on this, we suggest segmenting the 'general public' groups by age because the evidence indicates that those at different life-stages may have different attitudes on this topic. There is some limited evidence that gender may have a bearing on attitudes. We also feel that, given the possible subject matter (for example domestic violence or sexual assault), it would be beneficial to segment the groups by gender so that all participants feel comfortable expressing their opinions.

We would aim for a racial mix within the 'general public' groups. Mixed race groups needs careful consideration, as the mix can affects the extent to which people feel comfortable in speaking up and sharing their stories. Where people feel they are a visible minority in a group, it can be much harder for them to share, particularly if they feel others in the group might not 'get' what they have to say. We know that – in focus groups (whether in-person or online) – people from racial minority groups

can feel like a 'token representative' if they are the only person who is not white. This affects their experience of taking part in research, and limits what we hear from people who bring different perspectives and stories. In a qualitative study, we cannot hope to ensure that all cultural, ethnic and racial groups are represented, but boosting the numbers of visibly minoritised groups helps everyone to have a voice. In some research locations, populations will be almost entirely ethnically homogenous. In others, there will be a greater ethnic and racial diversity. We recommend the 'City rep' approach to sampling on the basis of race and ethnicity, as promoted by Colour of Research group. This means that we will adapt the sample specification based on the recruitment location – participants in rural areas and locations such as Northern Ireland and North Wales might be primarily White British, but participants from urban areas in England would be more ethnically and racially diverse.

An option is to conduct one online group discussion with those living in more rural areas to ensure that we include this perspective.

Our proposed group composition is shown below. This differs from the version in the original proposal but does fit the stated budget (and engages the same number of participants as previously specified).

There is an argument for conducting online groups with a number of different audiences and budget allows for three separate groups to be conducted. We would like further discussion with you about the final selection.

Table 1: Our suggested group composition

'General public' groups (6-8 participants) Face to face	Age	Gender
1	18-29	Male
2	18-29	Female
3	30-49	Male
4	30-49	Female
5	50-69	Male
6	50-69	Female
7	70+	Male
8	70+	Female

All groups will include a mix by recent experience of visiting a doctor as well as a mix by gender, socio-economic group and presence of dependent children. We will agree quotas in relation to 'heavy' users of health services. We will include some who are on Universal Credit and/or under household income of £21K pa

Specific focus: 3 online groups conducted in total (each with 5-6 participants)	Separate groups could be conducted with three of the following audiences: • People with long-term conditions or disability • Unpaid carers • People with mental health conditions • People with recent experience of maternity/pregnancy services • People living in a rural area • People who have made a complaint about a health professional

Suggested locations for the face to face sessions are shown below. The devolved nations are included, in addition to a broad geographic spread of locations in England. Participants for the online sessions will be drawn from across the UK.

Table 2: Our suggested locations for the 'general public' face to face sessions

Location
Central London
Leicester
Manchester
Cheltenham
Norwich
Llandudno
Glasgow
Belfast

4. Considerations for research approach

4.1 Overall approach

We appreciate thought processes relating to these issues are also highly nuanced and that there are a broad range of views in respect of the subject. We note from the GMC's 2014 consultation on changes to the Indicative Sanctions Guidance[27] that there was a fairly even split between those in favour (48%) and those opposed to the idea (52%) that Panels should be guided to consider taking action to maintain public confidence even when a doctor has remediated. Although it should be noted that higher proportions of the public were in favour (69%).

We know from our previous research on the concept of trust for the Food Standards Agency[28] that it is a fairly complex area in itself. One of the main take-outs from this research are that decisions to trust are as much emotional as rational, that they can be contradictory and people can be reluctant to analyse their decisions/viewpoints.

The interplay between trust and confidence is also a complex area. According to a paper on the topic[29], a "confidence judgement typically has a very specific referent, and is influenced by base rates and prior probabilities. A trust judgement has a broader scope and referent and is characterized by a specific lack of information, and by the need to take a "leap of faith" from what is known to what is unknown". However, the study also notes their commonalities and the challenge of differentiating. This is evidence in that many of the research reports cited in this rapid review appear to use the terms interchangeably which seems to reflect how participants tend to discuss the issues. For example, in the HCPC research[26], participants strongly agreed that it was important that the public could be confident in the profession and this was often interpreted as being able to trust the profession.

Some of the quantitative studies[4] relating to this area conflate the two and ask whether the public trust and have confidence in health professionals in the same question.

All of the above means that the subject requires a research approach that allows for time and space for an exploration of nuanced opinions. However, we are recommending an initial online forum (with an offline version for any digitally excluded audiences) prior to the group discussions as a convenient way of collecting individual views (mitigating against group think at the group discussions and facilitating analysis of views of different demographics) and introducing the

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[27] GMC consultation 2014 https://www.gmc-uk.org/-/media/documents/8__Consultation_on_changes_to_the_Indicative_Sanctions_Guidance_and_on_the_role_of_apologies_and_warnings.pdf_58721424.pdf

[28] https://www.food.gov.uk/sites/default/files/media/document/trust-deliberative-forums-research-fsa-2018.pdf

[29] Trust vs. Confidence

scenarios. This approach also builds in time and space for participants to consider their views. Participants will first encounter the scenarios during the online forum. They will have the opportunity to review the scenarios over a period of days and give us their initial feedback. They will also be able to think about the scenarios (and potentially discuss with family/friends) in the period between the online forum and groups/ interviews so that they bring a more considered viewpoint to discussions.

The staged approach also gives scope for some explanation of the GMC's statutory objective to maintain and uphold public confidence in the professions they regulate to ensure that participants understand the context for the discussions. This will be introduced following exploration of spontaneous views.

We note that the topics for debate include discrimination, violence and domestic abuse. We need to ensure that participants aren't triggered in any way by the content and feel that the research setting is a safe space for discussion. We believe that the project, therefore, demands the very highest levels of sensitivity and it is, therefore, essential that there are strong protocols and procedures in place to minimise the risk of harm to participants, put their welfare at the forefront, and empower and support them.

