



# **Promoting and maintaining public confidence in the medical profession**

## **Full Research Report**

**January 2019**

*All interpretation and opinion in this report is that of the authors alone and does not necessarily reflect those of the General Medical Council.*

**The authors would like to thank all those who participated for their frank and honest contributions to this research.**

## Contents

<b>1. Executive summary .....</b>	<b>5</b>
<b>1.1 Objectives and methodology .....</b>	<b>5</b>
<b>1.2 Key findings .....</b>	<b>6</b>
<b>2. Background, objectives and methodology .....</b>	<b>10</b>
<b>2.1 Background.....</b>	<b>10</b>
<b>2.2 Research objectives.....</b>	<b>10</b>
<b>2.3 Methodology .....</b>	<b>11</b>
Overall approach .....	11
Qualitative approach .....	12
Quantitative approach.....	12
<b>2.4 Notes on reading the report .....</b>	<b>14</b>
<b>3. Context .....</b>	<b>16</b>
<b>3.1 Attitudes towards own doctors .....</b>	<b>16</b>
<b>3.2 Confidence in the medical profession as a whole .....</b>	<b>18</b>
<b>3.3 Awareness and understanding of regulation of the medical         profession and sanctions.....</b>	<b>20</b>
<b>3.4 Awareness and understanding of the GMC .....</b>	<b>21</b>
<b>3.5 Spontaneous awareness of cases of wrongdoing .....</b>	<b>24</b>
<b>4. Introduction to scenario-based approach .....</b>	<b>25</b>
<b>4.1 Testing scenarios of wrong-doing - research approach.....</b>	<b>25</b>
<b>4.2 Factors affecting response to scenarios.....</b>	<b>26</b>
<b>5. Clinical errors including relationship to the criminal law .....</b>	<b>28</b>
<b>5.1 Expected regulatory response to clinical errors .....</b>	<b>29</b>
5.1.1 Impact of outcome.....	30
5.1.2 Impact of conviction for GNM/ CH .....	35
5.1.3 Impact of sentence.....	41
5.1.4 Other factors influencing expected regulatory action following clinical error .....	42
<b>5.2 Relative impact of mitigating and aggravating factors .....</b>	<b>45</b>
5.2.1 Explanation of Max Diff statistical analysis .....	45
5.2.3 Max Diff statistical analysis results.....	46

<b>6. Criminal acts other than those relating to clinical errors .....</b>	<b>49</b>
<b>6.1 Expected regulatory response to criminal offences .....</b>	<b>49</b>
<b>6.2 Expected regulatory response to potentially criminal acts         outside of the workplace .....</b>	<b>51</b>
<b>7. Breaching professional boundaries .....</b>	<b>58</b>
<b>8. Overarching themes.....</b>	<b>62</b>
<b>8.1 When does a clinical error become a criminal act?.....</b>	<b>62</b>
<b>8.2 Confidence in the medical profession and the GMC.....</b>	<b>66</b>
8.2.1 Impact of the Research Process .....	66
8.2.2 Impact of wrong-doing on confidence in medical profession.	66
8.2.3 Impact of GMC regulatory action (or lack thereof) following clinical errors on public confidence in the medical profession .....	67
8.2.4 Impact of GMC regulatory action (or lack thereof) following clinical errors on public confidence in the GMC.....	68
<b>Appendices.....</b>	<b>71</b>
<b>Appendix 1: Rapid Evidence Review .....</b>	<b>71</b>
1. Context.....	71
2. Overall approach .....	72
3. Agreed approach to sampling and recruitment.....	74
4. Scenario development.....	76
<b>Appendix 2: Qualitative sample .....</b>	<b>80</b>
<b>Appendix 3: Research instruments .....</b>	<b>82</b>

## 1. Executive summary

### 1.1 Objectives and methodology

In January 2018, the General Medical Council (GMC) announced that it had commissioned an independent review to “consider gross negligence manslaughter (GNM) and, in Scotland, culpable homicide (CH) in relation to the perceived vulnerability of the medical profession to charges of GNM/CH.” This research has been designed to provide evidence to inform the independent review. More specifically, it aims to explore how the public expect the GMC to respond to specific behaviours/acts/omissions by doctors, particularly when these behaviours/acts/omissions have also been subject to action through the criminal justice system.

Consideration was given to the following questions:

- What behaviours/acts/omissions by doctors are likely to affect public confidence in the medical profession if not acted upon by the regulator?
- To what extent are public expectations regarding regulatory action influenced by the intrinsic seriousness of the behaviours/acts/omissions and/or the consequences of the behaviours/acts/omissions? So, for instance, does the question of whether serious medical errors caused significant harm to a patient impact on public expectations around regulatory action?
- Are there behaviours/ actions/omissions which would be regarded as so bad as to be incompatible with future practice as a doctor even if there is no question mark over the doctor’s ongoing medical skill and knowledge?
- To what extent are public expectations regarding regulatory action influenced by the context of the behaviours/acts/omissions (e.g. making a sequence of serious errors whilst working under considerable workload pressure)?
- To what extent are public expectations of regulatory action influenced by the consequences of the regulatory action itself (for instance, taking a skilled doctor out of the workplace)?
- What are the public’s expectations of the GMC where a doctor has been convicted of a criminal offence? In particular, to what extent is public confidence in the individual’s fitness to practise affected by the fact and nature of the conviction (e.g. a custodial sentence related to medical practice compared with a fine for affray) as opposed to the behaviour/actions/omissions which led to the criminal conviction?

To meet the project objectives effectively, a programme of qualitative and quantitative research was undertaken. The quantitative element provided the required level of statistical robustness for the research and the qualitative research provided an in-depth insight that no fully structured questionnaire could ever have achieved. Scenarios were used to explore the complex issues set out in the objectives.

Community Research undertook the following research activities:

- A series of 11 x 2 hour face to face and 3 online focus groups covering the four countries of the UK.
- An online survey with a nationally representative sample of 2,074 members of the public across England, Scotland, Wales and Northern Ireland.

## **1.2 Key findings**

### ***Confidence in the medical profession***

The research indicates 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 research further suggests that this level of confidence in the wider medical profession may be driven by the level of care provided by individual doctors. Detailed knowledge and understanding of regulation was relatively low. Whilst almost three quarters of the survey sample (74%) had heard of the GMC prior to taking part in the online survey, very few felt that they 'already knew a great deal' (3%) or 'already knew quite a lot' (14%) about the role of the regulator.

The qualitative 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 Bawa-Garba case, though none remembered her name. Rather people recalled media stories of wider, generic system pressures in the NHS, and local cases of misdiagnosis.

### ***Clinical errors including relationship to the criminal law***

The research indicates that, patient outcomes being equal, the public generally responded less stringently to a series of clinical errors set in a wider context (including mention of the doctor being very busy and relying on a more junior colleague) than they did to a one-off clinical error committed by a doctor in a position of authority.

The patient outcome of a clinical error has a notable effect on public reactions. The proportion of respondents who said that the GMC should strike off or suspend the doctor involved in a one-off clinical error rose from 19% (when the outcome of the error was not stated) to 67% (when the outcome was reported to be patient death). The public struggles to extricate the seriousness of the result from the seriousness of the mistake.

That said, even where a mistake results in patient death, the public do not automatically expect a doctor to be struck off; many called for a lesser sanction because: the doctor did not act maliciously; mistakes are a natural part of learning, and medicine is a high-stakes profession; doctors may still be able to practise safely; errors might, in part, be down to systemic pressures.

In response to a conviction of GNM or CH resulting in a prison sentence, well over half of respondents called for doctors to be struck off.

- In the scenario involving a one-off clinical error, 62% of the sample in England, Wales and Northern Ireland expected the doctor to be struck off (in response to a GNM conviction) and 60% expected this in Scotland (in relation to a CH conviction);
- In the scenarios involving a series of clinical errors committed against a backdrop of system issues, 62% of the sample in England, Wales and Northern Ireland expected the doctor to be struck off (in response to a GNM conviction) and 49% expected this in Scotland (in relation to a CH conviction).

However, the research also suggests that the public in England, Wales and Northern Ireland would be less inclined to expect a doctor to be struck off for receiving a suspended sentence.

- In the scenario involving a one-off clinical error, 41% of the sample in England, Wales and Northern Ireland expected the doctor to be struck off (in response to a suspended sentence for a GNM conviction)
- As one survey respondent explained *"Being found guilty and going to prison reflects the entire circumstances of what happened. If the sentence was suspended then there would be mitigating factors which led to what happened."*

The research asked members of the public about the relative importance of aggravating and mitigating factors. Two factors stand out as being particularly important aggravating factors which members of the public believed the GMC should take into account when considering cases of clinical error – the doctor falsifying patient records to avoid blame; and the outcome of the case being that the patient died. Both of these factors are seen as considerably more important than whether or not the doctor in question is convicted of a criminal offence.

### ***Criminal acts other than those relating to clinical errors***

The research suggests that the public does not automatically expect the GMC to have involvement 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 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.

When considering scenarios where doctors have committed potentially criminal acts in a non-work context, the more 'relaxed' view of the behaviours was more frequently expressed. As well as considering whether the doctor has harmed another person, it is expected that the GMC should base its response on whether the criminal behaviour had the potential to affect the doctor's ability to practise safely and effectively, whether there was a pattern of criminal behaviour, or whether the behaviour suggested the doctor was dishonest, aggressive or deceitful in character. A conviction and sentence had no more of an effect on public expectations of regulatory action than the criminal act and the circumstances surrounding it.

### ***Breaching professional boundaries***

Responses to scenarios on potential breaches of professional boundaries vary depending on individual's judgements about whether the behaviour has fallen below expected professional standards. For example, there was divided opinion over whether a relationship between a doctor and patient was 'allowed' or not, and therefore a spread of opinion regarding the expected GMC response.

Scenarios involving posting patient anecdotes on Facebook and misuse of NHS funds were clearly seen as wrong. These both called for regulatory action, but more so for misuse of funds as it implied dishonesty (not merely naivety) – a characteristic incompatible with what is expected of a doctor.

### ***Overarching themes***

For most members of the public, there appear to be two main components for a clinical error to be considered criminal – the act, and its effect.

- The act needs to be intentional, deliberate or reckless.
- The effect needs to be an outcome of grave and lasting harm or death.

Any attempts by a doctor to cover up, falsify or blame others for clinical errors also led to the public seeing criminality.

Cases of clinical errors and wrongdoing may do little to affect most people's confidence in the medical profession. The public tends to believe that the vast majority of doctors are there to do good, albeit that there are concerns about doctors' ability to provide the best care in the context of an under-resourced system.

The public starts with little knowledge of the GMC and its work to regulate doctors, and few have cause to question confidence in the regulator. There was a split in opinion on the impact of lenient regulatory action on confidence in the GMC. Some trusted the GMC to have thoroughly investigated the evidence, and to make the best decision regarding a doctor's ongoing fitness to practise. Others felt more lenient action than expected would cause them to doubt the GMC.

## 2. Background, objectives and methodology

### 2.1 Background

In January 2018, the General Medical Council (GMC) announced that it had commissioned an independent review to “consider gross negligence manslaughter (GNM) and, in Scotland, culpable homicide (CH) in relation to the perceived vulnerability of the medical profession to charges of GNM/CH.” The instigation of the review followed concern within the profession regarding two recent high profile cases involving doctors.

The review, which will be reporting in early 2019, is focused on considering how the GMC should handle such cases in future. In particular it is focused on considering the relationship between the criminal processes for GNM/CH and the professional regulatory process. Whilst not revisiting the two cases in question, the review is also considering the wider questions and issues that were raised by those cases.

One such issue which is specified in the review’s terms of reference is “[t]he meaning, appropriateness and measurement of ‘public confidence’ as an objective of the regulatory process.” The terms of reference goes on to state that this “will include understanding patient and public expectations of regulatory processes after a practitioner has been convicted of a criminal offence.” It is through exploring the concept of ‘public confidence’, including where a practitioner has been convicted of a criminal offence, that this research will help to inform the review.

A further point of note is the reference in the final judgement of the Bawa-Garba case<sup>1</sup> 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”.

### 2.2 Research objectives

This research has been designed to provide evidence to inform the independent review. More specifically, it aims to explore how the public expect the General Medical Council (GMC) to respond to specific behaviours/acts/omissions by doctors, particularly when these behaviours/acts/omissions have also been subject to action through the criminal justice system.

