



October 2020

**What needs to happen to
encourage engagement from
practitioners during a fitness
to practise investigation?**

Full Report

Research by ICE for the General Medical Council

Crafted especially for you by team **ice**



Executive summary

OVERVIEW & METHOD

Through the fitness to practise (FtP) directorate, the GMC investigate concerns from patients and the public, doctors, employers and anyone acting in a public capacity that call into question a doctors' FtP.

As part of work to prepare for proposed changes to legislation, the GMC is developing changes to the FtP process that may include extending the use of consensual disposal.

To effectively extend the use of consensual disposal, meaningful engagement from practitioners is important. Among other benefits, maximum and meaningful engagement early in the FtP process would result in the practitioner providing the evidence needed to inform decision making in a consensual disposal process.

The research objective was to explore:

“What needs to happen to encourage engagement from practitioners during a FtP investigation?”

Two research activities were conducted consisting of 42 in-depth telephone interviews with doctors and medical associate professionals and facilitated online workshops with 10 GMC and Medical Practitioner Tribunal Service team members.

¹GMC 'Deciding to investigate a concern'. Available [here](#)

KEY

FINDINGS

What influences practitioner's decision to engage with the GMC during an investigation?

Medical Defence Organisations

Most doctors will first seek advice from their medical defence organisation when an allegation is made against them.

The research suggests that many doctors perceive GMC investigations to be adversarial and bias towards patients. This leads many doctors to seek medico-legal advice to *defend* their case *against* the GMC.

While doctors didn't expect their defence organisation to discourage engagement, they will nonetheless be guided by their advice. This suggests that medical defence organisations have a strong influence on doctor's behaviour as either a driving or restraining force for engagement.

Renowned for his work in the field of psychology, Daniel Kahneman suggests that behaviour is influenced by driving force (factors that motivate a practitioner to engage) or restraining force (factors that prevent this from happening).

Driving forces

Among other driving forces, practitioners are motivated to engage to speed up the process and reduce the stress of being under investigation. Many also believe they have a moral obligation to accept responsibility if things go wrong and learn from their mistakes by fully engaging in the process that is there for "good reason" to ensure patient safety.

Restraining forces

The research suggests that practitioners "fear the worst" and "panic" when they are informed of an allegation against them. As a result, many may put off engaging with the GMC out of fear that something they say would be "later used against them" or because the emotional distress of being investigated would impact their ability to meaningfully engage.

What do practitioners expect from the GMC during an investigation?

Practitioners expect the GMC to conduct a fair, robust and transparent investigation and to provide or signpost to support resources. Medical associate professionals expected to be fully supported by the GMC and doctors had much lower expectations. Some doctors didn't expect to be treated fairly, compounded by the belief that the GMC is biased towards patients.

This suggests there is a need to re-balance perceptions of the purpose of FtP by widely communicating the fairness of the process through a clear and consistent narrative.

"It would be prudent to speak to legal rep as I don't know whether it would be wise to send comment or not"

(GP, P4)

"I'd want to get it done swiftly so all the stress hanging over me will be over sooner"

(SAS, P36)

"If the GMC helped you get support, even if it's not from them, it would show that they recognise that it's a scary moment for a doctor and that support is here for you"

(GP, P4)

“I hope when we become registered that all the information of who to go to for what is easily accessible for us because the process is so new, it would be difficult to know where to start”

(MAP, P42)

“Some doctors might take any sanction even if tribunal might have worked in their favour... that’s why MDU is so important, to guide doctors to do what’s right”

(SAS, P30)

What are the ‘tipping points’ for not accepting conclusions made by GMC?

Several questions were asked to explore the acceptability of conclusions made by the GMC in different circumstances.

The findings suggest that practitioners will not accept conclusions made by the GMC in a consensual disposal process if they believe wider contextual factors have not been considered or if they do not fully agree with the terms of the conclusion - especially if the terms are believed to be “harsh” and likely to cause reputational damage and impact their future careers. In these cases, practitioners would pursue a tribunal hearing to get all the facts out in the open and seek to “clear their name”.

Others said they may accept a conclusion they didn’t fully agree with to avoid “the risk” of a more serious sanction that could be imposed by the Medical Practitioners Tribunal Service.

Considerations

Several consolidated considerations have been made for changes within the fitness to practise process and considerations for wider communication and engagement that fall outside the process redesign, all of which will be important to consider in shaping the future of fitness to practise.

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1 Introduction

1.1 Background

The General Medical Council (GMC) is the regulatory body for doctors and soon to be the regulatory body for some medical associate professionals¹. The GMC is responsible for protecting the public and improving medical education and practice across the UK.

Through the fitness to practise (FtP) directorate, the GMC investigate concerns from patients and the public, doctors, employers and anyone acting in a public capacity that call into question a doctors' FtP. Where necessary, the GMC takes action to protect the public; this includes protecting, promoting and maintaining the health, safety and wellbeing of the public, promoting and maintaining public confidence in the medical profession and / or promoting and maintaining proper professional standards and conduct.

As part of work to prepare for proposed changes to legislation, the GMC is developing possible changes to the FtP process, which includes extending the use of consensual disposal, to speed up the overall FtP process in cases where a consensual outcome is agreed and encourage a less adversarial process. Not holding unnecessary hearings has the potential to enable GMC resources to be diverted towards education, training and standards.

To effectively extend the use of consensual disposal, meaningful engagement from practitioners is important. Among other benefits, maximum and meaningful engagement early in the FtP process would result in the practitioner providing the evidence needed to inform decision making in a consensual disposal process.

This research has been designed to understand **“What needs to happen to encourage meaningful engagement from practitioners during a fitness to practise investigation?”**

¹ In 2019, the GMC was asked to take on responsibility for regulating two groups of medical associate professionals (MAPs), physician associates and anesthesia associates. GMC regulation is expected to start in late 2021, pending legislation.

1.2 Objectives

The specific objectives of this research are to understand:

- Practitioners' perceptions of GMC and what implications this has for trust in the fitness to practise process
- Practitioners' understanding of the fitness to practise process and disposal methods (and their understanding of how their level of engagement may impact the outcome of an investigation)
- The factors that motivate practitioners to engage with the fitness to practise process
- The barriers to early engagement with GMC when a registrant has been informed of an allegation made against them
- Ways in which the fitness to practise process can be extended/adapted to encourage early engagement and increase trust in the process
- The 'tipping points' for when consensual disposal is not deemed to be suitable and may not be accepted
- Ways in which the consensual disposal process can be extended/adapted to improve the overall effectiveness of the fitness to practise process
- Practitioners understanding of the purpose of the fitness to practise process
- Practitioners understanding of what being "fit to practise" is.

Methods



2 Methods

2.1 Research Activity 1: Facilitated groups with GMC & MPTS teams

A total of 3 facilitated focus groups (60 minutes) were conducted with **10 GMC and Medical Practitioners Tribunal Service (MPTS) team members** to fully understand the experiences of teams who interact with practitioners during key stages of the FtP process.

GMC and Medical Practitioners Tribunal Service (MPTS) team members were represented in the research. These individuals interact with practitioners at key stages of the FtP process and are well placed to discuss the challenges and opportunities related to engagement. Represented roles included:

- Triage officer
- Provisional enquiries officer
- Investigations officer
- Specialist health investigation officer
- Case examiner
- MPTS case management members
- Legal team member.

2.2 Research Activity 2: Depth interviews with practitioners

2.2.1 Sample characteristics

A total of **42 telephone interviews** (45-60 minutes) were conducted with practitioners.