4.2 Approach with specific audiences

We are proposing a mix of face to face and online groups, choosing the methodology to suit the audience. We recommend online sessions with audiences who are unlikely to be geographically clustered, and those who would struggle to attend in-person, for example the following:

- People with long term conditions or disabilities that mean that they would be unable or unwilling to attend a face to face session in person
- Unpaid carers or those who have used maternity services recently who may find it challenging to those that they care for or find the time to attend an in-person session
- Those living in rural areas who would be unable to travel to a centrally held group discussion.

4.3 Using scenarios in research

We have found in previous research that Community Research has conducted that examples of health professionals' wrong-doing tend not to be top of mind for the public, other than the most serious, clinical cases. The PSA report[24] also found that there was little or no awareness of dishonesty from public professions within the health professions.

The use of scenarios, therefore, is a sensible approach in order to ensure that participants have a good understanding of the sort of things that can go wrong. Other research projects covering similar topics have also adopted this approach.

When using scenarios in research, consideration needs to be given to the following:

- The number of scenarios
  - The scenarios shown to participants need to cover the range of issues but also not overwhelm. We would limit the number to around eight.
- The order of scenarios
  - The research design needs to take account of the fact that there may be an order effect in terms of which scenarios are shown first. We would need to mitigate against this by rotating the order in which scenarios are presented in both the qualitative and quantitative stages.
- The length of scenarios
  - They need to include a level of detail to ensure that the scenario is meaningful but without becoming too long and inaccessible. Scenarios used in other projects for use with patients and public tend to be up to three paragraphs.
  - In our experience, scenarios work well when information is layered on gradually, for example outlining the basic scenario and then discussing different circumstances or related mitigating/ aggravating factors.
- The exact wording
  - We will need to ensure that the phrasing of the scenarios is neutral and does not influence the response in any way. For example, some of the scenario examples provided from other research projects ascribe a name to the registrant in question (from which the reader could potentially determine gender and ethnicity). We would caution against doing so and suggest that a preferable approach would be to use Doctor A or Doctor B etc.

5. Considerations for content

The research brief provides a list of potential areas that the GMC would particularly be interested in getting feedback on, as follows:

- Dishonesty
  - outside professional context i.e. in the registrant's personal life
  - within a professional context but which did not involve patients. For example, theft in a hospital.
- Violence
  - outside a professional context i.e. in the registrant's personal life but not domestic abuse which is covered separately
  - within a professional context but which did not involve patients. For example, a physical altercation between colleagues
  - in a domestic context i.e. directed towards a partner or family member
- (Mis)Use of social media and freedom of expression.
  - for example, expressing views on issues like gender identity and the conflict in the Middle East which some people may find offensive and/or discriminatory, but that wouldn't necessarily be deemed illegal.
- Criminal cases
  - where the registrant was charged with an offence arising in their personal life, had a trial with full consideration of the available evidence and was found not guilty by jury verdict
  - where the behaviour underpinning the offence was non-violent and motivated by a political or personal belief for example:

    Criminal damage or a breach of a High Court injunction arising from participation in a protest.

    Extremist views but police taking no action as no criminal offence has been committed. For example, expressing support for acts of terrorism such as the 9/11 attacks.

5.1 Other related research projects using hypothetical scenarios

Other related research projects have used hypothetical scenarios as a way of bringing the issues to life and helping research participants to think through any complex dilemmas. These include:

- The GMC's 2014 consultation[27] on indicative sanctions guidance, which included case studies of doctors' behaviour.
- Research[22] to inform the updating of the GMC's *Good Medical Practice*. This used a scenario exercise with members of the public to explore their perceptions of the conduct of doctors.
- Research into public confidence[2] conducted on behalf of the GMC.

- Qualitative research conducted on behalf of the Professional Standards Authority[24] explored public, patient and registrant perceptions of dishonest behaviour by healthcare professionals.
- Quantitative research by the Solicitors Regulation Authority which explored public and professionals' attitudes to trust, again using a range of scenarios.[30]
- Research on behalf of the Centre for Health and Social Care Research[36] explored professional boundaries, using scenarios.
- The GOC research[23] into public views of the standards of practise of registrants.
- GMC qualitative research[25] to investigate the public's views to inform updates to their standards.
- HCPC research[26] exploring public perceptions of the Indicative Standards Guidance.

The scenarios which are most relevant from the above projects are provided in the Appendix.

5.2 Issues to consider including in selected scenarios

A review of relevant evidence and the types of scenarios used in previous related projects (outlined in above) suggests that the inclusion of the following issues is important (either because research participants tend to have strong views on the issues or because the issues have been key points of debate in recent cases):

Types of cases

The GDC/NMC review[18] found that some types of misconduct carry a presumption of seriousness. These are broadly consistent across all regulators' guidance and are cases involving sexual misconduct, dishonesty and criminal convictions, especially those resulting in a custodial sentence. They also identified various forms of harm that are considered within Fitness to Practise cases, namely physical harm, emotional distress, financial harm and abuse of trust. However, when it to comes to situating an act or omission on a spectrum of seriousness, they found variance within and between regulators.

According to a PSA review[17] on maintaining public confidence during fitness to practise decision making, a number of the health professions regulators provide specific examples in their guidance of behaviours for example, dishonesty, sexual misconduct, violent behaviour, bullying and harassment and/or scenarios which would undermine public confidence. The HCPC sanctions guidance highlights child pornography as a particular area for concern in relation to public confidence.

[30] Solicitors Regulation Authority Professional Standards survey (2015); UCL Solicitors' professional standards: A Question of Trust

The PSA typology research[31] further categorises dishonesty as follows:

- Dishonesty by omission - not disclosing - where the truth is withheld
- Dishonesty by commission - lying - where a registrant tells an untruth
- Impersonation - impersonating - assuming the identity of another person
- Theft - stealing
- Fraud - deceiving
- Academic dishonesty - cheating.