Consideration was given to the following questions:

- What behaviours/acts/omissions by doctors are likely to affect public confidence in the medical profession if not acted upon by the regulator?

---

<sup>1</sup> <https://www.judiciary.uk/wp-content/uploads/2018/08/bawa-garba-v-gmc-final-judgment.pdf>

- To what extent are public expectations regarding regulatory action influenced by the intrinsic seriousness of the behaviours/acts/omissions and/or the consequences of the behaviours/acts/omissions? So, for instance, does the question of whether serious medical errors caused significant harm to a patient impact on public expectations around regulatory action?
- Are there behaviours/ actions/omissions which would be regarded as so bad as to be incompatible with future practice as a doctor even if there is no question mark over the doctor's ongoing medical skill and knowledge?
- To what extent are public expectations regarding regulatory action influenced by the context of the behaviours/acts/omissions (e.g. making a sequence of serious errors whilst working under considerable workload pressure)?
- To what extent are public expectations of regulatory action influenced by the consequences of the regulatory action itself (for instance, taking a skilled doctor out of the workplace)?
- What are the public's expectations of the GMC where a doctor has been convicted of a criminal offence? In particular, to what extent is public confidence in the individual's fitness to practise affected by the fact and nature of the conviction (e.g. a custodial sentence related to medical practice compared with a fine for affray) as opposed to the behaviour/actions/omissions which led to the criminal conviction?

## 2.3 Methodology

### *Overall approach*

To meet the project objectives effectively, a programme of qualitative and quantitative research was undertaken. The quantitative element provided the required level of statistical robustness for the research and the qualitative research provided an in-depth insight that no fully structured questionnaire could ever have achieved. Both elements of the research were informed by a rapid literature review (see Appendix 1) which informed both the sampling and recruitment, as well as the development of scenarios to be used in the research.

Scenarios were used to explore the complex issues set out in the objectives and focussed on:

- A doctor making one or more serious clinical errors.
- A doctor engaging in behaviour that may be regarded negatively (and could be criminal) but is confined to their life outside medicine.
- A doctor having inappropriate sexual relationships with a patient.
- A doctor breaking professional boundaries.

The full set of scenarios used for both the qualitative and quantitative research elements can be found in Appendix 4. All scenarios were developed in conjunction with the independent review team.

### ***Qualitative approach***

Community Research undertook a series of 11 x 2 hour face to face and 3 online focus groups across the four countries of the UK. The sample was designed to obtain the views of a cross section of the public, in terms of: lifestage, ethnicity, socio economic grade, and frequency of visiting the doctor.

In addition to seeking the view of a cross section of the public, there were specific focus groups conducted with:

- Minority ethnic groups who were considered to have poorer health outcomes than the general population.
- Individuals living with long term health conditions.
- Individuals with extensive, informal, caring responsibilities.
- Individuals who have previously raised a complaint about a medical professional.

The full rationale for the sample design can be found in the rapid literature review (Appendix 1) and a complete breakdown of the qualitative sample can be found in Appendix 2.

#### **Participant recruitment**

Two independent specialist market research recruitment agencies, Saros Research Ltd and Criteria Fieldwork Ltd recruited a diverse spread of members of the public to the agreed specification. These participants were either 'free found' via traditional telephone or face to face recruitment methods or, the more specific audiences, were found via a nationwide database of approximately 40,000 individuals who had actively signed up to take part in market research studies.

The 2 hour focus groups followed a semi-structured discussion guide, which included the exploration of 2 clinical and 2 non-clinical scenarios (set out in Appendix 4). These scenarios were rotated across the groups, in order to mitigate against order bias.

### ***Quantitative approach***

An online survey was conducted with a nationally representative sample of 2,074 members of the public across England, Scotland, Wales and Northern Ireland.

Community Research was responsible for the survey design and analysis of the data; whilst the data collection, survey mechanics and sample management was managed by Populus Data Solutions.

#### **Respondent recruitment**

The quantitative survey of 2,074 members of the public was conducted via PopulusLive. This is Populus Data Solutions' panel of approximately 130,000

active panel members. Quotas were set by the four countries in the UK to ensure that the findings are nationally representative of the public at large.

The total sample for the survey was 2,074. The sample size in each nation within the UK was as follows:

England	Scotland	Wales	Northern Ireland
824	529	515	206

The size of the samples in Scotland, Wales and Northern Ireland were boosted to ensure that analysis by each nation would be possible. The total sample data was then weighted to ensure that results were nationally representative for the UK as a whole.

Quotas were set to ensure that the sample was representative in terms of age, gender and socio-economic group. The proportions applied to the quotas were provided by Populus Data Solutions in line with their standard approach to polling for nationally representative samples in the UK.

The quantitative survey results come from a sample of 2,074. For a question where 50% of a sample responds with a particular answer, the chances are 99 in 100 that this result would not vary more than + or – 2.8% from the result that would have been obtained from a census of the entire adult population of the UK. Strictly speaking, these tolerances apply only to random samples with an equivalent design effect. Although the Populus panel itself is non-random, given that we are sampling a random group within this, it is accepted statistical and industry practice to treat the sample as random and apply the confidence interval tests as described.

Different groups within a sample (e.g. men and women) may have different results for the same question. A difference has to be of a certain size in order to be statistically significant though. Throughout the analysis of the survey data we tested if a difference in results between two sub-groups within the sample was a statistically significant one, at the 99% confidence interval. This is a high threshold but it was applied purposefully given the importance and likely scrutiny attached to this project. Where differences are not significant at this level they have not been drawn out within the findings. Again, strictly speaking the tests for significance apply only to random samples but in practice they are used as a helpful rule of thumb to decide whether findings should be highlighted or not.

Each survey respondent was asked to give their views on 1 clinical and 1 non-clinical scenario. Two of each type of scenario was developed therefore each scenario was seen by half of the sample (see Appendix 4). The survey also

included a Max Diff question aimed at giving order to mitigating and aggravating factors that respondents believed the GMC should take into account when considering what action to take against a doctor.

Max Diff is an approach for obtaining preference/importance scores for multiple items. Max Diff is also known as "best-worst scaling." Scores from such exercises can demonstrate greater discrimination among items and between respondents. Respondents make choices rather than expressing strength of preference using a numeric scale. This can make it easier for respondents, as well as for researchers in interpreting the feedback. The approach is described in more detail at Section 8.1.

## **2.4 Notes on reading the report**

Throughout the report, members of the public who took part in the qualitative phase are termed 'participants' and those who took part in the quantitative phase are termed 'respondents'.

The report includes direct quotes from respondents and participants. The quotes are anonymised. Quotes from focus group participants are attributed according to the demographics of the group. This includes lifestage, location, and socio-economic grouping. The latter are defined in Appendix 2. Quotes from bulletin board participants are attributed according to their status as carers, people with long-term conditions, or people who have previously made a complaint about a healthcare professional ('complainants').

Whilst everything is done to ensure that a broad cross section of the general public is reached, including the payment of incentives, there is an inherent risk with all research that those individuals who actively choose to participate are somehow different to overall the population.

Readers should note that the different research formats have implications for interpretation of the findings, particularly in the context of such a complex subject matter. There were differences both in the amount of time participants had to consider the issues, and in the opportunity to hear different viewpoints. There were some differences in responses from the quantitative and qualitative research elements. There are a number of possible explanations for this:

- In focus groups, participants had two hours to consider the issues and discuss them in depth. They were also able to listen to others' perspectives and develop their own views;
- In the bulletin board, participants considered the issues over the course of a week. They initially gave individual responses to questions, and then were able to see and consider the responses of other participants;

- In the quantitative research, participants were answering an online survey individually, and did not have the opportunity to hear others' views on the issues.
  - The signs are that survey respondents were highly engaged in the subject matter as, on average, respondents took 28 minutes to complete the survey (which was timed at 15 minutes when programmed based on the number of questions). There was limited drop-out and no complaints about the length of the survey in spite of it taking longer to complete than a typical online survey. This suggests that the vast majority of respondents were taking their time to consider the issues and their answers.

It should, therefore, be noted that the findings in this report are based on the views of people who have considered the issues in greater depth, for more time, and with more information than members of the public who consider the issues in the course of their day-to-day lives. The wider general public's views may often be based solely on media headlines rather than more detailed information. Given the need to ensure that public confidence is viewed in light of the views of "a fully informed and reasonable member of the public" (as outlined in Section 2.1), this makes the results useful and relevant to the independent review, albeit not necessarily representative of a less informed public view.

### 3. Context

#### Summary:

The research indicates 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'.

Research further suggests that this level of confidence in the wider medical profession may be driven by the level of care provided by individual doctors. Detailed knowledge and understanding of regulation was relatively low. Whilst almost three quarters of the survey sample (74%) had heard of the GMC prior to taking part in the online survey, very few felt that they 'already knew a great deal' (3%) or 'already knew quite a lot' (14%) about the role of the regulator.

The qualitative 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 recalled the Bawa-Garba case, though none remembered her name. Rather people recalled media stories of wider, generic system pressures in the NHS, and local cases of misdiagnosis.

#### 3.1 Attitudes towards own doctors

Across the qualitative sample, many participants praised their own current doctors (both in primary and secondary care).

However, many participants were quick to qualify their high ratings: not all doctors they had seen had inspired confidence, and most agreed standards varied in the medical profession. Former and current experiences shaped individuals' confidence in their doctors. Factors that inspired and undermined confidence in an individual doctor are shown in the table below.

Inspires confidence in individual doctor	Undermines confidence in individual doctor
Knowledgeable about patient's condition and treatment options	Little or no knowledge – 'Googling' symptoms, asking patient for their opinion, hasn't read notes before appointment
Listens, pays attention, approachable empathetic, caring	Staring at screen, no eye contact, little empathy, uncaring
Gives time, goes the extra mile, explains things	Appears dismissive or hurried, brushes over details

Links in with other healthcare professionals	No communication with other professionals; contrary advice
Accurate diagnosis, prescribing effective treatment	Diagnosis or treatment advice questioned by other professionals e.g. pharmacist
Long-term relationship	No prior relationship; locum/ on-call

**Figure 1: Factors that inspire and undermine confidence in individual doctors.**

*"I absolutely love my doctors. They are very thorough and seem to have my best interests at heart. They don't just diagnose problems but help me understand issues too." (Carer, Bulletin Board)*

*"I just know, I get the feeling anyway, that he's switched on and he knows what he's talking about. And he cares about me. Instant confidence." (Retiree, ABC1, Newport)*

*"My experience with doctors is positive, but because I've avoided the ones that I know are rubbish." (Empty Nester, ABC1, Manchester)*

In some groups, particularly retired participants in lower socio-economic groups and Bangladeshi women, participants held all doctors they had seen in high regard. Some mentioned a historic attitude of deference towards professionals (and doctors in particular), and said that they had had no cause to doubt their trust in doctors.

Bulletin board participants who had previously made a complaint against a healthcare professional rated their doctors the least favourably. For most in this group, their experiences (including medical negligence, missed and mis-diagnosis, lack of knowledge, delayed referrals) had had a lasting impact on their trust in their doctors:

*"Having had a problem with medical negligence in the past with my daughter, trusting the medical profession is something I struggle with." (Complainant, bulletin board)*

In most groups, participants were quick to say that system pressures caused some dissatisfaction, over and above the quality of care from individual doctors. In particular they mentioned:

- 10-minute GP appointments being too short;
- Long waiting times for GPs and long referral times for secondary care;
- Under-staffing (especially shortage of doctors);

- Doctors' working long hours;
- Poor communication between primary and secondary care and departments;
- Bed shortages;
- 'Red-tape' and paperwork.

Many blamed system pressures as the reason why they do not always have the best care from doctors. Most participants expressed empathy for doctors, saying they were doing a very difficult job under real pressure.