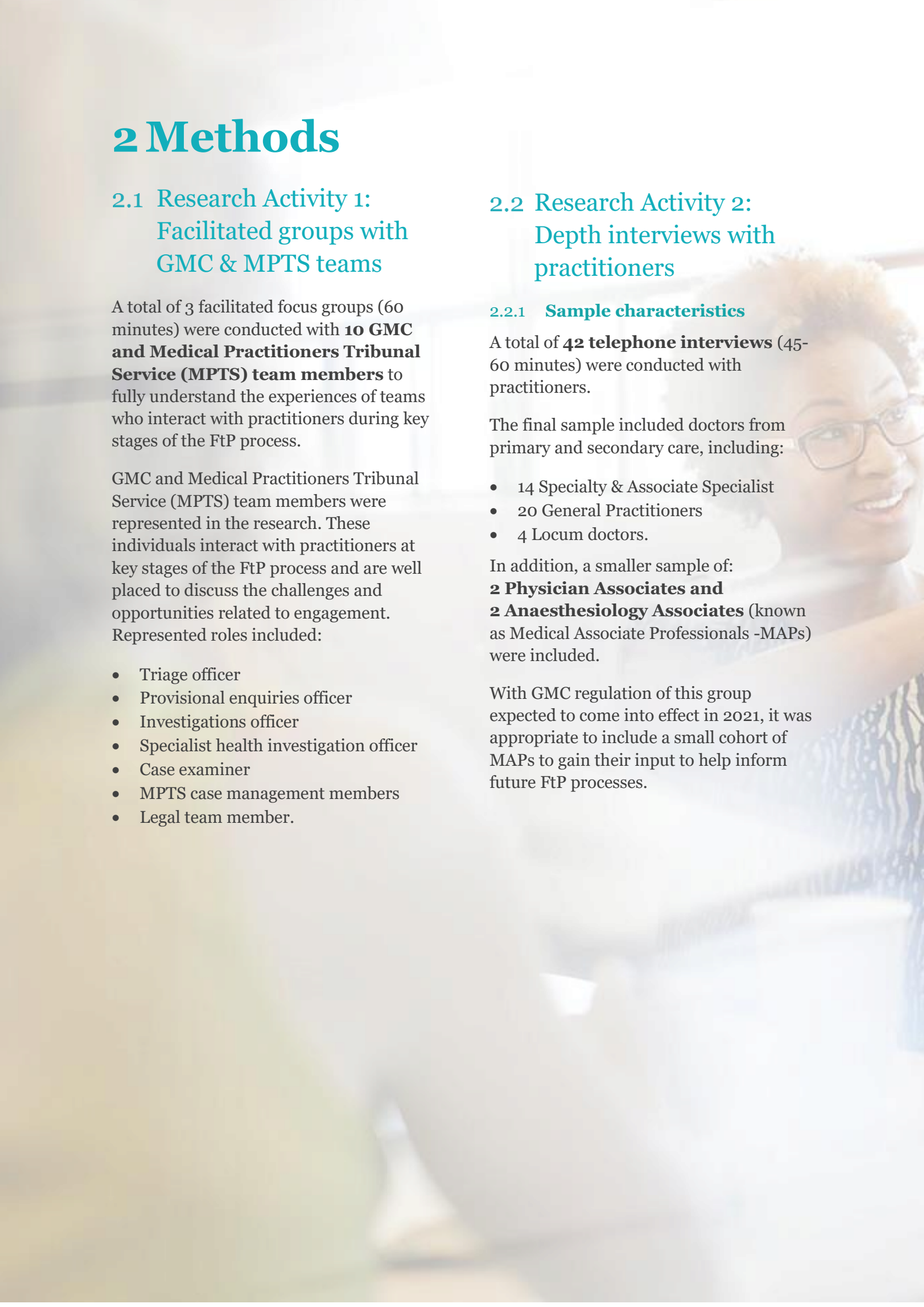
The final sample included doctors from primary and secondary care, including:

- 14 Specialty & Associate Specialist
- 20 General Practitioners
- 4 Locum doctors.

In addition, a smaller sample of:

2 Physician Associates and 2 Anaesthesiology Associates (known as Medical Associate Professionals -MAPs) were included.

With GMC regulation of this group expected to come into effect in 2021, it was appropriate to include a small cohort of MAPs to gain their input to help inform future FtP processes.



As shown in Table 1, the final sample was representative of all 4 nations. Participants were predominantly from England, across a wide spread of geographical regions.

Table 1: Participant sample by location

<i>Location</i>	<i>No. of participants</i>
<i>North West</i>	<i>6</i>
<i>North East</i>	<i>3</i>
<i>Yorkshire</i>	<i>3</i>
<i>Midlands</i>	<i>12</i>
<i>South West</i>	<i>3</i>
<i>South East</i>	<i>8</i>
<i>Scotland</i>	<i>4</i>
<i>Northern Ireland</i>	<i>1</i>
<i>Wales</i>	<i>2</i>
<i>Total Participants</i>	<i>42</i>

The sample included a mix of males and females and was representative of Black, Asian and Minority Ethnic (BAME) groups. Participants ranged from early career practitioners (1 year) to more established practitioners with up to 28 years' experience in the medical profession.

Anecdotally, some participants disclosed that they had previously been investigated by the GMC, but importantly no doctors who took part were currently under investigation at the time of the research.

2.2.2 Recruitment strategy

All practitioners who were approached for this research were screened to ensure a robust and diverse sample was recruited.

Practitioners were screened during the recruitment and again at the start of the research activities to ensure they were not being investigated by the GMC at the time of the research. This is because including doctors currently under investigation would be unethical/sensitive and perhaps a conflict of interest.

Additionally, practitioners were screened for their job role/specialism, location, years of experience and number of other research projects they've recently taken part in, to ensure a diverse sample was obtained.

2.3 Qualitative research techniques

In line with the research objectives, tailored discussion guides (See Appendix) were created and approved by the GMC for the **two research activities** to answer the specific research questions defined for each. ICE researchers used similar questioning and laddering techniques throughout, to continually explore the ‘why’ behind the decisions and behaviours that the participants had retrospectively or prospectively reported.

Constructed scenarios approved by the GMC (see section 3.4), were also used in research activity 2 to explore the ‘tipping points’ for when consensual disposal would be accepted by practitioners in key scenarios.

2.4 Informed Consent

All research participants were required to provide informed consent to take part in this project² and were informed prior to the interview that all data would be anonymised by removing person identifiable information. Therefore, no person identifiable details are included in this report.

ICE researchers reminded participants at the start of the interview that the interview would be audio recorded for analysis purposes and gained additional verbal consent.

2.5 Data analysis

Thematic analysis was used for all the data collected, which is a well-documented form of analysis in qualitative research. As a theory-free approach, thematic analysis allows for the flexibility to provide a rich, detailed and complex synthesis of data that meets a very specific and applied aim relevant to the project objectives (Braun and Clarke, 2006; Kerr, Nixon and Wild, 2010).

The data was analysed using an induction-abduction approach to identifying themes (Kelle, 2005), with themes emerging directly from the data (inductive inference) and by applying prior knowledge and behaviour theories to further understand the research findings (abductive inference). This enabled the analysis to remain firmly grounded in the data, with participants identifying areas of importance for them, while taking into consideration the parameters of what constitutes viable and realistic solutions for improving practitioner’s engagement in FtP investigations.

² Informed consents form are available on request subject to approval by GMC and ICE Creates.

A person with dark hair, wearing a blue button-down shirt, is looking at a large screen. The screen displays a circular diagram with a light blue background and a dark blue border. The diagram is divided into several segments, some of which are highlighted in a darker blue. The person's face is partially visible on the right side of the frame, looking towards the screen. The overall image has a teal overlay.

Primary Insight Findings

3 Primary Insight Findings

Layout of findings

The findings from the research activities are presented in the following sections and have been triangulated to provide both prospective and retrospective evidence gathered from doctors, medical associate professionals (practitioners), the GMC and MPTS team members. The findings have been pooled into the following four sub sections:

- Perceptions and expectations of the GMC
- What happens when a practitioner is informed of an allegation?
- What influences a practitioner's decision to engage with the GMC?
- Exploring 'tipping points' for accepting decision made by the GMC.