Personal / professional considerations

The GDC/NMC review[18] found from analysis of case decisions that regulators' approaches to considering cases centring on conduct outside registrants' professional practice may vary. It identified that decisions about whether misconduct in a registrant's private life has relevance to their professional practice, and therefore how serious it should be considered, can be challenging for panels. These decisions involve consideration of where the conduct occurred, whether the practitioner was registered at the time it took place, any impact on their professional practice, and any use of their professional knowledge as part of the conduct.

Some of the research studies specifically explore perceptions of wrongdoing in a registrant's personal life and implications for public confidence. For example, the GMC report on standards[22] indicates that 'behaviour that was not felt to affect their ability to practice medicine - alcohol consumption when not at work, minor criminal convictions such as a parking ticket or speeding tickets, for example - were seen to be inconsequential'. Doctors engaging in criminal behaviours, in particular serious crimes such as assault were one of the few areas where participants felt a doctor's private conduct overlapped sufficiently with their professional status as a doctor to impinge on the trust a patient may have in them. This included incidents outside of a doctor's workplace that may have had little direct impact on the quality of medical care they provided.

GMC research on public confidence[2] suggests that the public does not automatically expect the GMC to be involved where a doctor commits a criminal offence outside of the workplace. The most important consideration as to whether the GMC should get involved appears to be whether the doctor has (intentionally) harmed another individual. There is more divided opinion on the extent to which professionalism from doctors is expected outside of the workplace. For some patients and the public, a doctor is 'never off duty', and there is an expectation that the GMC will have oversight of behaviour outside of the workplace that could be regarded as

[31] PSA Typology Dishonesty report (2017); University of Surrey Microsoft Word - PSA Report_TypologyDishonesty_Final.April2017.docx

unprofessional. Others feel that doctors need to be able to be off duty and that their behaviour outside of the workplace should rarely be of concern to the GMC.

It has been suggested that the public may have a higher threshold for dishonesty in private life where a professional role is viewed as more technical[31]. In the PSA dishonesty research[24], a conviction for theft was felt to disqualify a nurse for a role in caring for vulnerable elderly whilst tax fraud on earnings from a buy to let property was not seen as relevant to a dentists' fitness to practise.

In the HCPC research[26], the context of the behaviour was also considered, with participants noting that actions that happened within the workplace, or had a direct link to working duties were more serious.

Who was involved

Whether the case involved vulnerable patients was a key influence and mentioned in the PSA review[17] and extensively in other research reports. For example, in the GMC standards research[22], participants felt that if the patient was particularly vulnerable or had poor mental health then doctors should be careful not to cross professional boundaries even if this occurred after they had ceased to be their doctor.

In the GMC research on GMP[25], participants suggested that the appropriateness of a relationship between a doctor and patient may be determined by the setting. For instance, participants gave the example that it would be inappropriate to pursue an intimate relationship with a current or former psychiatric patient (in part because they are likely to be more vulnerable), compared to a patient being treated for a broken bone in a fracture clinic. Other examples of vulnerable patients included children, people with learning disabilities/difficulties, mental health problems, and people without mental capacity.

Registrant's intention/attitude

The following all had a bearing on views:

- The perceived intention of the doctor – evidence of pre-meditation; objective for personal financial gain or sexual exploitation.
- If the case involved recurrent or ongoing issues or was a first time error/transgression.
- Cases which are influenced by a registrant's medical condition (for example, alcohol and drug addiction or mental health issues, such as depression).

In the GMC quantitative confidence research[3], the most important factor that respondents considered could soften the GMC's approach to cases of clinical error was that 'the error was a completely honest mistake, with no suggestion at all that the doctor had been reckless'. This was only slightly more important than 'the doctor

immediately admitting the mistake and taking responsibility' and 'the doctor taking subsequent action to improve their practice'.

Participants in the HCPC research[26] strongly felt that the degree of patient impact should be a key factor considered by the panel to determine potential risk in the professional continuing to practise. They also reacted more strongly to cases where they felt that the professional's behaviour had been planned and intentional.

The GDC/NMC review[18] shows that assessment of attitudinal issues can have a huge impact on the determination of seriousness within a case decision as entrenched attitudes indicate a risk of repetition.

Different aspects of social media/public communication

There are various angles in terms of use of social media/communication that could be explored in scenarios, including behaving unprofessionally, sharing personal beliefs or sharing patient details (anonymously or otherwise).

Views on maintaining confidentiality appear to be clear cut, for example the GMC research on standards[22] found that maintaining confidentiality was viewed as a key component of professional conduct. Breaking confidentiality outside of safeguarding concerns (for example 'gossiping' about patients) was considered a major breach of professionalism.

A scenario in the GOC standards research[23] about a registrant getting advice on a patient via a WhatsApp group of professionals engendered a mixed response indicating it may be interesting to explore similar ground. There was some discussion about the degree of privacy of different platforms; posting to a more public platform, such as X (Twitter), was seen as markedly different to private messages on a service like WhatsApp. Other behaviours mentioned in the GOC report as being likely to impact public confidence include:

- Writing negatively about a patient or revealing patient details.
- Writing negatively about their optical practice.
- Posting 'false or dangerous' claims about eye care.
- Crossing professional boundaries, e.g. messaging patients privately or via social media.
- Sharing extreme views, such as around political beliefs.
- Inappropriate language or content, such as using bad language or posting something hateful or discriminatory.
- Reposting negative posts.
- Posting unprofessional images, such as showing themselves intoxicated.

GMC research report on GMP[25] focussed on the unacceptability of medical professionals making discriminatory remarks about a patient in any setting whether that be at work, in public or in private. Participants saw such behaviour as being

reflective of the registrant's character and calling into question their ability to be a 'good doctor'.

Registrant's response

The following appear to influence views:

- How the doctor responds to the error/issue coming to light for example, if they self-reported/fully disclosed; if they lied about the issue when questioned.
- If, and how, they engage with the Fitness to Practise process.
- If the registrant demonstrates insight/ remorse; evidence of remediation/ behaviour change.

The PSA dishonesty research report[24] indicates that 'the tendency was towards an emphasis on behaviour change and learning and rehabilitative and constructive outcomes which allowed registrants to continue in the profession. This was particularly the case where individuals showed insight and remorse'.