*"I've got more empathy with doctors in general, whether it be hospital or GPs. I do think they work hard but I think they are completely over stretched, and the job role is unmanageable." (Pakistani man, Birmingham)*

*"If I have to go to the hospital, [the satisfaction score for doctors is] generally lower. But it's not normally their fault. You can see they are stressed. I ended up in A&E once this year and I spent 6 hours and by the time I got in there and you could tell was just stretched too thin. And they are just knackered, and they can't help it, but they will do their best. Others, they just don't care. They're done with it. Don't want to be there anymore." (Pre-family, C2DE, Newport)*

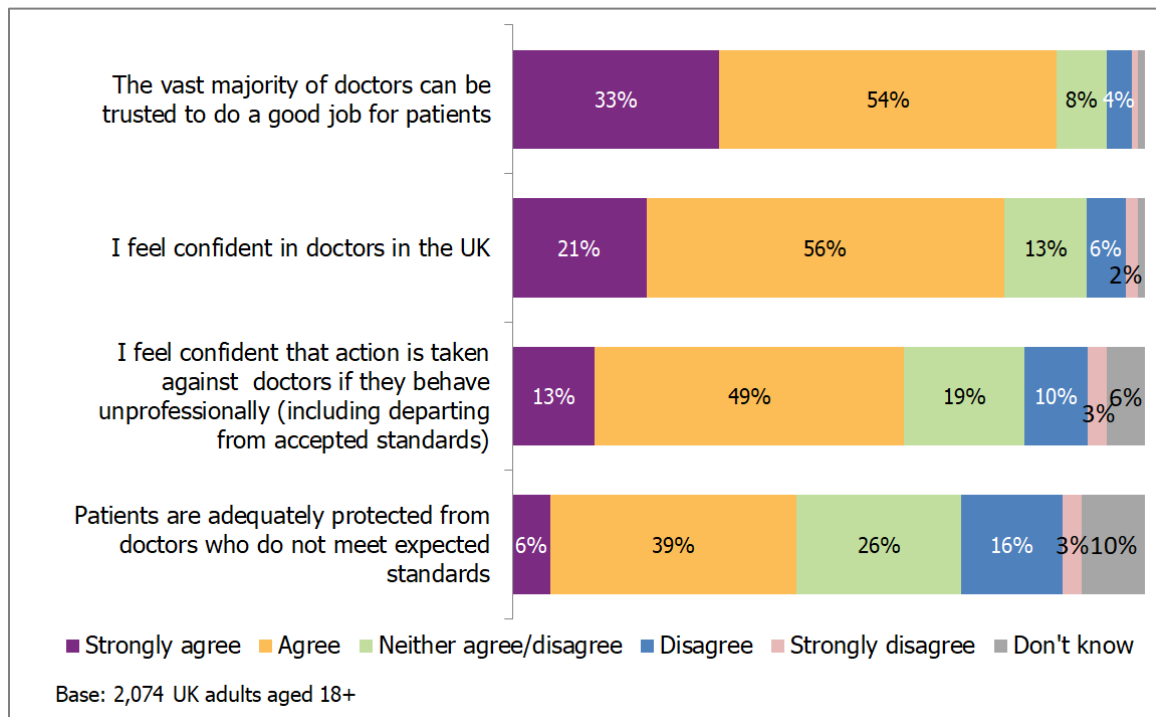
### **3.2 Confidence in the medical profession as a whole**

The survey showed that respondents have high levels of confidence in the majority of medical professionals. Figure 2 shows the levels of agreement and disagreement with a series statements related to this confidence. Whilst 87% of respondents agreed (54%) or agreed strongly (33%) that the majority of doctors can be trusted to do a good job, and 77% agreed (56%) or agreed strongly (21%) that they are confident in the UK's doctors. Older patients were more likely to agree or agree strongly with these statements than those from younger age groups.

There were higher levels of neutral opinion, disagreement and / or uncertainty when it came to feeling confident that action is taken if doctors behave unprofessionally and that patients are protected from sub-standard doctors. As Figure 2<sup>2</sup> shows, over half (55%) of the sample expressed either a neutral opinion, disagreement or said 'don't know' in response to the statement *"patients are adequately protected from doctors who do not meet expected standards."*

---

<sup>2</sup> Throughout the report, in charts showing quantitative survey results, percentages of 2% or below are not always labelled.



**Figure 2: Q1. To what extent do you agree or disagree with the following statements about the medical profession?**

The qualitative research also highlighted that confidence in the wider medical profession was generally high – in large part based on participants’ personal experience of care from doctors – mostly, they (and people they know) usually had positive outcomes in terms of their diagnosis, treatment and recovery.

In addition to this ‘personal experience’ a number of other, more subconscious, factors contributing to confidence in the wider medical profession are outlined below:

- A belief that doctors go into the profession to do good, and have the best interests of their patients at heart;
- Trust in doctors’ expertise – they know more than us, so there’s no choice but to trust them!;
- Doctors have had years of training;
- Doctors take an oath to ‘do no harm’, and they have a duty of care to patients;
- Awareness that the medical profession is ‘licensed’ – doctors have to have a licence to practice, and this licence can be taken away;

- A (historic) culture of trust in professions (especially doctors).

However, for some, significantly negative personal experiences and awareness of system pressures have potential to erode this confidence.

With regards to system pressures, media coverage (and some personal experience) of issues such as waiting times and understaffing (especially in A&E) meant that they were less confident doctors would be able to provide the best care. They felt that – while doctors would do the best they could – system pressures might force errors.

A minority of participants (mostly amongst those who had previously made a complaint against a healthcare professional) did not have confidence in the medical profession as a whole. Their own experiences (of missed/mis-diagnosis, medical negligence and delays in referrals) had been significant enough to undermine their confidence in the whole profession. Likewise, in the online survey a minority – only 8% – disagreed (6%) or disagreed strongly (2%) with the statement *"I feel confident in doctors in the UK."*

### **3.3 Awareness and understanding of regulation of the medical profession and sanctions**

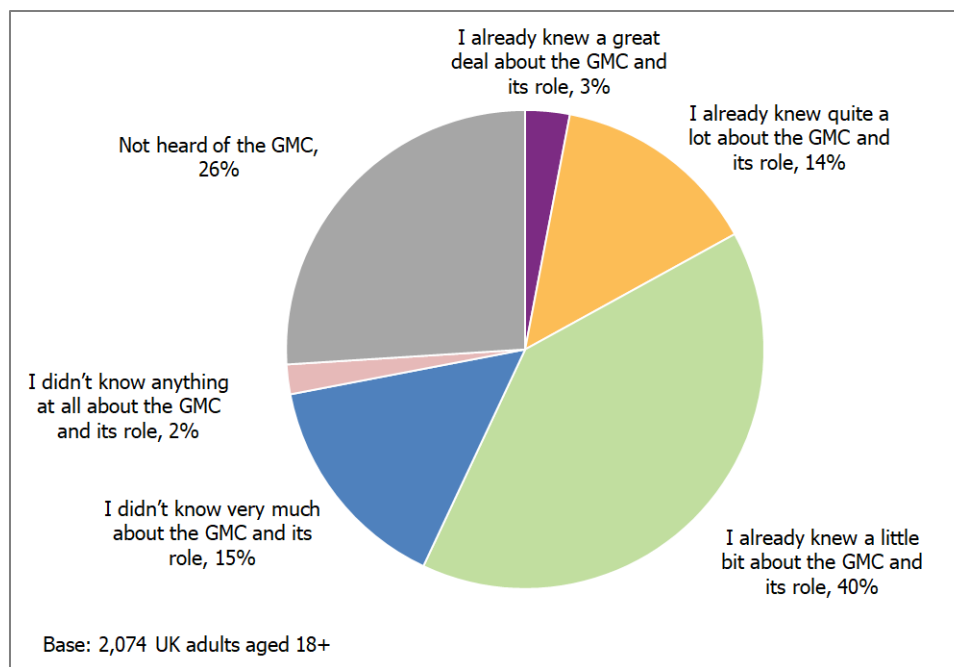
When asked about regulation of doctors in the qualitative research, participants assumed that doctors would be regulated by a governing body, much in the same way as other professions (police officers, teachers) are regulated. Participants expected doctors to be closely regulated because the stakes are high in their profession – they deal with human lives.

Beyond an assumption or belief that doctors are regulated, few participants felt confident they knew *how* doctors were held to account, or how patients could raise concerns over a doctor's behaviour. Some participants (especially those who had previously made a complaint) made reference to the complaints process – going through the practice manager or NHS Trust to challenge a doctor's actions.

Participants were also unsure of sanctions a doctor could face if they fell below professional standards. A number of participants talked of doctors being 'licensed' and that they could have their licences taken away. On further prompting, many participants knew that doctors could be 'struck off' (because this is what happened in some high profile cases of wrongdoing).

### 3.4 Awareness and understanding of the GMC

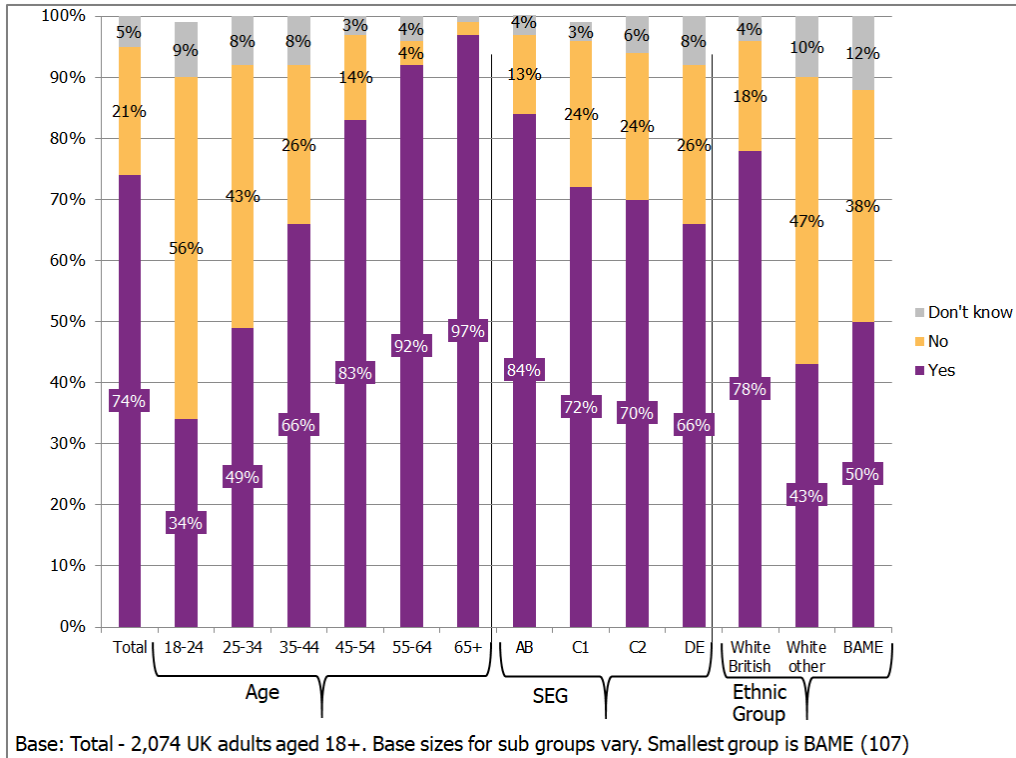
As Figure 3 illustrates, nearly three quarters of the survey sample (74%) had heard of the GMC prior to taking part in the online survey. However, very few felt that they already knew a great deal about the role of the regulator (3%). Just over half the sample (54%) felt they knew a little bit (40%) or a quite a lot (14%) about the role of the GMC; while 15% said they didn't know very much and 2% admitted they knew nothing at all about the GMC and its role.



**Figure 3: Q2. Prior to taking part in this research, had you heard of The General Medical Council? Q3. And how much, if anything, did you understand about the role of the GMC?**

Very few participants in the qualitative research spontaneously named the GMC as the regulator for the medical profession. However, when prompted, many participants said they had heard of the GMC, though awareness was lower amongst Bangladeshi women and pre-family participants.

The survey results, 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). These results are illustrated in Figure 4.



**Figure 4: Q2. Prior to taking part in this research, had you heard of The General Medical Council? Analysis by sub groups.**

Participants in qualitative research had limited knowledge of the GMC’s powers. Most who had heard of the GMC knew it could strike doctors off for ‘malpractice’ or ‘violating their duty of care’. However, it was generally assumed that this only happens in extreme cases. Some also talked about the GMC having powers to suspend doctors and to require doctors to retrain.

For the majority of participants, the GMC was remote. They wouldn’t know how to contact the GMC and would not think of them as a first port of call if they were dissatisfied with a doctor.

Notably, because the GMC and regulatory action are not top of mind for most participants at the start of discussions, it has a negligible effect on their confidence in the medical profession.