Please note, if a theme was elicited consistently across the different target audience groups, then findings are pooled across the study sample. Differences between sub-groups are described only when they occur.

3.1 Perceptions and expectations of the GMC

3.1.1 Perceptions of the GMC

Participants described the GMC as a **regulatory body for practitioners** to ensure they maintain standards of good medical practice. Many agreed that the fitness to practise (FtP) process was in place for ‘good reason’, **for protecting patients** and maintaining public confidence. Some also noted the GMC’s function in setting medical education standards.

While nearly all participants agreed that it was important to have a professional body dedicated to FtP, many doctors (not MAPs) described the GMC as “draconian”, “adversarial” and the “medical police”. They believed the GMC was biased towards the patients interests and was “heavy-handed” in punishing doctors, which led many doctors to have low expectations of the GMC regarding a FtP process (see section 3.1.2.3)

Doctors believed the GMC was *against* doctors and reported being wary of engaging with the GMC at the start of an investigation. Many said before engaging, they would seek legal advice and support from their medical defence organisation (discussed in section 3.2.3.1) to support their defence *against* the GMC.

“Their tagline is to protect patients, rather than doctors, I don’t feel like the GMC has my interests in mind at all, so I’d be speaking to my union before I did anything” (GP, P18).

Additionally, many doctors perceive the GMC to have a **low threshold for investigating allegations made by members of the public**. This perception was driven by the belief that the GMC doesn’t fully consider whether allegations are vindictive or unfounded, raised by aggrieved patients who are looking for someone to blame.

Additionally, a small number of participants, who self-reported their ethnicity as BAME, said they expected their ethnicity to be a factor in the reason for an allegation, and expected the GMC to overlook racial motives that might contribute to why the patient made an allegation.

The insight suggests doctors have low trust in the GMC. There is a need for the GMC to rebalance this perception by communicating how they investigate allegations in a fair and impartial way. This should include raising awareness that the GMC “closes approximately 80% of cases without investigating”³, and publicising information which demonstrates the fairness of the process, as well as the fact that many investigations close with no action being taken against the doctor.

“You want to have faith that if someone does make a complaint it is dealt with in a fair way... it gives confidence that you’re not penalised by your professional body” (GP, P13).

³ GMC. *Deciding to investigate a concern, where we won’t investigate*. Available [here](#)

3.1.2 Expectations of the GMC during a fitness to practise investigation

3.1.2.1 To conduct a thorough and fair investigation

Participants were asked what they would expect from the GMC if their FtP had been called into question. It was widely discussed by practitioners that they would **expect a thorough and fair investigation to take place** that considered all the facts, including wider contextual factors that may have contributed to a patient safety incident. The importance of considering contextual factors within an investigation is discussed in section 3.4.1.2. Many also expected the GMC to support them to remediate concerns and help them ‘get back on track’.

Importantly, these factors **give doctors confidence and reassurance that the GMC is acting in a fair and impartial way**, which will help combat the perception that the GMC ‘takes sides’ with patients.

“Doctors need a greater degree of reassurance that this isn’t intended to strip them of their practice but to explore what’s gone wrong and remediate... for the GMC to be supportive, they need to make it more public that they do look at both sides” (SAS, P32).

3.1.2.2 To provide support

The insight suggests that participants have limited to no knowledge of support the GMC provides for practitioners under investigation. For instance, doctors discussed that they interact with the GMC to revalidate and pay registration fees but didn’t know of any support resources available from the GMC.

Interestingly, most participants believed the GMC needed to provide more support (discussed in section 3.2.4.2), whereas some doctors believed it was contradictory for the body that was investigating, to also provide support. This suggests there is a need to raise awareness of GMC resources that both provide and signpost to support, helping to combat perceptions that the GMC is unsupportive of doctors.

“The organisation that investigates you, can’t be the one that consoles you” (SAS, P28).

In comparison, medical associate professionals (MAPs) described the GMC as a ‘comfort blanket’ that in future they expected would be highly supportive of them by providing clear policies and procedures for MAPs to follow, designed to help them practise safely and remediate concerns that are raised.

“I’d expect constructive feedback about what I need to do to resolve it and support me to continue working safely” (MAP, P40).

3.1.2.3 Low expectations of the GMC

While some doctors expected the GMC to conduct an impartial and thorough investigation, many said they didn’t expect this to happen in reality, rather they **expected the GMC to scrutinise their practice, blame the doctor and take punitive action** in favour of the patient.

Notably, many doctors spontaneously referred to the case of Dr. Bawa Garba, stating that they expect the GMC to treat them in the same way they perceived she was treated by the

GMC. In this regard, they expect the GMC to blame the doctor, overlook wider contextual factors and take punitive action, given the GMC “went out of their way” to appeal Dr. Bawa Garba’s case at tribunal, which resulted in her erasure from the register.

Importantly, doctors strongly empathised with Dr. Bawa Garba because they believed the same thing could happen in their practice. As a result, doctors fear the GMC will treat them harshly and take punitive action if a similar patient safety incident happens to them.

*“I don’t have very high expectations of the GMC. You hear horror stories, which there are plenty of, and it’s almost like he or she is guilty even before the process has started”.
(SAS, P34).*

*“I first thought the GMC were advocates for doctors and wanted to help them rectify errors, but the case made us all worry, because that could have been any doctor in the NHS”.
(SAS, P9).*

This suggests that **many doctors have low trust in the GMC to carry out a fair investigation**. As a result, many doctors will be cautious about engaging with the GMC because of the perceived adversarial nature of a GMC investigation, believing they need to *defend* their practice *against* the GMC.

This suggests there is a need for the GMC to rebalance this perception by communicating how they conduct thorough and fair investigations, while supporting doctors by providing and signposting to support. This will give reassurance and confidence that the GMC will treat doctors fairly during an investigation.

What happens when a practitioner is informed of an allegation against them?

When the GMC decide to investigate an allegation, the GMC will inform the practitioner by letter or email and provide a copy of the redacted referral containing the allegation against them.

3.2 What happens when a practitioner is informed of an allegation against them?

3.2.1 What would this experience be like?

Participants were asked to put themselves in the shoes of a practitioner who has been informed that an allegation has been made against them. Many said they would immediately think the worst-case scenario (erasure) and feel “frightened” and “distressed” that their whole career was at risk.

“5 years at Uni, 8 years training, I only want to be a doctor, and this puts your whole career at stake” (SAS, P3).

Some practitioners said they may have a “knee-jerk reaction” and say something they later regret if they were angry, believing the allegation was unfounded or vindictive. Whereas others said they would be upset knowing a patient was aggrieved by their actions.

A small number of doctors disclosed that their FtP had been investigated by the GMC before. They experienced sleepless nights, depression, low self-confidence and said it was difficult to continue practising during the investigation because the distress of the investigation added to pressures at work.

Practitioners widely discussed that they would worry about the impact on their reputation and future job prospects. Many also said they would feel ashamed and embarrassed among colleagues, believing there was a social stigma associated with being investigated by the GMC, with many saying it feels like practitioners are “guilty until proven innocent”.

“Not only did I question every decision I made in my day-day work, but I also held my head in shame among colleagues and had to tell the trust, the deanery, CQC... it’s embarrassing!” (GP, P24).

3.2.2 How are practitioners informed of an allegation against them?

3.2.2.1 Letter or email

It was widely discussed by doctors (not MAPs) that GMC letters and emails were generally “cold and formal”. Many doctors said they had a “heart sink moment” every time they received a letter or email from the GMC, even if it was regarding revalidation or annual fees. They said they could “recognise the GMC fonts a mile off” and because they didn’t regularly hear from the GMC, worried that the correspondence was a complaint.