The GDC/NMC review[18] found that a registrant's response to involvement in Fitness to Practise proceedings (i.e. responding to the regulator, co-operating with investigations and evidence gathering processes, and attending panels) can be a key factor in determining the seriousness of the case, and the eventual outcome of it.

In the HCPC research[26] participants felt that insight, apology, remorse and remediation were closely linked, and it was difficult to isolate the specificities of each. Many participants placed a greater emphasis on the role of remediation as an action that could be more easily measured, feeling that proactive remediation was a strong mitigating factor. However, there were some concerns that remediation could be carried out without genuine insight as means of securing a lesser sanction. Participants therefore suggested that it was important for panels to consider insight, apology, remorse and remediation together to help determine which professionals were genuine.

The GDC 'Exploring remediation in Fitness to Practise' report[32] stresses the importance of remediation being tailored to the specific issue. It also makes the point that there are mixed views on the acceptability of remediation among different stakeholders. It states "while patients and patient advocacy groups may favour punitive measures, there is an understanding that effective remediation can ensure future safety and quality of care. Indemnifiers and registrants generally view remediation positively, seeing it as a way to resolve issues without resorting to more severe sanctions. However, there is some apprehension about the level of support

[32] GDC Exploring Remediation in FtP, 2025, Collaborative research team Exploring remediation in Fitness to Practise at the GDC

from the Professional Standards Authority (PSA) and patient bodies, which may view remediation as a lenient approach".

The GDC/NMC review[18] found that in cases where the registrant is judged to have fully remediated and have insight, and thereby no longer present a risk, panels also judge whether the registrant is impaired on the grounds of public confidence only. The threshold for this centres around both the seriousness of the misconduct, and on how the panel perceive a member of the public may respond if they were aware of the facts of the case. Thresholds for public confidence tend to align with seriousness more generally – risk or extent of harm, repetition, an abuse of trust, intent or attitudinal issues all make a finding of impairment on the grounds of public confidence more likely.

Outcomes/impact

The following appear to have an impact on views:

- The outcome or consequences for any individual affected/level of harm
  - The GDC/NMC review[18] identified various forms of harm that are considered within Fitness to Practise cases, namely physical harm, emotional distress, financial harm and abuse of trust.
  - In the GMC qualitative research[2] on confidence, outcome was the single biggest influence on participants' expectations of regulatory action.
- Involvement of the police/courts i.e. if the registrant accepts a police caution
  - In the GMC research[2] on confidence, the conviction of a doctor strongly impacted views in terms of expected GMC actions. In the GMC standards research[22], criminal behaviours were felt to be the 'tipping point' for participants was when doctors' behaviour outside of medicine was seen to be of consequence. Having a criminal conviction was felt to bring into question the character of the doctor, and impact on the trust and confidence patients had in them generally.
- Implications for patient safety or registrant performance
- The outcome for the registrant
  - The balance between public interest vs the rights of the registrant, registrant investment in their career and future ability to earn a living/ and impact of resources of losing registrants from the profession. This is mentioned in relation to the Bawa-Garba case33 but also in other research reports3418

[33] Dr Bawa-Garba was cleared by the MPTS to return to practice, subject to conditions. The Tribunal referred to Bijl v General Medical Council [2001] UKPC 42; [2002] Lloyd's Rep Med 60, in which Lord Hoffmann said that "proper concern with public confidence in the profession and its procedures for dealing with "doctors who lapse from professional standards" should "not be carried to the extent of feeling it necessary to sacrifice the career of an otherwise competent and useful doctor who presents no danger to the public in order to satisfy a demand for blame and punishment". Bawa-Garba v GMC

which indicated that there is public concern about the loss of professionals from the profession.

Systemic/organisational issues

The GDC/NMC review[18] indicated that environmental factors (interpersonal relationships, staffing and resources, workplace culture, supervision and management, organisational issues, including unclear or inadequate processes) are considered by panels to place a registrant's conduct into a wider context. These issues were only considered in cases relating to professional practice, and mainly in cases from regulators of professional groups working in larger organisational settings.

The PSA research[35] on the categorisation of fitness to practise cases which involve dishonesty, theft and/or sexual misconduct explores how and why wrong doing occurs. It distinguishes 'three different types of perpetrator: first, a category of instrumentally-focused perpetrators (bad apples) operating as sole agents; the second group is characterised as follower-based action in which individuals' wrongdoing has a clear social dimension emanating from learning and transfer from key others, and involves the normalisation of misconduct, and thus the erosion of perpetrators' moral compasses (corrupting barrels); the final category is typified by a different set of antecedent processes, and central here is the accumulative erosion of individuals' resources through stress or resource depletion, and therefore misconduct emerges through omission and error (depleting barrels)'. So for example, sexualised workplace cultures have also been recognised as a potential factor in some cases of sexual misconduct.

The previous project conducted by Community Research for the GMC on public confidence[2] included consideration of systemic / organisational issues as mitigating factors i.e. pressure on resourcing or under-staffing or the exertion of pressure from senior members of staff to breach protocols. Whilst this feels less relevant for some of the scenarios under consideration for this project, it may be appropriate to think about stress levels, level of seniority or the impact of organisational culture in certain scenarios, for example a violent dispute between colleagues. The GDC/NMC review[18] notes that organisational context, including bullying, pressurised working environments, and a lack of adequate supervision may impact on a registrant's conduct and performance in a variety of ways. In some cases analysed, difficulties in interpersonal relationships at work were recognised as causing problems within the work environment, and contributing to circumstances in which poor practice occurred.

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[35] PSA Bad apples? Bad barrels? Or bad cellars? Antecedents and processes of professional misconduct in UK Health and Social Care (2017); Coventry University research report

Summaries of mitigating or aggravating factors

The GDC/NMC review[18] highlighted that the consideration of a range of aggravating and mitigating factors was part of determinations of seriousness, including the registrant's honesty or dishonesty, any repetition of misconduct, the risk of harm to patients, and whether the registrant had shown remorse or insight into their conduct, or had undertaken remediation.