*"I didn't know who they were till this study... so I'd say I wouldn't know if they were or weren't maintaining public confidence in doctors... Personally I trust my doctor... and trust the system that trained them. It's a bonus knowing there is the GMC and how it operates so my confidence is more or less the same." (Carer, Bulletin Board)*

When they find out more about the GMC and the range of sanctions it can impose, most participants are reassured to know it is there and that it can take strong action against doctors who do wrong.

*"It's quite refreshing, that GMC, because it's very difficult to challenge a professional, isn't it? You can't say to a doctor 'you've diagnosed me wrong or given me the wrong medication, how are you to tell him?' So that's quite refreshing to know you've got the GMC to go to." (Family lifestage, C2DE, Northampton)*

Some participants who had had negative experiences of doctors said that they wished they had known that the GMC was there when they were going through the complaints/ litigation process (or considering it). They felt that the GMC would have helped their case in holding the doctor to account.

Finding out more about the GMC raised questions for some participants, including:

- How do cases come to the GMC's attention?
- How does it link in with local procedures (such as incident reporting and complaints)?
- Who is on decision-making panels – is it the panel all doctors? Some assumed that it would be made up of 'doctors protecting their own' or 'doctors marking their own homework'.
- How long do sanctions last, and what impact do they have on doctors?
- Is there a higher body to hold the GMC itself to account?

For some participants, these questions raised doubts about thoroughness and effectiveness. In particular, they questioned how the GMC could monitor the actions of *all* doctors and take action on *all* errors or wrongdoing. They worried that some cases would slip through the net or be 'swept under the carpet'. This concern is perhaps exacerbated because participants had little understanding of other mechanisms for holding doctors to account, such as supervision, revalidation, incident reporting, and local complaints processes.

Bulletin board participants who had made a complaint against a healthcare professional had lower confidence in the GMC holding doctors to account.

### 3.5 Spontaneous awareness of cases of wrongdoing

Cases of wrongdoing by doctors were not front-of-mind for participants in the qualitative research, and they struggled to recall individual cases. When participants did recall individual cases of wrongdoing, they tended to be more historic. These included cases of Harold Shipman, a surgeon inscribing initials on the livers of two patients, and an unregistered psychiatrist practising for a number of years. Across the qualitative sample, there were only three mentions of the Bawa-Garba case, though no-one could recount the case in much detail.

Media coverage of such cases was said to have little impact on participants' confidence in the medical profession as a whole, for a number of reasons:

- Cases of wrongdoing were seen as 'one or two bad apples'. Participants strongly believed that the vast majority of doctors have good intentions and are doing the best they can;
- Participants were sympathetic to doctors working under extreme pressure, and were quick to blame errors on long hours, poor communication and under-staffing, rather than inadequacy of doctors;
- Participants felt that they can't trust the media to tell the full story, that they sensationalise facts in cases, and that they only publish 'bad news'.

*"I feel like the media hypes those up... But we don't know the ins and outs of these cases. And I think the media blows them up massively." (Pre-family group, C2DE, Newport)*

*"I guess you only hear the bad press really. You only hear about doctors when they've done something wrong, or they have lapsed." (Pakistani man, Birmingham)*

A small minority of participants said that media coverage of some system pressures did make them question care they would receive from doctors in hospitals (especially A&E), but again – they blamed this on the system, not the individual doctor.

## 4. Introduction to scenario-based approach

### 4.1 Testing scenarios of wrong-doing - research approach

The independent review wished to understand participants' expectations of regulatory action in response to a range of types of wrongdoing. It was also important to explore the impact of circumstances, mitigating factors, and aggravating factors. To achieve this, a series of scenarios was used featuring doctors involved in different aspects of wrongdoing. These were loosely based on real-life cases, albeit anonymised and with some details added or changed. The purpose of this scenario-based approach was to enable participants and survey respondents to relate to the situation and think through its complexities, which is easier than considering a concept in abstract.

To develop the scenarios, Community Research undertook a rapid evidence review (see Appendix 1). The selected scenarios covered the following areas of wrong-doing:

- Clinical errors that could lead to a conviction for gross negligence manslaughter (in England, Wales and Northern Ireland) or culpable homicide (in Scotland);
- Engaging in behaviour that may be regarded negatively (and could be criminal) but is confined to the doctor's life outside medicine;
- Breaking professional boundaries (including having inappropriate sexual relationships with patients).

In the qualitative research, there were eight scenarios. There were two scenarios involving errors in clinical practice, and all groups considered both (the order of the scenarios was rotated between groups to mitigate against order bias). Each group considered a further two of the scenarios unrelated to a clinical error.

In the quantitative research, respondents each considered one of two scenarios concerning wrongdoing unrelated to the doctor's clinical practice, and one of two clinical errors scenarios (the scenarios were split across the sample for both clinical and non-clinical scenarios, so that half of the sample saw each case study).

In both the qualitative and quantitative research, participants were asked to decide individually what action they would expect the GMC to take in this scenario (based on limited information). They were then introduced to a series of mitigating and aggravating factors ('what ifs') to gauge the impact of these factors on their expectations of regulatory action.

Scenarios differed between Scotland on the one hand and England, Wales and Northern Ireland on the other to reflect the differences in law between the jurisdictions. Participants were presented with the definition of either GNM (England, Wales and Northern Ireland) or CH (Scotland). Other offences and sentences were also adapted depending on the legal jurisdiction. The presentation of scenarios and aggravating and mitigating factors differed slightly between the qualitative and quantitative research in order to make the process more manageable within the online survey environment.

**Note:** All scenarios were presented in the research as gender neutral – they did not specify whether the doctor was male or female. Facilitators were also careful to ensure they used gender neutral language in talking about the scenarios. However, in many cases, participants assumed the doctor was male, and this is sometimes reflected in direct quotes from participants.

#### 4.2 Factors affecting response to scenarios

In considering scenarios in the qualitative research, participants approached the scenarios from different starting points. A number of factors influenced their starting positions, including:

- **Cultural attitude towards doctors/ professions** – a minority (notably amongst older men and Bangladeshi women) had an attitude of greater deference and were less likely to question a doctor's actions in the workplace;
- **Own work experience** – participants who were part of another profession (e.g. teachers, police officers, solicitors) talked more about professional standards, both inside and outside of work. Those who were (or had been) managers talked more about workplace processes and protocols guiding behaviour at work, and showed more understanding of the impact of workplace pressures on decision making;
- **Personal relationships with doctors/people working in the NHS** – people who knew doctors and other health professionals had more empathy with doctors and a degree more understanding of systems, processes and pressures;
- **Personal experience of care** – 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;
- **Attitudes towards mistakes in medical practice** – some participants held the view that mistakes are an inevitable – and acceptable – part of the learning process in medicine. Others felt any mistakes were unacceptable when doctors 'hold our lives (and livelihoods) in their hands'.

- **Level of empathy** – some participants found it easier to put themselves in the shoes of the people involved (whether doctors, patients or other staff). They were more sympathetic to system pressures and more forgiving of human errors.

These factors affected how participants in the qualitative research reacted to the act/ omission/ behaviour itself, how receptive they were to circumstances, and the regulatory action they favoured. Participants appreciated the complexity and nuances of the scenarios – most found it hard to make decisions on the scenarios and were quick to look for explanations and mitigating factors. However, a small minority of participants approached scenarios with a more 'black-and-white' attitude and expected a more hard-line regulatory approach.

Having observed these differences within the qualitative element of the research, there was a remarkable degree of consistency in views across the public within the quantitative survey. Sub-group analysis of scenario responses revealed very few statistically significant differences.

## 5. Clinical errors including relationship to the criminal law

### **Summary:**

The research indicates that, patient outcomes being equal, the public generally responded less stringently to a series of clinical errors set in a wider context (including mention of the doctor being very busy and relying on a more junior colleague) than they did to a one-off clinical error committed by a doctor in a position of authority.

The patient outcome of a clinical error has a notable effect on public reactions. The proportion of respondents who said that the GMC should strike off or suspend the doctor involved in a one-off clinical error rose from 19% (when the outcome of the error was not stated) to 67% (when the outcome was reported to be patient death). The public struggles to extricate the seriousness of the result from the seriousness of the mistake.

That said, even where a mistake results in patient death, the public do not automatically expect a doctor to be struck off; many called for a lesser sanction because: the doctor did not act maliciously; mistakes are a natural part of learning, and medicine is a high-stakes profession; doctors may still be able to practise safely; errors might, in part, be down to systemic pressures.

In response to a conviction of Gross Negligence Manslaughter (GNM) or Culpable Homicide (CH) resulting in a prison sentence, well over half of respondents called for doctors to be struck off.

- In the scenario involving a one-off clinical error, 62% of the sample in England, Wales and Northern Ireland expected the doctor to be struck off (in response to a GNM conviction) and 60% expected this in Scotland (in relation to a CH conviction);
- In the scenarios involving a series of clinical errors committed against a backdrop of system issues, 62% of the sample in England, Wales and Northern Ireland expected the doctor to be struck off (in response to a GNM conviction) and 49% expected this in Scotland (in relation to a CH conviction).

However, the research also suggests that the public in England, Wales and Northern Ireland would be less inclined to want a doctor struck off for receiving a suspended sentence.

- In the scenario involving a one-off clinical error, 41% of the sample in England, Wales and Northern Ireland expected the doctor to be struck off (in response to a suspended sentence for a GNM conviction)
- As one survey respondent explained *"Being found guilty and going to prison reflects the entire circumstances of what happened. If the sentence was suspended then there would be mitigating factors which led to what happened."*

The research asked members of the public about the relative importance of aggravating and mitigating factors. Two factors stand out as being particularly important aggravating factors which members of the public believed the GMC should take into account when considering cases of clinical error – the doctor falsifying patient records to avoid blame; and the outcome of the case being that the patient died. Both of these factors are seen as considerably more important than whether or not the doctor in question is convicted of a criminal offence.

Participants in qualitative and quantitative research considered two scenarios relating to clinical errors. These were as follows:

<p><b>Scenario 1A:</b> Dr C instructed a doctor in training to inject an anticancer drug into a patient's spine. The drug should have been injected into a vein (<b>ADDED IN ONLINE SURVEY:</b> in the arm or leg) but Dr C had confused this drug with another that is given at the same time, which is injected into the spine.</p> <p>Within a few minutes Dr C realised they had made a mistake and was visibly shaken.</p> <p><b>QUALITATIVE ONLY:</b> The patient was luckily unharmed.</p>	<p><b>Scenario 1B:</b> A patient turned up at A&amp;E and was admitted to hospital due to a suspected kidney infection. Dr D saw the patient after they were admitted and prescribed them painkillers, and ordered a scan. At this point, Dr D decided to 'wait and see' instead of prescribing antibiotics for the suspected infection. Dr D was in charge of the patient's care but was very busy and therefore relied on a more junior colleague to keep them informed of the patient's condition. When it was first brought to Dr D's attention that the patient needed a surgical procedure it was revealed that the nearest doctor qualified to carry out the procedure was not at the hospital so Dr D decided that the procedure could wait until the morning. Dr D later admitted to having confused the patient with another patient with a less serious infection, (<b>ADDED IN ONLINE SURVEY:</b> also admitting that the surgery should have been prioritised for the same day).</p> <p><b>QUALITATIVE ONLY:</b> Two days later, after having to have an emergency procedure, the patient died.</p>
---	--

Figure 5: Clinical error scenarios

### 5.1 Expected regulatory response to clinical errors

For each scenario, participants were asked to choose an action they would expect the GMC to take based on the scale in Figure 6:

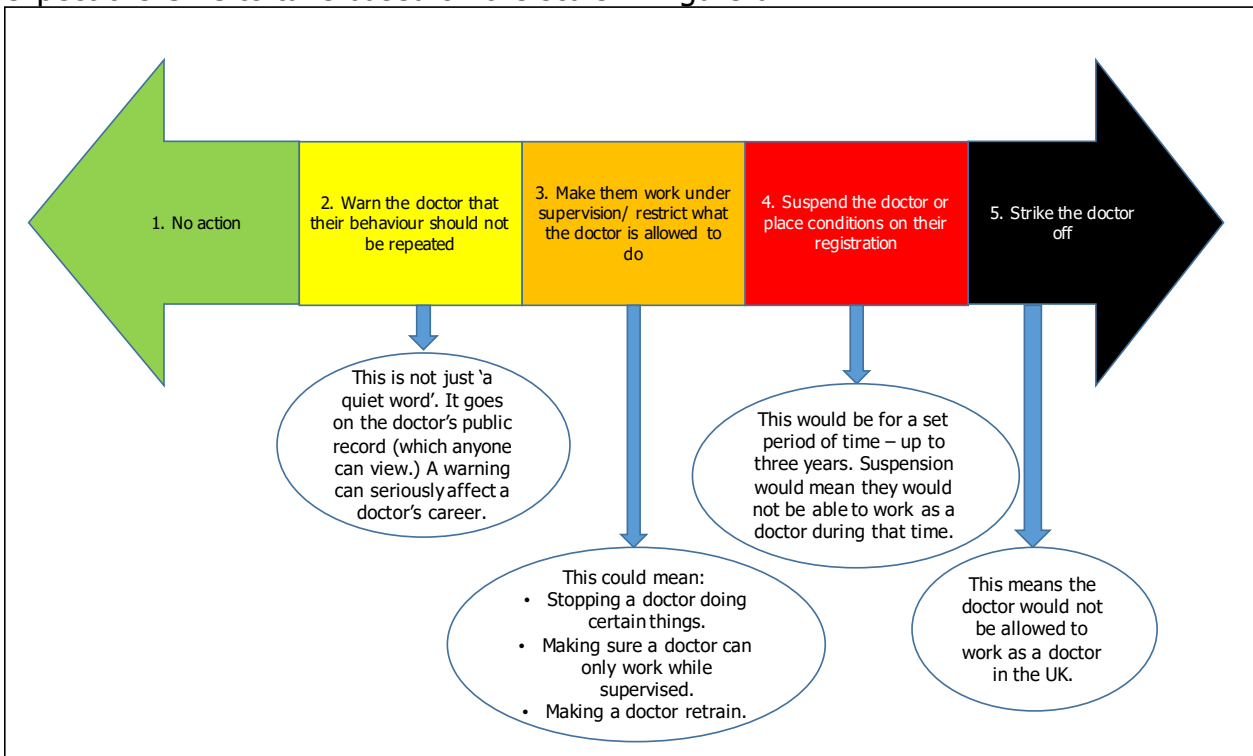
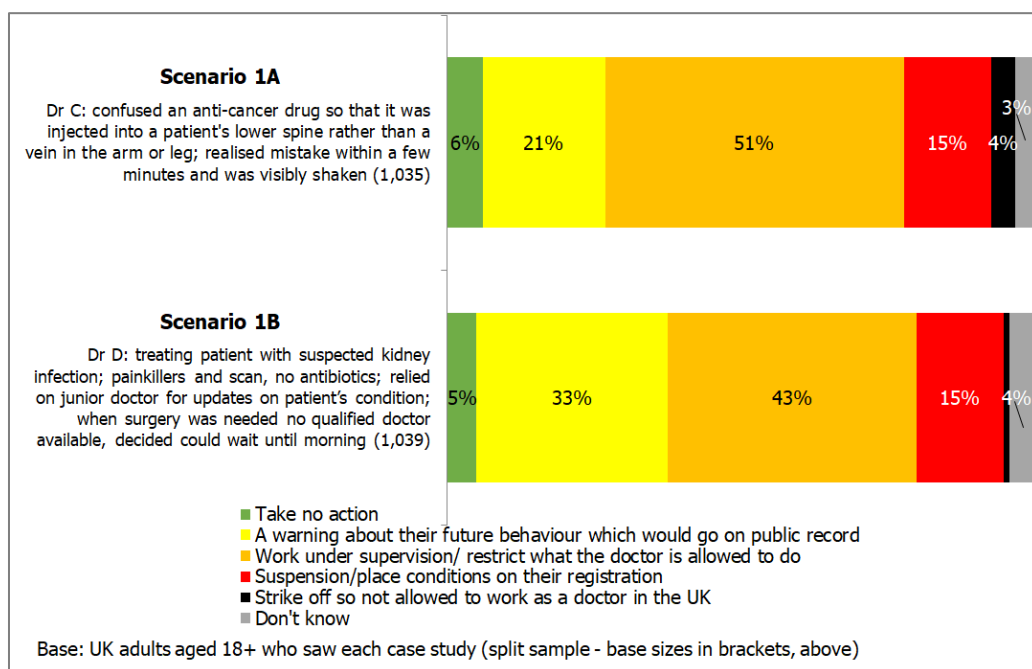


Figure 6: Scale for rating scenarios

As Figure 7 shows, in the quantitative research respondents' first expectations of regulatory action differed slightly for the two clinical error scenarios shown. A higher proportion of those seeing Scenario 1A suggested that working under supervision would be the expected action (51%) than was the case for Scenario 1B (43%), whilst a smaller proportion opted for a warning (21%) as the response to 1A as compared to 1B (33%). In addition a higher proportion of respondents (albeit still a small minority) suggested the doctor should be struck off under Scenario 1A (4%) as compared to Scenario 1B (just 1%). It should be noted that in the quantitative survey, at this stage, the two scenarios did not indicate any particular outcome for the patient. Scenario 1B with its wider context, including mention of the doctor being very busy and relying on a more junior colleague, received the less stringent response.



**Figure 7: Q9/11: What would you expect the GMC to do in these circumstances?**

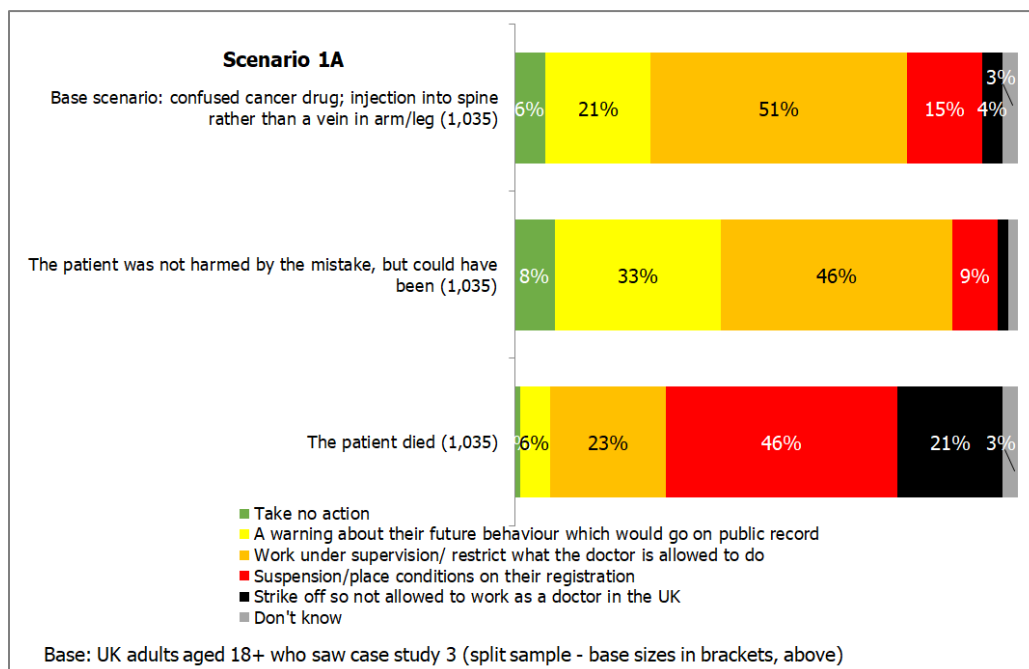
The responses to both clinical scenarios were remarkably consistent across all sub groups within the sample, with barely any significant differences evident at all. The degree to which people express confidence in doctors within the UK does appear to have some influence over the type of action expected by the GMC. Those who agreed or agreed strongly that they had confidence in doctors in the UK in general were more likely to suggest a warning in response to both scenarios (24% 1A and 36% 1B) than the minority of respondents who disagreed or disagreed strongly that they had this confidence (2% 1A and 15% 1B).

### 5.1.1 Impact of outcome

In the online survey the outcome for the patient had a clear and very strong impact on expectations of GMC actions. In the survey, respondents were first

presented with baseline scenarios without specific outcomes. In Scenario 1A, they were then asked how the outcomes of 'no harm' and of 'patient death' affected their expectations of regulatory action. As Figure 8 shows, outcome had a notable effect on respondents' expectations. The proportion of respondents who said the GMC should strike off or suspend the doctor was:

- 19% where the outcome was not explicitly stated;
- 10% if the patient has been unharmed; and
- 67% where the patient died (21% 'struck off'; 46% 'suspended').



**Figure 8: Impact of patient outcome on expectations of GMC response in relation to Scenario 1A (Q9. What would you expect the GMC to do in these circumstances? Q10. What would you expect the GMC to do in Dr C's case if .....?)**

Likewise, in Scenario 1B, 19% of survey respondents expected the doctor to be suspended or struck off when the outcome is not stated, falling to 10% where the outcome is no harm to the patient<sup>3</sup>.

Survey respondents were asked to give comments about why they chose the actions they did and what the GMC should consider in cases where things go wrong with a doctor's treatment of a patient. In relation to both scenarios there were frequent comments related to the unacceptability or seriousness of a

<sup>3</sup> Survey respondents considering Scenario 1B were not asked to consider an outcome of patient death separately. Instead they were asked about an outcome of patient death resulting in a conviction for GNM/ CH. This is covered in detail in section 5.1.2.

patient's death and the strong bearing that this fact had on the respondent's view about appropriate actions:

*"The death of a patient is of utmost seriousness. The Doctor should not be allowed to continue to be allowed to make such mistakes."*  
(Survey respondent)

*"The resultant death from the doctor's mistake changes everything about the case. Although conditions such as working a double shift should be taken into consideration, ultimately it is the protection of the public and the prevention of a similar mistake that is of primary importance here."* (Survey respondent)

In the qualitative research, outcome was the single biggest influence on participants' expectations of regulatory action: the vast majority of participants expected stronger action from the GMC where the patient died than where the patient was unharmed. This is reflected in the differences in initial responses to the scenarios designed for the qualitative research that stated outcomes (1A – patient unharmed; 1B – patient dies), and in the fact that nearly all participants shifted their scores along the spectrum of sanctions if the outcome in scenario 1A was changed to patient death. In addition, participants said they opted for a 'warning' or 'supervision' for the doctor in 1A initially (and not a more severe action) because – although confusing the drugs was a serious error – no-one was harmed.

Participants expected stronger action where a mistake results in patient death for a number of reasons:

- They see it as the doctor's duty of care to preserve life wherever possible. They expected the action to reflect the severity of this breach of duty of care;
- They could not extricate the seriousness of the result from the seriousness of the mistake: the outcome of patient death makes it a more serious mistake, and a more serious mistake demands stronger action;
- Some also felt that a patient death has greater implications for patient safety, so stronger action is needed to restrict the doctor's practice;
- The outcome of patient death suggests to some that this is a high risk procedure/ case, and so the onus is on the doctor to take even greater care;
- Some felt that the patient's family would want and expect to see firm action taken, and that this should influence the regulator's response;

- A minority expect the doctor to be 'punished' or held to account by the GMC for mistakes resulting in death, so call for stronger action (in spite of being informed that the role of the GMC is not to punish).

For a small minority, the outcome did not affect their expectation of regulatory action. They felt that other factors needed to be considered, for example:

- Had the doctor followed protocol?
- Was it an easy mistake to make?
- Could/ had other doctors make/made the same mistake?
- Had they made similar mistakes previously?

Even where a mistake results in patient death, participants did not automatically expect the doctor to be struck off. They were more likely to assume from the start that the doctor had the best of intentions.

*"You can't strike off every doctor who accidentally killed someone, because to me it is an accident. It's not malicious." (Pre-family, C2DE, Newport)*

*"What we can't get from these scenarios [1B] is that golden word really: 'intent', and to me there is no intent. It seems to me it's a busy A&E on a Saturday night... there's a big massive error of judgement, more than any intent. I think it can happen, the mix up of patients, but you know what the A&Es, we all know there's people coming in and out and there's different scenarios all the time. I think he's made an error of judgement. Unfortunately, the patient's died, but..." (Family lifestage, C2DE, Northampton)*

Even where they attributed errors to the doctor (e.g. In Scenario 1A – confusing drugs/ injection sites; in Scenario 1B: mixing up patients and not prescribing antibiotics straightaway), they were more sympathetic to other factors contributing to the error. In particular, they were sensitive to system pressures and failures, the contribution of other departments and individuals, and the doctor's apparent level of carelessness or recklessness.