Interestingly, due to Covid-19, rather than receive a letter, doctors are informed about a concern by email. Doctors first receive a verification email to confirm their contact details, before being sent confidential information about the allegation. GMC team members reported that receiving this “suspicious looking” email, led doctors to phone the GMC in “panic” to find out what the email was about.

These findings suggest that GMC correspondence evokes a sense of panic and concern in practitioners, which may add to the distress practitioners experience when the GMC first contacts them about their FtP. but may also reinforce the perception”. Some participants explicated stated that GMC communications felt formal and accusatory in tone, which

reinforced this perception that the GMC is “out to get you”. Notably, GMC team members said the communication templates were there as a guide, but they often had little time or resource to make them more personable.

Improving the language and channel of communication when informing practitioners of an allegation, may help reduce the panic practitioners experience when they are first contacted by the GMC about a concern. Additionally, wider communication efforts that are designed to demonstrate support for practitioners may help reduce the fear associated with receiving correspondence from the GMC.

3.2.2.2 Phone call

As mentioned above, GMC team members said many doctors who received the verification email subsequently phone the GMC to find out what it is about. As a result, the GMC case officers would speak to doctors, explain that an allegation has been made and what would happen next. In many cases, ***case officers were able to reassure doctors and allay their fear of erasure***, which not only eased the distress for doctors but also helped to combat the perception that the GMC is the “big bad wolf out to get you” (GP, P23).

Speaking prospectively, some participants said having one person from the GMC (e.g. case officer) to speak to would help “decriminalise the process” and encourage practitioners to be more co-operative, honest and open throughout an investigation. These findings suggest that the opportunity to speak to someone from the GMC at the start of an investigation will help reassure practitioners and reduce the initial distress and panic.

“You’d want a friendly voice to put your mind at rest that they’ll do things properly... to say ‘we are obliged to investigate but we are impartial, and we want to hear your side’ (SAS, P32).

Importantly, it was noted by GMC team members that initial contact by phone may lead practitioners to respond emotionally and say something in the moment that they later regret. However, it was suggested giving practitioners the option to call the GMC when they receive the verification email or letter would demonstrate the GMC endeavours to support practitioners during this process.

3.2.3 Where would practitioners seek support and advice?

3.2.3.1 Medical defence organisations

Nearly all doctors (not MAPs) said they would first seek advice from their medical defence organisation (MDO) when an allegation is made against them and before commenting or submitting information. Some participants said they would be ‘tempted’ to comment to show willingness to comply and to try to “nip it in the bud” quickly, but nonetheless would be guided by their MDO.

“It would be prudent to speak to a legal rep as I don’t know whether it would be wise to send a comment or not” (GP, P4).

Nearly all doctors said seeking legal advice and support from a medico-legal adviser would support their defence in a case opened by the GMC. Many doctors likened the process to

getting a lawyer if they were convicted of a crime and believed any case opened by the GMC was serious enough to warrant seeking legal advice and guidance from their MDO.

Participants said they would **trust and follow advice from their MDO**, because they were “on side” and because doctors themselves had little knowledge of GMC processes. They would expect their medico-legal adviser to read the concern, advise how to respond, review draft responses, and attend tribunal hearings if needed; ultimately making sure nothing the doctor submitted could be misinterpreted or later used against them.

“I would have a low threshold for going to the MDU for advice, it’s what I pay them for and they’re outside of the thick NHS structures... they don’t have a second agenda other than my defence” (SAS, P7).

Given most doctors would seek advice and support from their MDO (with only a few participants saying they would hire a lawyer), it is evident that MDOs are key influencers in determining how a doctor engages with the GMC. This is discussed further in section 3.3.1.

3.2.3.2 Colleagues/Seniors/ practice managers/partners

Some participants said they would openly speak to their trusted colleagues and seniors/managers, stating that they would:

- Lean on colleagues for moral support
- Ask colleagues what they would have done in the same circumstance relating to the patient safety incident in question
- Ask colleagues to provide a statement of their good character
- Inform colleagues that the GMC may contact them for information.

However, it was discussed that not all practitioners have trusted relationships with their colleagues (e.g. locum doctors) which may lead some practitioners to close up and isolate themselves, rather than seeking advice and support from colleagues at work. It can be suggested that practitioners who don’t access peer support are more likely to experience emotional distress during an investigation, which is discussed further in section 3.3.3.2.

3.2.3.3 British Medical Association

A **small number of doctors** said they would seek emotional support from BMA who are known for supporting doctors in distress. As discussed in section 3.1.2.2, many participants had low awareness of available support resources, including emotional support.

Many participants said it would be beneficial to access not only emotional support during an investigation, but practical support which they expected the GMC to provide.

3.2.4 What do practitioners need from the GMC when an allegation is made against them?

Participants were asked what they would need from the GMC if an allegation was made against them. The key needs identified were:

- Clear guidance about the process and what the GMC expects from practitioners
- Provide/signpost to support.

3.2.4.1 Clear guidance about the process and what the GMC expects from practitioners

Owing to the lack of knowledge of the FtP process participants said they would need the GMC to be transparent about the investigation proceedings and timelines and would want the **GMC to communicate what it expects from practitioners at key stages of the investigation**. Participants suggested that clear guidance and expectations would make it easier for practitioners to engage in the process co-operatively.

Participants said they would need to know if they could continue to practice during the investigation and expected the GMC to assess whether a practitioner was FtP, due to the added distress of being under investigation that may impact their daily practice and consequently cause further risk to patient safety.

“If they set that expectation early and keep you fully informed about what you need to do, then you have peace of mind that progress is happening” (GP, P15).

GMC team members said it was beneficial for practitioners to have medico-legal advisors to support them to understand and navigate the process, but that not all practitioners were represented – either at all or by medico-legal specialists. This meant **some practitioners didn’t know how to engage with the GMC or what was expected of them**.

It was discussed that the GMC do have some responsibility to help practitioners understand the process and set expectations. For instance, GMC team members said the initial correspondence practitioners receive doesn’t make it clear that they can comment on the case at any point. It was suggested that setting clearer expectations about how to comment and why, may encourage engagement.

Other team members said during case examiner meetings (Rule 7), the GMC are often wary of giving too much specific guidance to practitioners, at risk of compromising public confidence. However, it was discussed that the GMC needs to “be brave” in giving practitioners clearer advice on what they need to provide, making it easier for them to meaningfully engage with the process.

“We can’t be seen to be too lenient on doctors by suggesting what they should or should not say in their final response because it risks public confidence, but at the same time the GMC needs to be brave in giving clearer advice to doctors that it is then up to the doctor to take” (GMC team member).

This suggests that while MDOs play an important role in supporting practitioners to understand and navigate the process, there is a need for the GMC to provide clearer guidance about what the GMC *expects* practitioners to do/provide at key stages of the investigation.

3.2.4.2 Provide/signpost to support

As discussed in section 3.1.2.2, many participants had limited to no knowledge of the support the GMC provides for practitioners under investigation. It was widely discussed that practitioners would need both legal advice and emotional support during an investigation, to navigate an unfamiliar process at a time when practitioners are likely to be feeling distressed and overwhelmed.

Support needs differed between doctors and MAPs, which are discussed separately in the following sections.

3.2.4.2.1 What support do doctors need/want?

Some doctors believed it was inappropriate for the GMC to provide legal advice and emotional support as the investigatory body (see section 3.1.2.2). However, it was suggested that the GMC could acknowledge the need for support by clearly signposting to services, such as BMA and MDOs (or other legal support if doctors weren't a member of a MDO).

“If the GMC helped you get some support, even if it's not from them, it would show that they recognise that it's a scary moment for a doctor and that support is here for you” (GP, P4).