The PSA report[24] has useful hierarchies of mitigating and aggravating factors in relation to the seriousness of dishonesty cases:

Figure 1. Aggravating factors in professional dishonesty
A stairway of significance within professional dishonesty

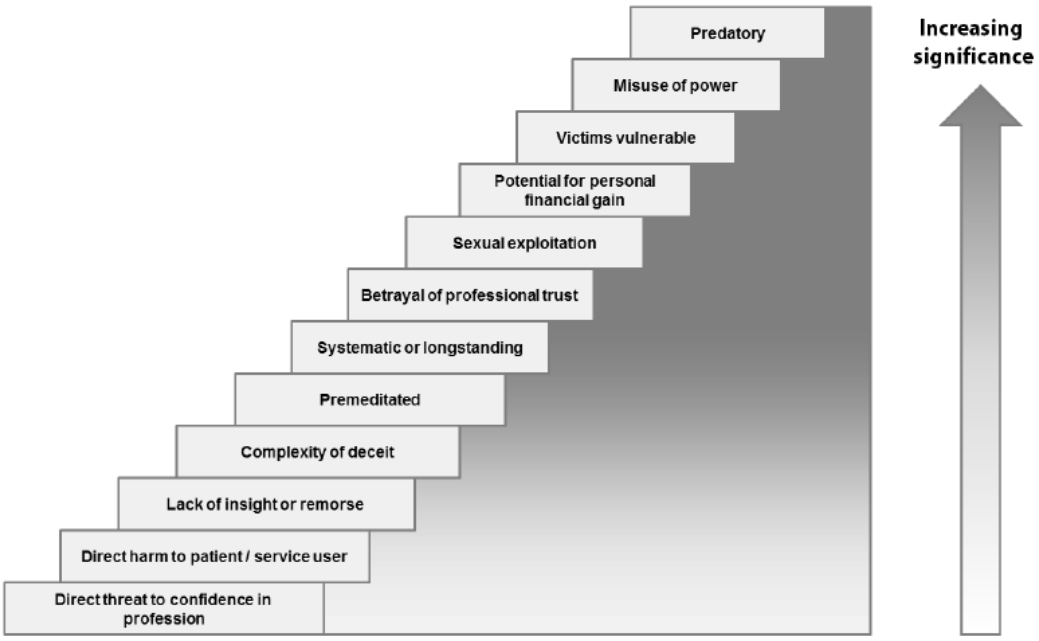
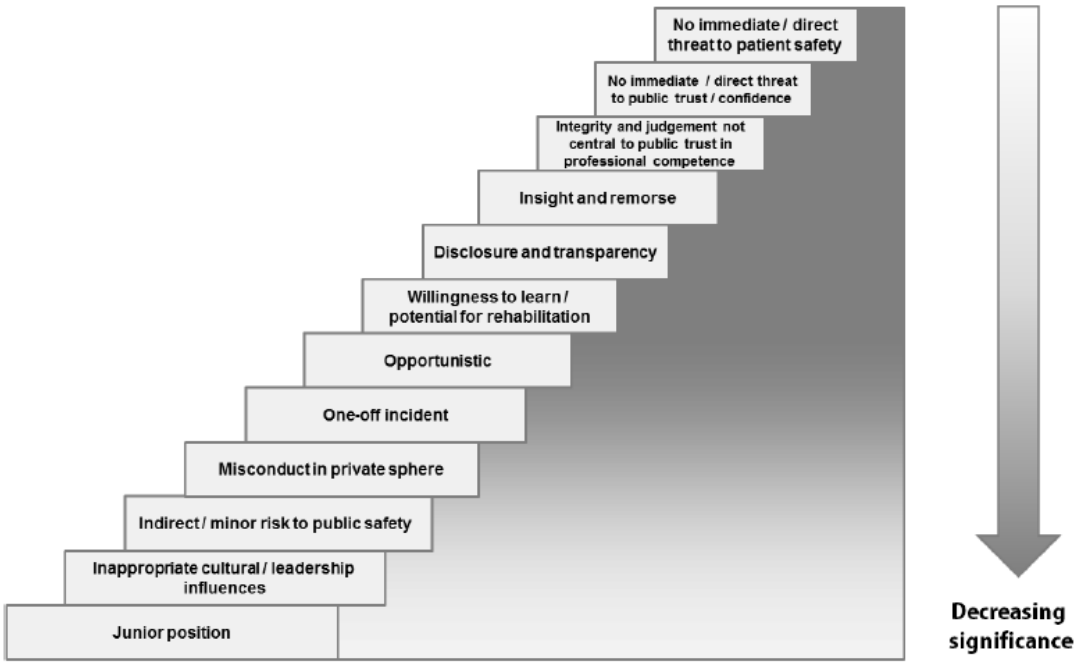
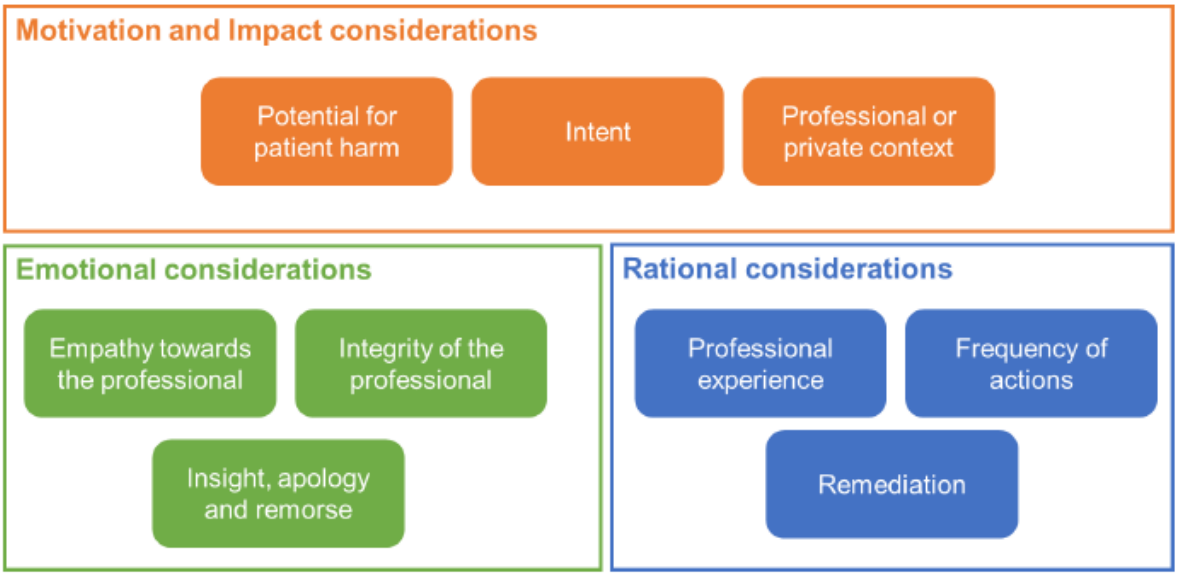