They felt that the doctor may still be able to practise effectively and safely (albeit with further training/ restrictions on their practice). Several participants also felt that the doctor would 'punish themselves enough' or have had a sufficient penalty from the court, and that the GMC did not need to add to their 'punishment' by striking them off.

Some also felt that it was not pragmatic to strike doctors off for every mistake resulting in patient death. Their rationale was that doctors carry out high-risk procedures, often on very ill patients, and it is only human to make errors from time to time. Some also suggested that routinely striking doctors off for errors resulting in death would contribute to doctors becoming too risk-averse in their practice and add to a further to a shortage of good doctors and could, therefore, add further pressures!

*"I think the reason why people don't get struck off but they do get a severe reprimand or penalty is because they [the GMC] see the difficulty and, at the end of the day, people are only human, mistakes do happen." (Empty Nester, C2DE, Belfast)*

*"I don't think [death] should be a determining factor in whether you strike them off, because at the end of the day, these doctors, they are there to make life and death decisions, and if a doctor is worried about, 'Actually if I take this decision I'm going to be then struck off, my livelihood is going to go out of the window.' What if a doctor turns around and says, 'You know what, I'm not going to take that operation, I don't want to do that. It's too risky.'?" (Pakistani man, Birmingham)*

*"I think they're so short staffed... the doctors in the NHS. So, yes, I just think look into it but I don't think we can afford to keep losing doctors, we haven't got enough to go around." (Family lifestage, ABC1, Oxford)*

There were also calls for hospitals, employers and 'management' to be held to account where errors like those in the scenarios occur. Participants were keen to see changes in procedures, protocol and staffing decisions following death by clinical error to avoid similar mistakes happening again. While some suggested that the GMC should play a role here, others recognised that the GMC has to focus on doctors, and hospitals/employers are beyond their remit.

*"If they are over worked, they should be able to go back to the hours that they are allowed to work and that's all. It's management making them work these long hours. And they need to look at that before they start disciplining doctors and staff." (Empty Nester, ABC1, Manchester)*

There was a minority of participants in the qualitative research who expected a doctor to be struck off whenever they have made a mistake that results in death. There were no obvious similarities (e.g. in demographics, experiences of healthcare) between these participants – in most focus groups, a couple of

participants aired these views. These participants were far less tolerant of mistakes, and especially when mistakes lead to death. They were also more likely to empathise with the victim and their family. This attitude was slightly more prevalent (but not pervasive) amongst participants who had previously complained about a healthcare professional. This minority was less likely to be influenced by mitigating factors such as system failures and the role of others in sub-standard care. For them, where a doctor makes a ('stupid') error resulting in death, they should no longer be able to practise as a doctor.

*"Their job is to preserve life and he's not done that as a doctor... I do think it's bad enough for them to be struck off. That's their job, to preserve life." (Family lifestage, C2DE, Northampton)*

*"If they made a stupid error and somebody didn't die, this wouldn't be a 5 [striking off] this would be a 2 [warning] or a 3 [supervision/restrictions on practice]. But because somebody died, it's a 5." (Pakistani man, Birmingham)*

*"The only reason I put striking off, is because the average person would expect a response like that... Because, his culpability is now worse really than if the patient hadn't been harmed. But, you know, with that result, people would look for some heavy, heavy response." (Retiree, ABC1, Newport)*

### **5.1.2 Impact of conviction for GNM/ CH**

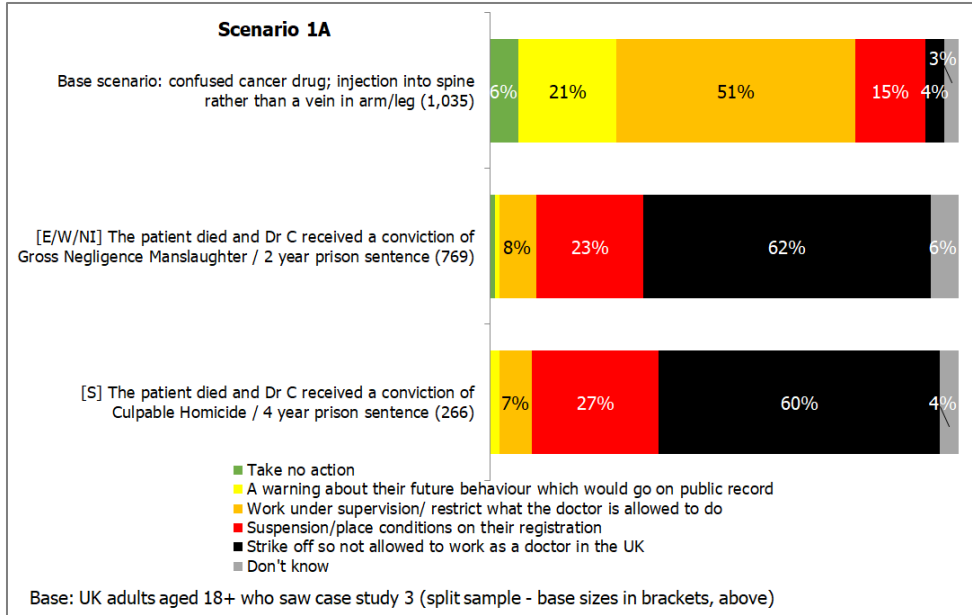
Participants in both the qualitative and quantitative research were asked how a conviction for GNM (in England, Wales and Northern Ireland) and Culpable Homicide (in Scotland) would affect their expectations of action from the GMC. The definitions provided within the research instruments are shown in Figure 9.

	<b>Gross Negligence Manslaughter definition (England, Wales, Northern Ireland)</b>	<b>Culpable Homicide definition (Scotland)</b>
<b>Qualitative groups</b>	<p><b>Gross Negligence Manslaughter</b> happens where (patient) death is a result of a grossly negligent act or omission on the part of the doctor.</p> <p>It requires the doctor to have been judged to have done something so far below accepted standards of medical practice as to be 'truly, exceptionally bad'.</p> <p>It does not require 'intent to harm' (it does not have to be proved that the doctor deliberately set out to harm the patient). Nor does it have to be proved that the doctor acted recklessly – an accused (doctor) can be guilty of Gross Negligence Manslaughter simply on the basis of a complete failure to turn their mind to an obvious and serious risk of death.</p>	<p>A person (e.g. a doctor) could be found guilty of <b>Culpable Homicide</b> if they act recklessly while they are carrying out an otherwise lawful act (e.g. providing or overseeing care to a patient) and someone dies as a result.</p> <p>The recklessness must be "a total indifference to and disregard for the safety of the public"*. It is not merely carelessness or negligence on the part of the accused.</p>
<b>Quantitative online survey</b>	<p>Sometimes such cases can result in criminal proceedings against a doctor leading very rarely to a conviction for a crime called <b>Gross Negligence Manslaughter</b>.</p> <p>Gross Negligence Manslaughter happens where a patient death occurs as a result of a grossly negligent act or omission (failure to act) on the part of the doctor.</p> <p>This requires the doctor to have been judged to have done something so far below accepted standards of medical practice as to be 'truly, exceptionally bad'. It does not require 'intent to harm' (it does not have to be proven that the doctor deliberately set out to harm the patient). Nor does it have to be proved that the doctor acted recklessly.</p>	<p>* <i>RHW v HM Advocate (1982)</i></p>

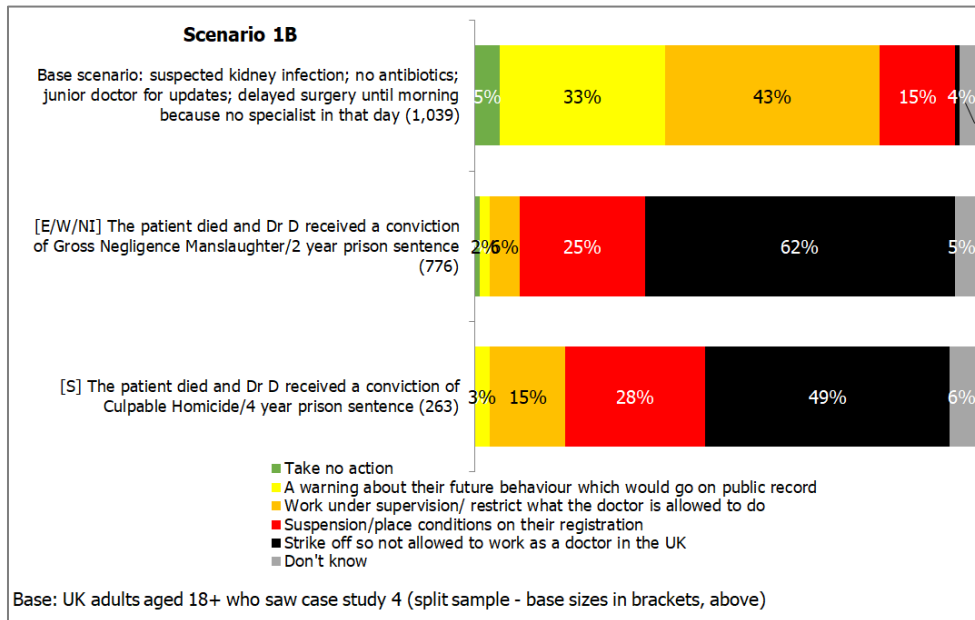
**Figure 9: Definitions provided within the research**

Within the survey, the conviction of a doctor strongly impacted views in terms of expected GMC actions, as shown in Figures 10 and 11. In responding to the baseline scenarios (no outcomes specified), 4% of respondents expected the doctor in question should be struck off in each of Scenarios 1A and 1B. Where there was a conviction of GNM or CH resulting in a prison sentence, the proportion of the sample saying the doctor should be struck off increased considerably:

- In Scenario 1A, 62% of the sample in England, Wales and Northern Ireland expected the doctor to be struck off (in response to a GNM conviction) and 60% expected this in Scotland (in relation to a CH conviction);
- In Scenario 1B, 62% of the sample in England, Wales and Northern Ireland expected the doctor to be struck off (in response to a GNM conviction) and 49% expected this in Scotland (in relation to a CH conviction).



**Figure 10: Impact of convictions on expectations of GMC response in relation to Scenario 1A (Q9. What would you expect the GMC to do in these circumstances? Q10. What would you expect the GMC to do in Dr C's case if .....?)**



**Figure 11: Impact of convictions on expectations of GMC response in relation to Scenario 1B (Q11. What would you expect the GMC to do in these circumstances? Q12. What would you expect the GMC to do in Dr C's case if .....?)**

As the following respondents' explanations illustrate, for many, the court's decision (given that it is based on a judicial investigation) makes strong action by the GMC a necessity.

*"The court's findings resulting in a conviction would be the end result of an investigation and so would have to be taken into account when determining what should happen to the doctor's career." (Survey respondent)*

However, echoing qualitative research findings from focus groups in Glasgow, some comments from Scottish survey respondents suggested that respondents found it hard to reconcile the facts of Scenario 1B with the definition of CH.

*"There's a question here regarding the conviction of Culpable Homicide, given the finding of "careless disregard" against your description of what actually took place. However, the court did find the verdict justified under law. He has therefore been convicted of culpable homicide and that being the case, the GMC cannot be seen to be taking a different course and putting itself in conflict with the law of the land. He has to be struck off." (Scottish Survey respondent considering Scenario 1B)*

*"There just seemed to be so many mitigating factors involved in the doctor's behaviour and as written it did not appear reckless, just overworked" (Scottish survey respondent considering Scenario 1B)*

*"In no way did the doctor do this deliberately so was not culpable homicide merely careless so he probably needs future supervision." (Scottish survey respondent considering Scenario 1B)*

This may explain why respondents in Scotland were less likely to call for the doctor in Scenario 1B to be struck off than the doctor in Scenario 1A. This perhaps echoes the qualitative findings, where participants were more likely to attribute the error to the doctor in Scenario 1A than in Scenario 1B (in which a number of other professionals, departments and factors could have contributed to the outcome).