Given that the GMC do signpost to support resources on their website⁴ and have commissioned BMA to provide the Doctor Support Service⁵, the insight suggests that there is a need to raise awareness of the support resources available from the GMC to ensure doctors access support they may need and to help combat perceptions that the GMC is unsupportive of doctors.

3.2.4.2.2 What support do medical associate professionals need/want?

MAPs had limited to no knowledge of where to access legal or emotional support during an investigation, with many assuming the GMC would provide this support, including the provision of indemnity cover. Some MAPs said they would approach their union (e.g. Unite and Unison) for legal support but were unsure if they had the 'medical know-how' to help them navigate the FtP process.

“I hope when we become registered that all the information of who to go to for what is easily accessible for us because the process is so new, it would be difficult to know where to start” (MAP, P42).

This suggests there is a need to increase awareness and knowledge of the FtP process and specific support available to MAPs, while setting parameters of the GMC's role and responsibilities. This will help the new regulatory group feel prepared and familiar with the FtP process and understand more about the GMC's role.

⁴ GMC. Support Resources. Available [here](#)

⁵ GMC and BMA (2015) Doctors Support Service Leaflet. Available [here](#)

What influences a practitioner's decision to engage with the GMC?

When a practitioner has been informed about the allegations against them, they have an opportunity to comment on the allegation and to provide evidence. It is desirable for practitioners to comment and provide evidence early during an investigation to inform decision-making.

3.3 What influences a practitioner's decision to engage with the GMC?

The insight suggests that there are several factors that motivate practitioners to engage with the GMC and equally, there are factors that may be a barrier to early and meaningful engagement.

This section is framed by the work of Daniel Kahneman, renowned for his contribution to the field of psychology and behavioural economics⁶ and will present the driving and restraining forces for engagement to help understand what influences a practitioner's decision to engage with the GMC or not.

Kahneman suggests that behaviour is influenced by driving forces (the factors that motivate a person to do something) and restraining forces (the factors that prevent this from happening). Attitudes, beliefs, and perceptions, as well as environmental factors can all exert control on a person's behaviour as a driving or restraining force.

Before discussing the driving and restraining forces, it is worth revisiting the influential role of medical defence organisations in acting as either a driving or restraining force for engagement.

3.3.1 Key influencers: medical defence organisations

As discussed in section 3.2.3.1, many doctors will seek advice and support from their MDO as to how, and to what extent, they engage with the GMC.

Most doctors said they couldn't imagine their MDO would discourage engagement, but nonetheless would be guided by their advice. GMC team members reiterated that doctor's engagement is highly influenced by their MDO, who can sometimes advise not to comment. It was discussed that this obstructs the process by causing delay and additional effort, particularly when important information is disclosed later in the process.

This suggests MDOs have a strong influence on doctors' behaviour as either a driving or restraining force for engagement. It will be important to consult medical defence organisations to understand what they believe the GMC needs to do to differently, to increase the likelihood of MDOs encouraging doctors they represent to engage early in a FtP investigation.

⁶ Kahneman, D (2017) 'How to launch a behaviour-change revolution' Full transcript available at: www.freakonomics.com/podcast/launch-behavior-change-revolution/

3.3.2 Driving forces for engagement

Questions were asked to explore what would motivate practitioners to engage with the GMC during an investigation, including what would motivate practitioners to comment or submit information when requested by the GMC. The key driving forces for engagement are discussed in this section.

3.3.2.1 To speed up the process and reduce stress

The GMC try to conclude investigations as soon as possible (all of them within 12 months if possible). The length is partly fixed by the steps in the process, but it also depends on what kind of information is needed to make a decision.

Most participants were motivated to engage if it meant speeding up this process. Practitioners discussed that for the duration of the investigation, they would have a “grey cloud over their head”, which would impact their mental health and day-day life.

“I’d want to get it done swiftly so all the stress hanging over me will be over sooner” (SAS, P36).

“The longer it goes on, the worse you’re going to be, you can’t concentrate, you second guess your decisions and it’s not just your work that’s affected, but everything at home too” (GP, P24).

Others discussed that if they had been suspended from practice during an investigation, either by the GMC or their employer, that they would be motivated to return to work as soon as possible, particularly if they were not being paid.

“We all have mortgages... you’re going to engage to save your own skin and bring it to a conclusion as fast as possible because we all need to keep working!” (GP, P2).

Some participants said they wouldn’t want the speed of the investigation to compromise the robustness of the investigation but believed providing their “side of the story” early on, would help ensure the investigation was both thorough and timely. It was suggested that clear deadlines for submitting information would create a sense of urgency and motivate practitioners if it would move things along faster.

3.3.2.2 A moral obligation to “do no harm” and learn from mistakes

Many participants reflected that they would engage with FtP processes, because they have a moral obligation to “do no harm” to patients and to learn from their mistakes.

Participants reflected that medical practitioners have a moral obligation to learn from their mistakes. Within an investigation, this would involve being open and honest about what happened, accepting responsibility for their actions and showing a willingness to remediate concerns.

Participants believed that engaging in the process would demonstrate a willingness to learn from what had happened and show that they are taking the investigation seriously, respecting that the FtP process is in place for “good reason”.

It's not enjoyable, but it's there for good reason and in these situations, there is always something to learn" (GP, P8).

"To show you're taking it seriously and there is no arrogance on your part... it's our duty as doctors that if we get request for a record of accounts, we respond in a timely manner" (GP, P13).

A small number recognised that an aggrieved patient is at the "end of this concern" and that it was their moral duty to engage and acknowledge the patient's distress even if they believe the concern was unfounded and the allegation was vindictive.

It's a hard pill to swallow if you don't think you've done anything wrong, but at the end of the day a patient feels distressed and you have a duty to at the very least acknowledge that by following the process" (SAS, P11).

3.3.2.3 To influence the outcome

As discussed in section 3.2.1, the fear of erasure is the biggest worry for practitioners when an allegation is made against them and is in the "back of their mind" when making decisions about how to engage with the GMC.

Many participants rationalised that engaging with the process would not reduce their chance of a serious sanction, whereas others said engagement could potentially "paint you in a good light". These participants discussed that showing a willingness to comply and co-operate would demonstrate good character that may be considered by Case Examiners.

"The sanction is the sanction... you don't get off lightly by responding quickly" (GP, P8).

On the contrary, other participants said they would engage if they firmly believed they hadn't done anything wrong, to put their side of the story across and ensure a fair investigation could take place. It was discussed that patients sometimes make allegations based on grief and anger, and therefore, practitioners would want to engage to refute an unfounded concern, clear their name and keep their reputation intact.

3.3.3 Restraining forces for engagement

Questions were asked to explore what may deter a practitioner from early engagement during an FtP investigation.

Interestingly, **many participants believed engagement was mandatory**, and that practitioners who do not engage with the FtP process should "prompt a red flag" and be taken seriously by the GMC to explore the reasons why. It was discussed that choosing not to engage may reflect a deep-rooted problem with a practitioner's practice or character which may directly call into question their FtP and thus would need to be investigated.

"I didn't realise I had a choice, and actually if a doctor didn't engage that would be a serious matter in and of itself... you'd want to know if their reasons are justified" (GP, P2).

"If you've nothing to hide why not engage?" (GP, P3).

Participants went on to discuss several reasons why a practitioner may not engage.

3.3.3.1 Fear of the GMC

Many practitioners fear being “struck off” by the GMC when an allegation is made against them (see section 3.2.1). It was discussed by doctors (not MAPs) that they may be reluctant to engage with the GMC out of fear that something they said would be “later used against them”. Subsequently, most doctors take advice from their MDO (see section 3.2.3.1), whereas others may put off doing anything altogether.

“Even if you were innocent, you’d worry about proving that, because you always have that doubt in your mind that they’re out to get you” (SAS, P37).