Figure 2. Mitigating factors in professional dishonesty
A stairway of decreasing significance within professional dishonesty



The HCPC research[26] also summarised themes in relation to mitigating and aggravating factors as follows:



5.3 Content recommendations

Scenario recommendations

It will be important to select scenarios that are likely to generate most debate. For example, a report by Sheffield Hallam University on behalf of the Centre for Health and Social Care Research[36] exploring professional boundaries with registrants, students and educators noted that scenarios selected were deliberately those described as being in the 'shadows' of professional practice i.e. avoiding the obviously illegal or immoral so as to generate more illuminating debate. We note that the GMC research brief does not include sexual misconduct cases in the list of scenario examples because this is felt to be more clear cut an issue in many cases.

Consideration will need to be given to how mitigating and aggravating factors are layered onto the scenarios given that evidence shows that they have a significant impact on public perception. The information outlined in Section 5.2 provides a steer as to which factors to include in the scenarios.

Scenarios could be used which differentiate between the registrant's professional and personal life in different ways, for example:

- exploring the response to sexual harassment/assault cases involving a patient, colleague or someone who is neither.
- things that the registrant does in their personal life, for example assault, domestic violence.
- dishonesty which is related to the workplace in some way and that which is unrelated.
    - Evidence from other studies indicates that this has been a fruitful area of discussion.

In terms of specific topics, views about wrong doing or breaking the law as a result of strongly held personal beliefs is an important area to tease out in the discussions. It is both a topical issue (given the publicity about doctors involved in the Just Stop Oil protests and the ongoing Fitness to Practise cases) and one which appears to have been little explored in other research. For example, other studies have tended to focus on personal beliefs which impact on patient care i.e. abortion or treatment of same sex couples rather than issues of conscience.

Social media also feels that it is an area that is ripe for further exploration. There are some studies which have looked at this in a fairly limited way but it feels timely to do this now given technological advances and the prevalence of social media; together

[36] Centre for Health and Social Care Research Professional Boundaries research (2009); Sheffield Hallam University http://shura.shu.ac.uk/1759/1/Prof_Boundaries_FINAL_REPORT.pdf

with current debates over lack of moderation on X (Twitter) and Facebook, amongst others.

Some real life cases could be tailored for use in the research. Some examples which have been highlighted in the media or other research are shown below:

- The GDC/NMC review[18] contains examples of actual cases of falsifying documents and violent conduct in non-professional settings in Appendices C and D
- The recent examples of the registrants involved with the environmental protests feel particularly relevant. GMC case in focus: Should breaking the law always result in suspension? - Pulse Today; Emergency measures: the struggle against climate change
- Case involving denial of Covid-19 High Court Judgment Template
- Margate doctor given misconduct warning for praying with patient - BBC News
- A GDC case involving perceived Islamophobic comments being posted on an online dental forum garnered huge attention from dental professionals. The GDC has flagged this case as a clear example of where public confidence would be undermined by a lack of action and imposed a suspension order. The importance of cases like GDC and Pate - Dentistry.co.uk
- The case of junior doctor, Sharifa Scerif, for example, resulted in an 8-month suspension due to fare dodging on London transport by dishonestly using her sister's 'Freedom pass'. https://www.mpts-uk.org/-/media/mpts-rod-files/dr-sharifa-scerif-01-nov-19.pdf
- In Fatnani & Raschid v GMC, a 70-year-old doctor was involved in a court case regarding fraud which had been instigated by her daughter and to which the clinician denied having any knowledge Fatnani, Raschid v General Medical Council [2007]
- The headline-grabbing case involving a leading surgeon punching a fellow doctor over a drink fuelled row regarding Laura Kuenssberg: https://www.independent.co.uk/news/uk/home-news/surgeon-doctor-punch-laura-kuenssberg-bbc-attractive-david-wilkinson-a8516996.html
- Junior doctors are getting into trouble by posting nameless comments about their patients, who have then been able to identify themselves. https://www.medicalprotection.org/uk/articles/think-before-you-tweet
- Posting inappropriate material that questioned their professionalism, for example, participating in the lying down game. https://www.telegraph.co.uk/technology/facebook/6161853/Doctors-suspended-after-playing-Facebook-Lying-Down-Game.html

Topics for discussion

There are some areas which could usefully be woven into discussions, for example:

- Exploring how trust in registrants (outside of work) impacts on confidence in the care that they provide
- The importance of 'sending a message' in decision making i.e. making an example of an individual
  - NB note the British Medical Association's concern[37] that overemphasising public confidence could result in competent clinicians being 'punished' for the sake of the profession's reputation
- The importance of the regulator considering how decisions play out in public i.e. the media/Daily Mail test
- Asking participants to consider the trade off between sanctioning registrants to maintain public confidence and retaining the registrant in the profession (for their own sake and thinking about the potential impact on resources and patient safety from losing them from the profession)
- Considering the impact of a criminal sanction (and whether its presence means that the public feel that the registrant has been 'punished enough').