It is also striking that a conviction of GNM or culpable homicide is not universally seen as necessitating an automatic end to a doctor's career. Indeed, even in relation to a conviction of culpable homicide, with a four year sentence, in Scotland a minority (18%) of survey respondents who saw Scenario 1B opted for this doctor either to work under supervision / restrictions (15%) or to receive a warning (3%). Of course, this may be in part due to the fact that a four-year sentence will essentially mean that the doctor will be unable to practise for that time.

In the qualitative research, a conviction for GNM or CH also hardened attitudes towards the doctors in the fictitious scenarios.

The majority of participants in England, Wales and Northern Ireland expected a doctor to be struck off if they had a conviction for GNM. There are a number of factors driving these expectations:

- The language in the definitions of the offences drove expectations of removal from the register: if a doctor is found guilty of a 'grossly negligent act' that is 'truly, exceptionally bad', few participants were prepared for the doctor to continue practising;
- They trusted a court to have thoroughly investigated all the circumstances. If they found that the doctor was to blame, they trust this decision. There was some expectation that the GMC should mirror the level of the court's decision;
- Participants would not want to see a doctor with a conviction for GNM/ CH, and assume that the public would have no confidence in the doctor either;
- They also assumed that employers would not want to employ a doctors with a conviction for GNM/ CH, just as in other professions where a conviction affects employability;
- The patient's family would find it unacceptable for the doctor to continue practising;
- Some participants felt that a doctor practising with a GNM/ CH conviction would reflect poorly on the medical profession as a whole.

*"For me, the answer's in that first part of that sheet you gave us which says, 'gross negligence manslaughter happens where death is a result of a grossly negligent act'. If he's given him the wrong injection in the wrong part of the body that's a grossly negligent act. That becomes manslaughter so I don't need to read the rest of that. For me, that's a 5." (Family lifestage, C2DE, Northampton)*

*"I don't think anyone would want to see a doctor like this if they'd actually been convicted of manslaughter. You wouldn't have any confidence in that doctor at all." (Retiree, ABC1, Newport)*

*"For the public interests and personally, I would say he's not suitable as a doctor because I wouldn't place my life into somebody's hands like that. If they can make an error of judgement and they've admitted it and got a criminal record, I wouldn't want them on the register." (Bangladeshi woman, Leeds)*

In Scotland, almost all participants in the focus groups called for a doctor to be struck off if convicted of Culpable Homicide (CH). Up until a CH conviction was introduced, the participants' view of the clinical scenarios was reflective of those in other nations. In the qualitative research, the conviction of CH appeared to harden attitudes more so than the conviction of GNM in the other nations. This was largely attributed to the definition of CH, particularly the inclusion of 'recklessness' and 'total indifference'.

*"That's it for a doctor. It doesn't get any worse than that." (Retiree, C2DE, Glasgow)*

*"It's like knocking somebody down and then reversing [over them]." (Retiree, C2DE, Glasgow)*

*"That is recklessness so you would actually have to strike off" (Pre-family, ABC1, Glasgow)*

*"In my opinion, I would not be able to trust the GMC if they let him remain on their register. I'm sorry if I'm in the minority, but I would not be able to have faith in him or her again." (Person with long term condition, Bulletin Board (Scotland))*

However, not all participants in the qualitative research (in England, Wales and Northern Ireland) expected the GMC to automatically strike off a doctor convicted of GNM. A minority felt it would be acceptable for the doctor to continue practising. There were participants across the sample who held this view – there were no obvious uniting characteristics amongst those who held this view. This minority felt that – in exceptional circumstances, a doctor with a GNM conviction should be allowed to continue to practise because:

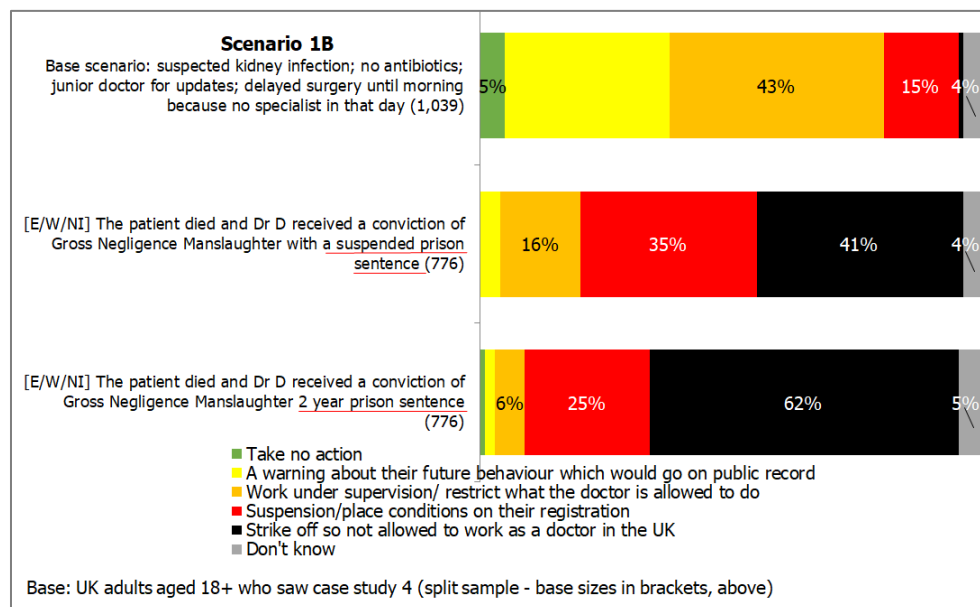
- They had been 'punished enough' by the court;
- They may still be competent in other areas of practice;
- System errors and other circumstances may have played a significant role in forcing the error;
- Some did not believe that the doctor in the scenarios had been reckless or careless;
  - A couple of Scottish participants shared this analysis: they did not believe that the doctor's actions in scenario 1B met the definition of culpable homicide, and therefore did not go along with the majority view to strike the doctor off.

In England, some participants challenged the appropriateness of the definition of GNM applying to doctors who have made a clinical error resulting in death. They felt that – for a doctor to be convicted – it should be proven that they were at least reckless or intentionally harmed the patient.

*"I feel they should change the rules and make it that they do require proof that the doctor intended to harm the patient or that they acted recklessly - it's not fair the current way." (Carer, Bulletin Board)*

### 5.1.3 Impact of sentence

In the quantitative survey, amongst the sample in England Wales and Northern Ireland, the clinical case study questions sought respondents' reactions, in terms of the expected GMC response, to suspended vs. custodial sentences for GNM. As Figure 12 shows, survey respondents considering Scenario 1B were more inclined to expect the GMC to strike a doctor off if they received a custodial sentence (62%) than was the case with a suspended sentence (41%). A very similar difference was seen for these same two sentencing options in relation to Scenario 1A.



**Figure 12: Impact of sentence on expectations of GMC response in relation to Scenario 1B (Q11. What would you expect the GMC to do in these circumstances? Q12. What would you expect the GMC to do in Dr D's case if .....?)**

Again, it appears that for many the rationale here is that the court's decision must be based on the details of the case and is therefore worthy of strong consideration by the GMC. As one survey respondent explained:

*"Being found guilty and going to prison reflects the entire circumstances of what happened. If the sentence was suspended*

*then there would be mitigating factors which led to what happened. This is why in the former scenario I would expect to see the doctor being struck off and suspended in the latter.” (Survey respondent)*

For the majority of participants in qualitative research, however, the sentence seemed to have little effect on the response they expected from the GMC. A small minority of participants felt that a lesser sentence for the conviction (suspended rather than custodial sentence) suggested there were mitigating circumstances (presumed to be system pressures).

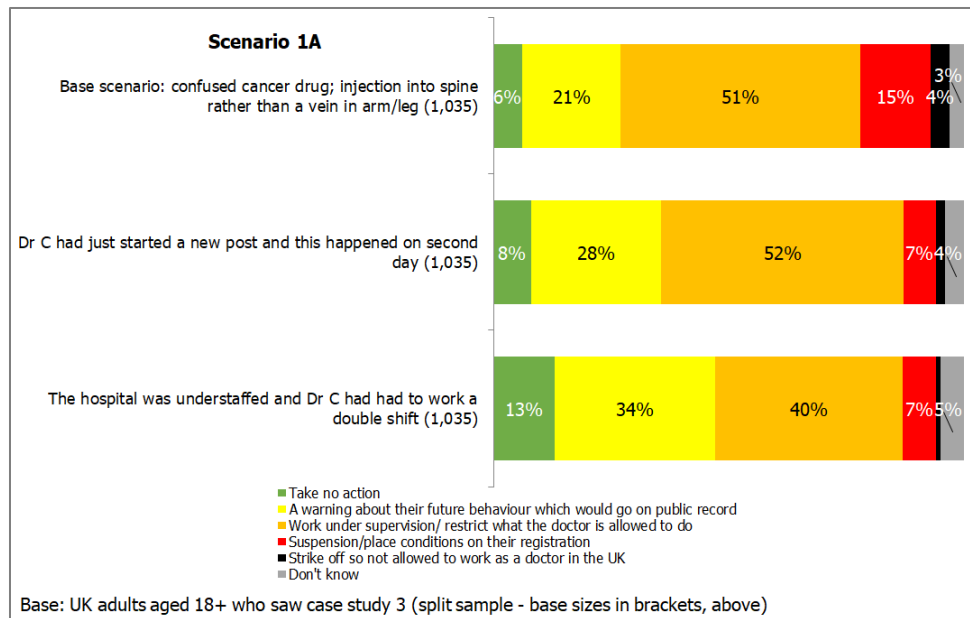
*“I think if he was on a suspended sentence there would be some discrepancies within the case and I would want to know... what led up to him committing this gross negligence.” (Pre-family, C2DE, Newport)*

Some also mentioned that they don't want to see a doctor who has been in prison, and that this could affect public confidence.

#### ***5.1.4 Other factors influencing expected regulatory action following clinical error***

Other factors were also introduced as part of the survey scenario questions. In relation to Case Study 1A the idea that Dr C was **new in post** and the error had occurred on only their second day, did reduce the proportion of respondents who felt that striking the doctor off or suspending them would be appropriate from 19% to 8%.

A bigger mitigating effect was seen in relation to the revelation that the hospital was **understaffed** and the doctor had been required to work a double shift. Under this set of circumstances, the proportion of the sample expecting the GMC to strike the doctor off or suspend them was also 8%. However, the proportion of respondents who expected supervision or restrictions dropped (from 51% to 40%) and the proportion suggesting no regulatory action rose (from 6% to 13%) when understaffing / overworking were explicit factors. These findings are illustrated in Figure 13.



**Figure 13: Impact of other factors on expectations of GMC response in relation to Scenario 1A (Q9. What would you expect the GMC to do in these circumstances? Q10. What would you expect the GMC to do in Dr C's case if .....?)**

Some participants in each of the qualitative research groups felt the GMC should consider the role of system pressures in clinical errors. For them, issues such as understaffing meant that the doctor in question was overworked, potentially on a double shift, stressed and exhausted, and this presented risks to patient safety. Some expected the NHS and/or the employer to take some of the blame for the error in these cases, and questioned the NHS's duty of care to doctors who are overworked. A minority even suggested it was the role of the GMC to hold employers to account and to minimise doctors' workload.

However, many participants felt that it was still the doctor's responsibility to perform at their best while at work. For them, if a doctor is at the end of a double shift when they make an error, it made little difference to their expectations of regulatory action. Some even suggested that the doctor has a duty not to work double shifts or make decisions when they recognise they are too tired to make good decisions.