Doctors that decide to “put off” responding to the GMC may experience ‘**omission bias**⁷. This is a person’s tendency to judge inaction (not engaging with the GMC), as less harmful than taking action that may result in a negative outcome. If practitioners believe that anything, they say may be used against them, they are more likely to “put off” engagement, judging their Whdecision to take no action as less harmful than engaging in the process.

It will be important for the GMC to reduce the perception that engagement is likely to have harmful consequences and communicate that practitioners who do engage, will help ensure a fair investigation can take place.

“You want to be open and sort it as quickly as possible, but you’d need to make sure anything you say doesn’t reflect on you badly” (GP, P23).

3.3.3.2 Emotional distress of being under investigation

Many participants believed that the distress and upset caused by being under investigation would impact a practitioner’s ability to meaningfully engage in the process and that they would need emotional support (see section 3.2.4.2).

It was reported that practitioners may feel overwhelmed with being investigated and with having to navigate an unfamiliar process at a time of high anxiety and stress. It was discussed that some may “bury their head in the sand”, particularly if they had not sought peer or wider support. Some doctors (not MAPs) said doctors may “put off” engaging with the GMC in the hope that the problem would “go away by itself” (the impact of this reaction is discussed in section 3.3.3.1).

3.3.3.3 Poor attitude of the doctor

A small number of doctors (not MAPs), discussed that some doctors may not take the concern seriously and obstruct the process if they believe the concern is unfounded.

⁷ The Decision Lab. Why we tend to react more strongly to harmful actions. Available [here](#).

Participants described some of their colleagues as arrogant and the type of doctor to refuse any responsibility if something went wrong.

It was discussed that doctors with a bad attitude were more likely to be stubborn and obstructive if an allegation was made against their FtP, rather than seeking to learn from what happened.

“Some doctors out there have obstructive personalities who think they’re above the process just because they believe the complainant is ridiculous and that their practice is flawless” (GP, P13).

Exploring ‘tipping points’ for accepting decisions made by the GMC

The GMC are working to put in place a new framework for FtP that is centred around the use of consensual disposal.

Although the shape of the new consensual disposal process is yet to be decided, progressing to a consensual disposal will involve the practitioner agreeing to the GMC’s description of the facts of the case and proportionate sanction based on the papers, without the need for a tribunal hearing (even the more serious sanctions of suspension and erasure from the register).

Practitioners will need to be informed about the allegations against them and be provided with an opportunity to provide evidence and assess the case against them.

Within the new consensual disposal process, practitioners will still have the opportunity to not accept the outcome offered by the GMC and progress the case to a tribunal hearing.

3.4 Exploring ‘tipping points’ for accepting decisions made by the GMC

Introduction to the scenarios

During the interviews, participants were presented with **4 constructed scenarios** concerning ‘Dr.X’. Each scenario was used to explore the acceptability of conclusions made by the GMC in different circumstances and to explore the ‘tipping point’ whereby practitioners would agree or disagree with GMC decisions.

Participants were informed that in every scenario, Dr X has the option to accept conclusion made by the GMC or refuse it. If Dr X does not accept the outcome offered, the case will be referred to a tribunal hearing.

The 4 constructed scenarios are presented below along with a discussion of the findings regarding each scenario.

3.4.1 Scenario 1: Dr X expressed regret and apologised

Dr X is a senior Clinical Fellow working in an emergency department. A complaint was made by a patient who was discharged from the emergency department by Dr X, deteriorated the same day, suffered a heart attack and had to be admitted to hospital for several months.

After investigation, including an expert report, the GMC determined that Dr X had failed to provide adequate clinical care to the patient in several areas, including not conducting an adequate examination, diagnosis or starting appropriate medication.

Dr X acknowledged making errors, expressed regret, and apologised. They identified learning points and said they intended to make changes to their medical practice as a result but had not yet had time to do so.

The GMC concluded that Dr X’s fitness to practise was impaired and that conditions should be placed on Dr X’s practice for 6 months to give them an opportunity to retrain and remediate the concerns.

3.4.1.1 Reasons why practitioners would accept this conclusion

Most practitioners said they would accept this conclusion from the GMC, given Dr X had ***accepted responsibility for what had happened*** and had simply not had time to remediate.

Many believed it was fair for the GMC to suspend Dr. X’s practice to ensure the concern was remediated. It was discussed that learning from mistakes is “integral to medical practice” in order to maintain patient safety and steps to ensure this could happen were reasonable.

Others said they wouldn’t pursue the case to a tribunal because it would cause more stress and may lead to a more unfavourable outcome (discussed further in section 3.4.5.1).

Participants discussed that they would accept this conclusion from the GMC because the outcome was not “detrimental”.

3.4.1.2 The ‘tipping point’ for not accepting this conclusion

Nearly all participants said they would not accept this conclusion ***if the GMC investigation had not considered wider contextual factors.***

It was widely discussed that mistakes don’t happen in isolation and that wider contextual factors and systemic failures, such as staff and time pressures and IT faults, may contribute to patient safety incidents, particularly given the impact of Covid-19 on health care demand.

In direct relation to the case of Dr Bawa Garba (see section 3.1.2.3), participants expressed a belief that when things go wrong, too much onus is placed on the individual and that this is a risk to patient safety if mitigating contextual factors go unnoticed and are not addressed.

As a result, in this scenario, participants said they would want to be certain that all contextual factors had been accounted for by the GMC before accepting individual responsibility and thus the terms of the conclusion made by the GMC.

“Mistakes often happen because extenuating circumstances and retraining won’t solve it... it’s difficult for the GMC to focus on the big picture because they are positioned to hold a specific case against a specific doctor but if systemic problems are overlooked then what’s to say that incident won’t happen again to another doctor?” (GP, P6).

3.4.2 Scenario 2: Dr X did not take responsibility

What if, Dr X did not take any responsibility for the errors and the GMC concluded that the outcome was a suspension of 6-months given the lack of insight and absence of any genuine willingness to remediate being shown by Dr X.

3.4.2.1 Reasons why practitioners would accept this conclusion

Interestingly, ***many participants struggled to put themselves in the shoes of Dr X*** and reflected on this scenario in third person.

These participants agreed with the conclusion made by the GMC, reporting that a lack of willingness to learn from the incident and remediate was a serious “red flag”. While participants agreed that 6-month suspension was reasonable, they expected a review to take place after this period to ensure Dr X was fit to return to practise.

“What makes you think after 6-months that they will suddenly hold their hand up and say I now understand what I did was wrong?” (GP, P4).

3.4.2.2 The ‘tipping point’ for not accepting this conclusion

Participants who ***did put themselves in the shoes of Dr X said they would refuse*** this conclusion. It was discussed that if Dr X had no insight and wasn’t willing to remediate, it was likely because they didn’t believe they were in the wrong.

Participants said that if they strongly believed they were ‘innocent’ they would be likely to “fight their corner” and pursue a tribunal hearing.

“If Dr X thought they’d done nothing wrong I assume they’d want to show their innocence and fight it” (GP, P3).

3.4.3 Scenario 3: Dr X does not entirely agree with the outcome

GMC concluded that Dr X had shown a reckless disregard of clinical responsibilities towards the patient and concluded that the outcome would be a suspension of 6 months. Dr X accepts that they made a mistake but didn't believe they had shown reckless disregard, rather it was a mistake that was in part due to time and staffing pressures.

Therefore, Dr X does not entirely agree with the 'case put to them'.

3.4.3.1 Reasons why practitioners would accept this conclusion

A small number of participants said they would accept this conclusion to avoid the risk of a more serious sanction being imposed at a tribunal hearing. It was discussed that the terms of the case were harsh, but that they may swallow their pride in order to get back to work after the suspension period, which they wouldn't be able to do if a tribunal concluded the sanction would be erasure.

"If there had been system errors and I didn't think it was reckless per se, it would be a bitter pill to swallow, but I would swallow it to avoid an even more serious sanction"
(GP, P23).