[37] Doctors could face "trial by media" under new GMC sanctions, BMA warns | The BMJ

6. Appendix: Scenarios used in other research projects

GMC public confidence research (Community Research)[2]

The research was largely focussed on clinical cases and gross negligence manslaughter. However there are a number of scenarios that may be relevant:

- Dr A was on a night out and got into a fight inside a nightclub. The fight started when Dr A accidently knocked a drink out of someone's hands and refused to buy a replacement. CCTV showed Dr A punch a person after that person had grabbed Dr A's arm to stop them walking away.
- Dr D, a GP, stole gloves worth £10 from a department store in their local town. Dr D was caught on CCTV removing a security tag and price ticket before putting the gloves in a pocket.
- DR G was driving a vehicle on an A road when they hit a crash barrier which caused severe damage to their vehicle, including two burst tyres. Dr G checked the damage before proceeding to drive off in a dangerous manner leaving the road when crashing the car a second time. Dr G consented to a roadside breath test which they failed. A second reading taken at a police station the following morning found that they were still over the limit.
- A number of doctors in training working a shift in an A&E department took part in an internet craze that involved doing handstands in strange places. As part of this game they did handstands in wards, operating theatres and a heli-pad and posted photographs on Facebook. No patients were ever pictured.
- Dr M made an amusing post on Facebook about how a patient had recently described their OCD behaviour and the impact it had on their life. Dr M didn't identify the patient but when the post got shared far and wide the patient involved knew that Dr M was talking about them.
- Dr P was using NHS resources to provide blood tests for private patients.

GMC standards research (NatCen)[22]

Most of the scenarios used were not relevant to this piece of work. There was a scenario on personal beliefs but this was related to a doctor not giving information about abortion to a patient. One other scenario is shown below:

- Mr Josh is a surgeon at a large London hospital. He has good relationships with his work colleagues and patients. Mr Josh has a son Charlie, aged 8, from a previous relationship. Mr Josh has a difficult relationship with the mother of his child Lily, and they often argue. Their confrontations will sometime upset and

scare the Charlie. Over the last year the relationship has worsened and Lilly has taken out a restraining order against Mr Josh.

GMC research to inform Good Medical Practice (ICE)[25]

Scenarios related to professional boundaries and expectations of care in specific situations i.e. disability, language needs.

There was one scenario whereby a medical professional is unwilling to carry out a procedure because they have a conscientious objection to the procedure due to their personal beliefs. In the scenario, the medical professional explains that the patient has a right to see another medical professional and gives the patient information to find another medical professional. At the end of this scenario, the patient has the procedure from another medical professional.

GOC standards research (Shift Insight)[23]

The research was looking more broadly at the standards of practice for registrants, including delegation, use of technology, professional boundaries.

One scenario in particular related to social media:

- Maya is a practising optometrist. She has carried out a patient examination, which involved taking a digital picture of the back of the eye. This helps to check the health of the eye and identify certain diseases. Maya wants a second opinion on the digital picture. She is part of a WhatsApp group with other registered optical professionals. She sends the digital picture to the WhatsApp group to ask what they think. She does not share any patient details such as their name.

SRA Standards survey (UCL)[30]

The quantitative research used 60 scenarios in rotation which relating to various types of wrong doing – many of which only relate to solicitors' professional activity. However there are a number which could be relevant:

- A solicitor is caught fare dodging on the tube after drinking too much on a night out with friends. She says she didn't intend to avoid the fare but that she forgot to tap in with her Oyster card. She accepts a penalty notice and pays a £60 fine.
- A solicitor writes a blog from which it is clear that he is a practising solicitor. After a night out at the pub he writes a post in which he rants about a barman who had refused to serve him, describing him in racially derogatory terms.

Centre for Health and Social Care Research Professional Boundaries (Sheffield Hallam University)[36]

These scenarios tended to be nuanced professional boundary scenarios:

- A [social worker] refuses to work with a same-sex couple because it contravenes his/her religious beliefs.
- A [social worker] invites a service user to pray with him/her.
- A [social worker] discusses the details of a service user (without using their name), to complain about their boss to other friends on Facebook.

GMC Consultation on changes to Indicative Sanctions Guidance and on the role of apologies and warnings[27]

Some of the more relevant scenarios are shown below:

- Dr Cardiff was convicted of embezzling £100,000 from a charity he set up to raise money for sick children. He is now extremely ashamed and sorry.
- A same-sex couple ask their doctor about fertility treatment on the recommendation of gay friends who successfully conceived via IVF at a local NHS clinic. Dr Wrexham makes offensive homophobic remarks.
- Dr Birmingham had been going through a difficult divorce for many months. After one session in court, he forced his way into his wife's home, causing severe bruising to her wrists. During the confrontation he also hit his seven-year-old son, fracturing his skull.
- Dr Durham went to a nightclub with Dr Oxford, and they both took illegal drugs. The next day, Dr Oxford was off sick from work, but Dr Durham went to work while he was still under the influence of illegal drugs. Dr Durham stole morphine intended for a patient, which he self-administered in the staffroom before going into theatre.
- Dr Lisburn started surgical training in trauma and orthopaedics six weeks ago. He is very enthusiastic about his new role and uploads several radiographs of patients' fractures onto his Facebook page.
- Dr Reading persistently sexually harassed three female colleagues over a 12-month period. Each of the women rejected Dr Reading's advances, but this did not alter his behaviour. One female doctor was so intimidated that she was signed off work for three months due to stress. Dr Reading has provided around 30 testimonials from his neighbours detailing youth projects he has set up in the community. He has not provided any testimonials from colleagues or patients.
- During a locum placement, Dr Newport was verbally aggressive to a number of patients and physically assaulted a colleague. He has been subject to an interim order of suspension for 18 months, and a fitness to practise panel has now found him impaired because he continues to present a risk to the public.

PSA Dishonesty research (Policis)[24]

The research used nine scenarios as part of the discussion involving dishonesty in relation to patient records, qualifications or employment history, registration status or indemnity insurance, working at another job, tax fraud, convictions or previous identity, patient interaction, lying about relationship with colleagues/patients to conceal inappropriate practice and theft.