"If I felt like I had no choice, and this was as good an outcome as I was going to get then you'd have to suck it up and accept it" (SAS, P38).

3.4.3.2 The 'tipping point' for not accepting this conclusion

Most participants said they would refuse this conclusion because Dr X fundamentally disagreed that their actions were 'reckless'. It was widely discussed that 'reckless' is an emotive and harsh word and that in comparison to an honest mistake, 'reckless disregard' would cause reputational damage and impact a practitioner's future career prospects.

"The word 'reckless' against your name is reputationally damaging and viewed differently to someone doing their best and making an honest mistake in difficult circumstances"
(GP, P6).

Interestingly, some participants did not dispute the outcome itself, but the terms of the outcome. Participants said they may accept a suspension of 6-months if the GMC had concluded that Dr X had made a mistake, rather than shown reckless disregard. Others said they believed this type of sanction was reflective of the "heavy-handed" approach by the GMC towards doctors and believed suspension was too severe if Dr X had made a genuine mistake.

3.4.4 Scenario 4: Dr X did not remediate a previous concern

A similar patient safety incident had happened before, and Dr X previously had restrictions on their practice as a result of this concern being investigated. The GMC concluded that Dr X had not remediated the previous concern or learnt from their mistakes, and thus concluded that the outcome would be erasure from the register.

3.4.4.1 Reasons why practitioners would accept this conclusion

Some participants said that erasure in this circumstance was not unreasonable given Dr X had had an opportunity to remediate the concern. They believed the principle of a “yellow then red card” was fair if there was a real risk to patient safety. Other participants believed the rule of “3 strikes and out” was more appropriate than being erased after a second incident had occurred.

“Erasure is harsh, but our line of work is serious... we deal with people’s lives and if there is a legitimate risk then removing them from the register isn’t unreasonable” (GP, P21).

Notably, participants reiterated that they would only accept this conclusion if wider contextual factors had been accounted for.

“If every extenuating factor was looked at and the GMC still found something happened twice that should of never of happened, and that resulted in patient harm then yes” (GP, P4).

3.4.4.2 The ‘tipping point’ for not accepting this conclusion

Erasure from the medical register is considered the most severe sanction and is the biggest fear of any practitioner.

Some participants said they would not accept this conclusion from GMC because there was nothing to lose in pursuing the case at tribunal and it would give peace of mind that they had explored “every avenue” to keep their licence.

“I’d follow process right to the Nth degree to fight for my licence and so I’m not left wondering ‘what if I’d have appealed it?’ (GP, P13).

“Knocking off a doctor needs to go through a tribunal of some sort, it’s only fair that they go through the full process because the result could be so serious” (GP, P14).

Many participants, particularly those in early and mid-career stages, said they would “fight” for their career, having spent years of training to get to their current position as a qualified practitioner. In comparison, it was discussed that some practitioners of retirement age may prefer to “go out quietly” and accept this conclusion.

3.4.5 What influences practitioner's decision to avoid or pursue a tribunal hearing?

3.4.5.1 Reasons to avoid a tribunal hearing

Practitioners believe that the most serious sanctions are imposed at tribunal hearings, which will influence many practitioner's decision to avoid a tribunal hearing.

For instance, some said if the GMC imposed a sanction that was less than erasure, they may choose to accept this decision to avoid the risk of a worse outcome at tribunal. Some practitioners believed the chances of a more favourable outcome at tribunal were minimal because the case had already been investigated by an expert panel.

"They are warning you, you're unlikely to win so take the deal and get out" (SAS, P35).

"You run the risk of a harsher penalty at tribunal because it's difficult to predict the outcome of how people perceive it... you've got to weigh it up because there is potential to be struck off" (GP, P5).

Many discussed that they would want to avoid tribunal to have the investigation "over and done with" and to prevent any more distress and upset, which they believed would be heightened at tribunal. Others said they would want to protect their reputation, which they believed would be more exposed to the public and press, and a small number said they would want to avoid additional legal fees associated with a tribunal.

Interestingly, MAPs believed that an FtP investigation would only be logged on their file if the case progressed to a tribunal and therefore, would want to avoid tribunal to protect their reputation and career in the long-term. This highlights the importance of equipping MAPs with clear knowledge of the FtP process so on a day-to-day basis they can provide advice.

"I think it goes on your record if you go to tribunal, so I'd probably accept it, so my reputation wasn't damaged in the long-term" (MAP, P40).

3.4.5.2 Reasons to pursue a tribunal hearing

Participants said they would pursue tribunal if they believed the outcome was unfair or they had been wrongly accused. They said they would want to "get the facts out in the open" and "clear their name", expecting a public tribunal to be more favourable and independent than a GMC investigation.

Notably some doctors said they would seek advice from their MDO as to whether the outcome was fair and whether they had a "good chance" of receiving a more favourable outcome at a tribunal hearing. However, many said if the GMC concluded erasure, they would have "nothing to lose" in pursuing the case at tribunal.

"Some doctors might take any sanction even if tribunal might have worked in their favour... that's why MDO is so important to guide doctors to do what's right" (SAS, P30).

"If you wholeheartedly believed the claims weren't true, you'd have to grit your teeth and get through it" (SAS, P33).

4 Considerations

This section discusses the key considerations that the GMC may wish to consider as part of the fitness to practise process redesign. All considerations are informed by the insights detailed in this report and are designed to help the GMC encourage maximum and meaningful engagement from practitioners during an investigation.

This section has been divided into consideration for changes within the fitness to practise process and considerations for wider communication and engagement that fall outside the process redesign. The latter will be important for the GMC to consider in relation to the future of fitness to practise given wider perceptions of the GMC strongly influence how practitioners engage with the GMC.

4.1 Considerations for changes within the FtP process

4.1.1 Use choice architecture and supportive language to ‘nudge’ practitioners to access support

The insight suggests that doctors perceive GMC communications to be “cold and formal”. It is likely that this perception is influenced by their beliefs about the GMC (e.g. adversarial, draconian, bias), and will seek information that reaffirms their pre-existing beliefs, discounting other, potentially relevant information such as support resources (the tendency to search and ‘anchor’ to information that reaffirms beliefs is known as ‘**confirmation bias**’).

It is suggested that the GMC letter templates are updated to convey a more personable and supportive language (e.g. acknowledging this is a stressful time), while being clear and transparent about the allegation and what will happen next.

As practitioners are likely to have low awareness of support resources *before* they enter the FtP process, the initial letter/email that practitioners receive, should clearly signpost to support resources, making it easy for practitioners to access support they may need and helping to combat perceptions that the GMC is unsupportive of doctors. A direct phone number should also be included to make it easy for practitioners to speak to someone at the GMC regarding the allegation, as it was widely discussed that speaking to someone (ideally a dedicated case officer) helps to reassure doctors, build rapport and reduce the initial distress and panic.

“Without window dressing the point, respectful and supportive communication with us will help disarm the idea that the GMC is out to get you” (GP, P37).

Notably, it is not recommended that a phone call is the first contact point as this may lead some practitioners to respond emotionally and say something they later regret.

Support resources should be displayed using **choice architecture** to ‘nudge’ practitioners to first access available support resources before contacting the GMC direct. Support resources should be featured early in the letter or email to demonstrate support for doctors.

Choice architecture

Choice architecture is the design and positioning of different choice options and is used to ‘nudge’ people to perform a desirable behaviour or make a specific choice.

4.1.2 Reframe the potential outcomes of an investigation at the start

The insight suggests that practitioners may experience ‘**negativity bias**’ when an allegation is made against them, with practitioners likely to react emotionally and ‘fear the worst’ (see section 3.2.1).

This fear is compounded since cases that result in erasure are widely publicised in the media, compared to the majority of cases that are concluded without serious sanction or the need for a tribunal hearing.