Two that may be relevant are as follows:

- Dentist A was investigated by the HMRC who suspected that he had defrauded the revenue of tax by knowingly understating the profits of his buy-to-let property portfolio over a period of some years. Dentist A admitted the fraud and reached an arrangement with HMRC to repay the lost tax together with appropriate penalties and therefore escaped criminal prosecution.
- Nurse C was convicted at Newcastle magistrates' court of theft, and sentenced to 4 months' imprisonment, suspended for 12 months. The theft conviction related to the registrant making three unauthorised withdrawals from an ATM on 3 separate occasions of £200 each, using bank cards belonging to a 71 year old resident of the Care Home (Patient D) where Nurse C worked at the time. The first two withdrawals were made on the same card, which was subsequently reported lost by the daughter of Patient D (it is not known whether this is because Nurse C took it). The third withdrawal was made on the new card that the bank sent to replace the lost one. The total loss to the patient's account was £604. Nurse C had significant financial problems of her own at the time and was herself in ill health. On discovery of the unauthorised withdrawals, Nurse C wrote to Patient D to apologise and returned the money in full.

PSA Dishonesty Typology research (University of Surrey)[31]

The report includes a number of examples. Some of the most relevant include:

- The Registrant was an Optician who submitted a series of claims to an insurance company with a view to recovering costs incurred for private healthcare treatment for himself, his wife and his son. These claims were fraudulent in that the treatment never took place, or the duration of hospital stay was falsely extended (4 nights instead of 1) or the cost of the treatment received was significantly exaggerated (for example £25 per hour for chiropody treatment becoming £225).
- The Registrant was a Pharmacist who was restored to the Register with a condition, which was due to be reviewed 6 months after the case was heard. The Registrant was removed from the Register after a criminal conviction of obtaining property by deception was issued. This deception related to claims the Registrant made for payments from the prescription pricing authority for which he was not

entitled. The Registrant was dishonest in that he received overpayments, which were then later repaid.

- The Registrant was a Nurse who stole drugs from his employer and then destroyed an incident report form, which related to a dispensing error of his colleague. Subsequently the Registrant engaged in dishonest behaviour in the non-professional domain when they were convicted of theft and two offences of failing to surrender to custody at the appointed time for other offences.
- The Registrant was a Nurse who was convicted of theft and was sentenced to 12 weeks imprisonment, which was suspended for a period of 12 months with a Community Order, with two requirements, a period of supervision and 120 hours of unpaid work. As a Nurse Prescriber the Registrant stole a prescription pad from which she forged a script to obtain a scheduled drug and that forgery demonstrates an example of impersonation within a professional domain. The Registrant claimed the events were due to her health and stress but the Panel did not accept this and felt that the Registrant lacked insight into her failings.

HCPC research on Indicative Sanctions Guidance (Gfk)[26]

Background:

- Mr W is an operating department practitioner. He is responsible for supporting operating theatre staff and providing care to patients at all stages of an operation.
- Mr W was convicted of driving a car under the influence of alcohol.
- He crashed his car into a parked lorry in the early hours of the morning. He damaged the lorry and did not harm any people. He was banned from driving for 17 months and fined £500.
- Mr W informed the HCPC of what had happened 5 days after his arrest.

The hearing:

- Mr W attended the hearing and told the Panel that he had been at a family member's birthday celebration and had more drinks that he had originally planned. The crash had taken place on a bend in the road in wet conditions. He had pleaded guilty at Court and attended an alcohol awareness course (which had reduced his driving ban by a quarter).
- Mr W told the Panel that he had learnt a very hard lesson and would never repeat his actions. He realised his judgement had been very poor and the alcohol awareness course had made him fully appreciate how regrettable his actions had been.
- Mr W's partner also gave evidence. She stated that Mr W's family had been shocked and surprised at his behaviour. She described him as a good person who had taken responsibility for his behaviour.

Background:
- Ms X is a social worker.
- Ms X posted comments on a social media site about a case that she was managing.

The hearing:
- Ms X attended the hearing. She said that lack of support from her manager was partly to blame for her behaviour. She also said that the information in the social media posts could have been relevant to a number of families in the local area and with this in mind did not feel that she had put the confidentiality of the family concerned at risk.
- The social media posts were provided as evidence to the Panel. The Panel noted that the social media posts were disrespectful and demonstrated poor judgement from Ms X.
- The Panel felt that a member of the public reading the social media posts would be likely to develop a very negative view of social workers especially as the posts were felt to be disrespectful and insensitive.
- Evidence was given by a member of the family whose case Ms X had posted comments about. The family member said that they had lost all confidence in social workers as a result of what had happened.

Background:
- Mr V is an operating department practitioner. He is responsible for supporting operating theatre staff and providing care to patients at all stages of an operation.
- Mr V was cautioned by the police for two offences of theft.
- On two separate occasions he had stolen a morphine based drug and taken this drug whilst at work.

The hearing:
- Evidence provided by the police case reported that Mr V had been seen alone in an operating theatre with a syringe in his hand. At the time, a search had been carried out and three empty drug ampoules were found.
- Irregularities were found with the latest entries in the hospital's controlled drug record book.
- During the police interview Mr V admitted that he had taken the drug and injected it on two separate occasions.
- Mr V whilst admitting his behaviour did not show genuine regret for his behaviour.

Background:
- Mrs Y is an occupational therapist. Occupational therapists help people overcome difficulties caused by physical or mental illness, accidents or ageing.
- Two years ago, on seven separate occasions Mrs Y worked as an agency worker whilst on sick leave from her employer.

The hearing:
- Mrs Y admitted that she had been dishonest.
- She stated that she had been experiencing financial difficulties at the time.
- Mrs Y was on sick leave when she carried out the agency work and therefore certified unfit to work.
- She said that two years had passed since this had happened and she had learnt her lesson and would not make the same mistake again.
- Evidence was given from witnesses who talked about Mrs Y's good character.