“The GMC needs to be seen to be more neutral, then there would be no reason why they shouldn’t engage, but at the minute we always hear of cases where the doctor loses... its like that what’s going to happen” (SAS, P108).

As negativity bias is influenced by where a person places their attention, reframing the situation will help practitioners gain perspective and give fair and equal weights to all likely events that will follow when an allegation is made (e.g. no action, warning etc.).

It is recommended that the initial letter clearly states all the potential outcomes of the case and where appropriate, utilises real life stories and key statistics to demonstrate that many cases are concluded without a tribunal hearing or serious sanction.

Reframing the potential outcomes in this way will help reduce the prevalence of negativity bias and help practitioners view the situation more rationally, which is likely to increase their ability to engage meaningfully.

Negativity Bias

Negativity bias explains that negative events elicit a more emotional and prominent response than neutral or positive events.

It explains why negative events strongly influence a person’s psychological state, emotions and behaviours.

4.1.3 Use behavioural messaging to increase urgency to respond

A key motive to engage with the GMC during an investigation is to speed up the process (see section 3.3.2.1). It is suggested that the GMC utilise behavioural messaging to reframe requests for information and reminders in a way that anchors to what’s important to practitioners. This should include setting clear deadlines to create a sense of urgency, linked to the benefit of ensuring a full review of “all the facts” can take place as fast as possible.

4.1.4 Explain what the GMC expects practitioners to do/provide at key stages of an investigation.

As discussed in consideration 4.2.1, the GMC have some responsibility to provide clear guidance and advice about the FtP process and explain what the GMC expects practitioners to do/provide at key stages of the investigation.

It is suggested that the GMC creates a leaflet guide (with supporting videos) that explain what types of information practitioners should consider providing the GMC the start of an investigation. This will not only help practitioners provide meaningful information, but also demonstrate that the GMC are making it easy for practitioners to provide information needed to ensure all the evidence and facts are obtained.

Specifically, clearer guidance should be given to practitioners about commenting on an allegation, as the insight suggests it is not clear that practitioners can comment on the case at any point. The GMC should explain why it is beneficial for practitioners to comment on an allegation early (linked to the key motives for engagement discussed in section 3.3.2), how they expect practitioners to comment (e.g. written format) and what type of comment they expect. This will encourage engagement by giving practitioners clarity of how to engage with the GMC in a meaningful way and help to reduce the fear of the GMC may misinterpret information and use it against them.

Similarly, clearer guidance and advice should be given to practitioners about what type of information/evidence they need to provide. A key opportunity for this is during case examiner meetings (Rule 7) before a final decision is made. It was discussed that the GMC is often wary of giving too much specific guidance at risk of compromising public confidence, but that clear guidance and expectations to help prepare practitioners for their final response is likely to result in them providing evidence needed to inform decision-making.

4.1.5 Communicate how decisions are made by the GMC to increase confidence in consensual disposal

The insight suggests that practitioners believe Medical Practitioners Tribunal Service (MPTS) deal with the most serious cases and sanctions. This perception may influence a practitioner's decision to accept GMC conclusions to avoid "risking" a less favourable outcome, and to refuse GMC conclusions in the belief that MPTS will take the case more seriously and review all factors that the GMC may have overlooked (see section 3.4).

It is suggested that the GMC develops clear guidance of the FtP process and explains what will happen at each stage to give practitioners reassurance that a ***fair, robust and transparent investigations*** will take place. Importantly, the GMC should communicate how they consider wider contextual factors, as the insight suggests this is a key reason for practitioners to refuse GMC conclusions if they believe systemic factors have been overlooked and too much onus has been placed on the individual.

Knowing that the GMC has made a decision based on an impartial review of all the facts will give practitioners reassurance that they are being treated fairly. This will increase confidence in GMC decision-making and increase the likelihood of accepting decisions made by the GMC. This will be particularly important to convey if consensual disposal is extended to include cases that result in serious sanctions, as practitioners will need reassurance that their chances of a fair outcome are equitable whether they are concluded with the GMC or the MPTS.

4.2 Wider engagement and communication

4.2.1 Consult medical defence organisations: key influencers to encourage engagement during an investigation

The insight suggests that medical defence organisations (MDOs) have a strong influence on doctors' behaviour as either a driving or restraining force for engagement. Most doctors who are a member of a MDO will seek advice and support from their MDO before they engage with the GMC and will take their advice as to how, and to what extent, they engage with the GMC.

While many participants didn't expect their MDO to discourage engagement, GMC team members said this was sometimes the case, which obstructs the process.

"Sometimes the defence organisations advise them to wait and see what the GMC pulls together before saying anything" (GMC team member).

Therefore, it is suggested that the GMC consult with MDOs to understand what they think the GMC needs to do differently to increase the likelihood of MDOs encouraging doctors they represent to engage early in a FtP investigation.

4.2.2 Increase knowledge of fitness to practise among MAPs before they are regulated

The insight suggests MAPs have no knowledge of the FtP process and misunderstand the role of the GMC (e.g. they will provide indemnity cover). It is suggested that the initiation of their regulation with the GMC is a key opportunity to educate MAPs on the role of the GMC and the process of FtP investigations. This narrative should focus on giving reassurance as to how GMC conduct fair, robust and transparent investigations and give proportionate weighting to potential outcomes (see section 4.1.2).

4.2.3 Reset the fitness to practise narrative among the public and professionals

The insight suggests that deep-rooted perceptions and beliefs about the GMC influence doctors' emotions and behaviours that play out during an investigation. Not only that, but it is likely that widely held beliefs about the GMC will snowball across the system to other more junior doctors and trainees and potentially to MAPs who are soon to be regulated by the GMC.

It must be acknowledged that large-scale behaviour change will not occur solely by changes to policies and procedures, and that there is a need to address the current culture that underpins the relationship between the GMC and doctors, and seek to reset and rebuild trust with the medical profession. As part of this it is important that the GMC shares and is seen to operate in line with its values.

It is suggested that the GMC utilise the legislative reform and FtP process redesign as an opportunity to 'reset the perceived balance' and to widely communicate the reason for this reform. This is an important time to help the medical profession, the general public and wider stakeholders to understand that FtP investigations are in place to investigate and establish facts in a fair, transparent and impartial way, and are not there purely to be

punitive and adversarial . This type of communication should be widely communicated to both the public and practitioners to help reset the purpose of the future of FtP through a clear and consistent narrative.

Additionally, it is recommended that the GMC consider publishing information which demonstrates the fairness of the process, as well as the fact that many investigations close with no action being taken against the doctor. In addition, show casing example ‘real-life’ stories of investigations that close with no action will be important to counteract other well-known stories that result in more serious sanctions. It will also be important to convey how the GMC mitigate against allegations that are unfounded, vindictive and/or racially motivated. This type of communication should be designed to be positive, factual and supportive to doctors, helping reduce the fear associated with receiving correspondence from the GMC.

4.3 Closing remarks

This research has provided evidence of the key factors that influence a practitioner's decision to engage with the GMC during an investigation. By exploring practitioners' perceptions, expectations, knowledge and experiences of the GMC and the fitness to practise process, this research has been able to distinguish between factors that will motivate practitioners to engage, compared to those factors that may prevent maximum and meaningful engagement.

In addition, this research has explored the factors that influence whether or not a practitioner will accept decisions made by the GMC as part of a consensual disposal process.

These findings have informed several considerations for changes within the fitness to practise process and considerations for wider communication and engagement that fall outside the process redesign, all of which will be important to consider in shaping the future of fitness to practise.

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ice

Head Office
2-3 Abbots Quay,

Monks Ferry,
Wirral CH41 5LH

+44 (0)845 519 3423
ideas@icecreates.com
www.icecreates.com

 @ice_creates
 ice creates ltd
 ice