*"If he's not sound of mind or physically able to do that shift then he has a responsibility to not continue because that's a complete error of judgment." (Family lifestage, ABC1, Oxford)*

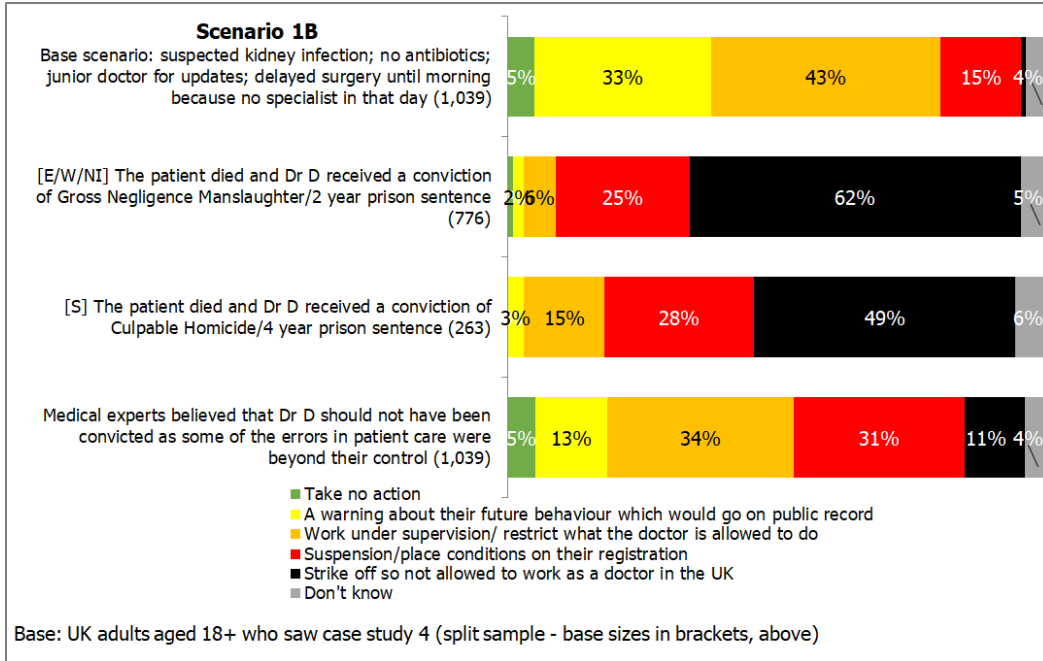
*"He's a doctor, I know they're under pressure and work long hours but, if he can't concentrate, he should go home and rest. He's professional enough and he's intelligent enough to know not to make a mistake... he knows if he's tired and his brain's not*

*functioning to go home and rest and maybe ask somebody else to make a decision.” (Empty nester, C2DE, Belfast)*

In Scenario 1B, respondents were introduced to the idea that the **scanning department was busy** and the patient had to wait 24 hours to get the scan requested by Dr D. This factor similarly changed many respondents' views about the appropriate level of action. Indeed, whilst initially only 5% of respondents felt that no GMC action would be necessary in response to Scenario 1B, the introduction of this scanning department delay saw 1 in 3 respondents (33%) state that, if that were the case, no action by the GMC would be expected.

In each scenario, the doctor was in a **senior, supervisory role**. Even if the doctor had only just started in that role, participants in qualitative research had higher expectations of doctors in a position of overseeing others. If they were deemed capable of a greater level of responsibility, participants held them accountable for their own decisions and for instructions given to more junior members of staff.

In the quantitative survey, respondents considered whether their view would change if **medical experts** believed that the doctor should not have been convicted of GNM/ CH in Scenario 1B, as some errors were beyond their control. Figure 14 shows that the addition of this element to the scenario considerably reduced the proportion of respondents who believed the doctor should be struck off (from 62% in England, Wales, Northern Ireland and 49% in Scotland to just 11% of all respondents). The largest increase in support for an action, if medical experts took this view, was for the doctor to work under supervision or restrictions.



**Figure 14: Impact of medical expert view on expectations of GMC response in relation to Scenario 1B (Q11. What would you expect the GMC to do in these circumstances? Q12. What would you expect the GMC to do in Dr D's case if .....?)**

Some participants in focus groups likewise felt that the GMC should consider the opinion of other medical experts, though primarily to understand what standard practice was in this case. However, some were also keen that the deciding panel should include doctors who have worked on the frontline and who understand the system pressures and their impact on doctors making life and death decisions.

A number of participants in the qualitative research expected the GMC to consider how the doctor's apparent level of **carelessness or recklessness** played a part in the error. If the doctor was taking a shortcut, disregarding protocol, or hurrying, they were inclined to suggest stronger action, particularly for high risk/ high stakes procedures.

Many in the focus groups were influenced by the fact that the doctor in Scenario 1A (cancer drug injected into wrong site) was 'visibly shaken' and 'quickly realised his mistake'. This suggests they feel that **remorse and remedial action** should be taken into consideration in deciding regulatory action.

## 5.2 Relative impact of mitigating and aggravating factors

### 5.2.1 Explanation of Max Diff statistical analysis

Within the online survey, after consideration of the clinical error scenario, respondents were asked to give their views about a range of factors that they

might consider should make the GMC take either a softer approach or a stronger approach in cases like the one they had just considered.

At Question 14 a total of 11 factors were shown that the GMC could consider to arrive at a softer approach (e.g. the doctor was under pressure or over-worked at the time); and at Question 15 a total of 10 factors were shown that the GMC could consider to arrive at a stronger approach (e.g. the patient died as a result of the error).

Max Diff, a method that is part of a family of statistical analyses referred to as Conjoint Analysis, is a statistical approach for obtaining the relative importance of multiple items (in this case, the relative importance of different factors in a case that the GMC could consider to arrive at their decisions on such cases). To make these long lists of factors manageable, respondents were shown a series of 'choice sets' (each containing three factors). Within each choice set, respondents were asked which factor the GMC should take most account of and also which they should take least account.

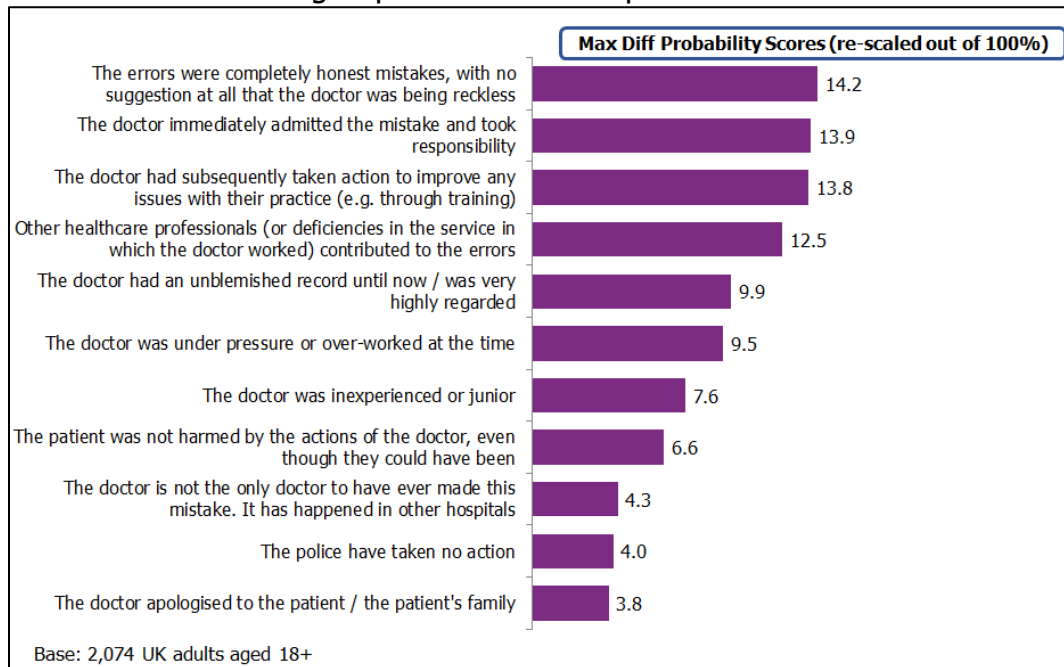
Participants did not see every choice set (which would be overly burdensome) but, across the sample as a whole, every choice set was seen and answered meaning that every factor 'competed' with every other factor.

Turning to the analysis, this leads to a series of scores which demonstrates the **relative importance** of the factors seen. The factor with the largest score is the item that is considered the most important. The scoring of the statements is calculated as a relative percentage compared to the other statements (they are re-scaled to collectively sum to 100%). So, for example, if Factor A achieved a relative importance score of 13.8 and Factor B a score of 6.9, this would demonstrate that both Factors A and B are worthy of consideration but also that, relatively speaking, Factor A should carry twice as much consideration (or is twice as important in the decision making process) as Factor B.

### ***5.2.3 Max Diff statistical analysis results***

As Figure 15 shows 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' (14.2% out of 100%). This was only slightly more important than 'the doctor immediately admitting the mistake and taking responsibility' (13.9%) and 'the doctor taking subsequent action to improve their practice' (13.8%). Whilst all of the 11 factors shown were seen as being important to some degree the three factors that came out of the analysis as having the lowest importance were 'the doctor apologised' (3.8%); 'the police have taken no action' (4.2%); 'the doctor is not the only doctor to have made the mistake'; and 'It has happened in other

hospitals' (4.3%). There was a remarkable degree of consistency within the results across all sub-groups within the sample.

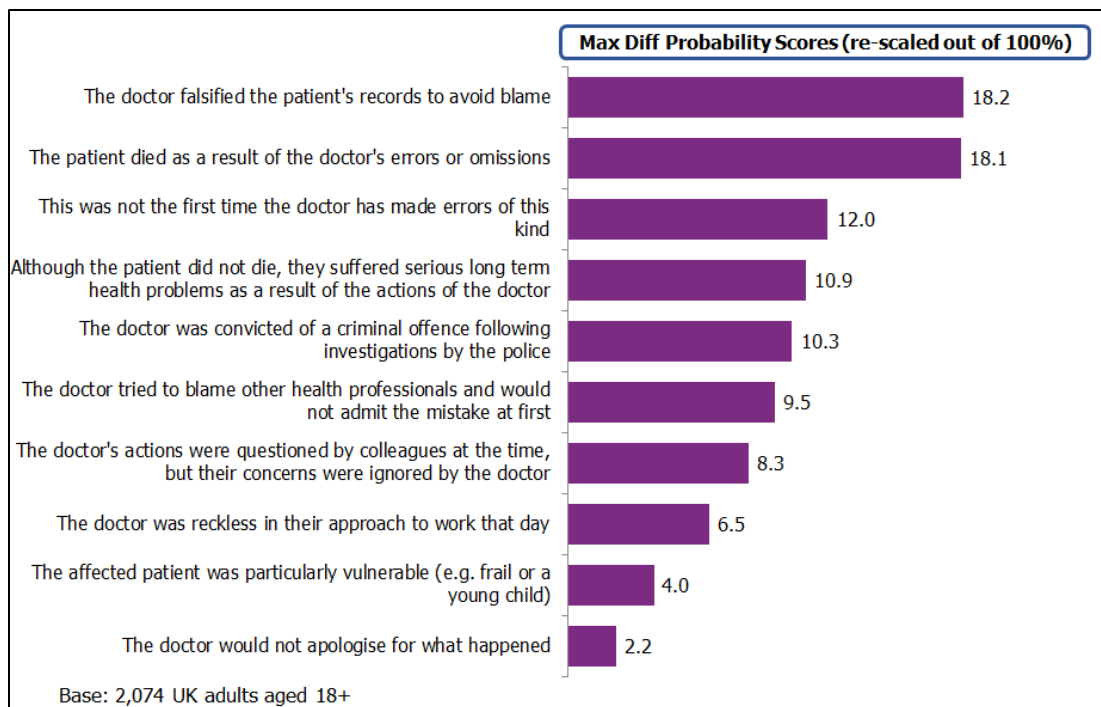


**Figure 15: Q14. We are first going to show you a series of factors that you might consider should make the GMC take a softer approach in cases like this. Each time we do this we want you to pick the one factor that you feel should make the most difference in softening the GMC's action, and the factor that should make the least difference in this respect (Max Diff analysis results).**

An equally strong degree of consistency across the sample was seen with regards to the factors that might **lead the GMC to strengthen their approach**. Figure 16 shows the results of the analysis.

Two factors stood out as being considerably more important than others – the doctor falsifying patient records to avoid blame (18.2%) and the outcome of the case being that the patient died (18.1%). Both of these factors were considerably more important than whether or not the doctor in question was convicted of a criminal offence (10.3%).

The vulnerability of the patient, whilst important to some degree (4.0%), was far less important than most other factors, only attracting around a fifth of the emphasis given to the two strongest factors. A doctor's refusal to apologise was the factor that received the least emphasis (2.2%) relative to the others shown.



**Figure 16: Q15. We are first going to show you a series of factors that you might consider should make the GMC take stronger action in cases like this. Each time we do this we want you to pick the one factor that you feel should make the most difference in strengthening the GMC's action, and the factor that should make the least difference in this respect (Max Diff analysis results).**

## 6. Criminal acts other than those relating to clinical errors

### **Summary:**

The research suggests that the public does not automatically expect the GMC to have involvement 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.

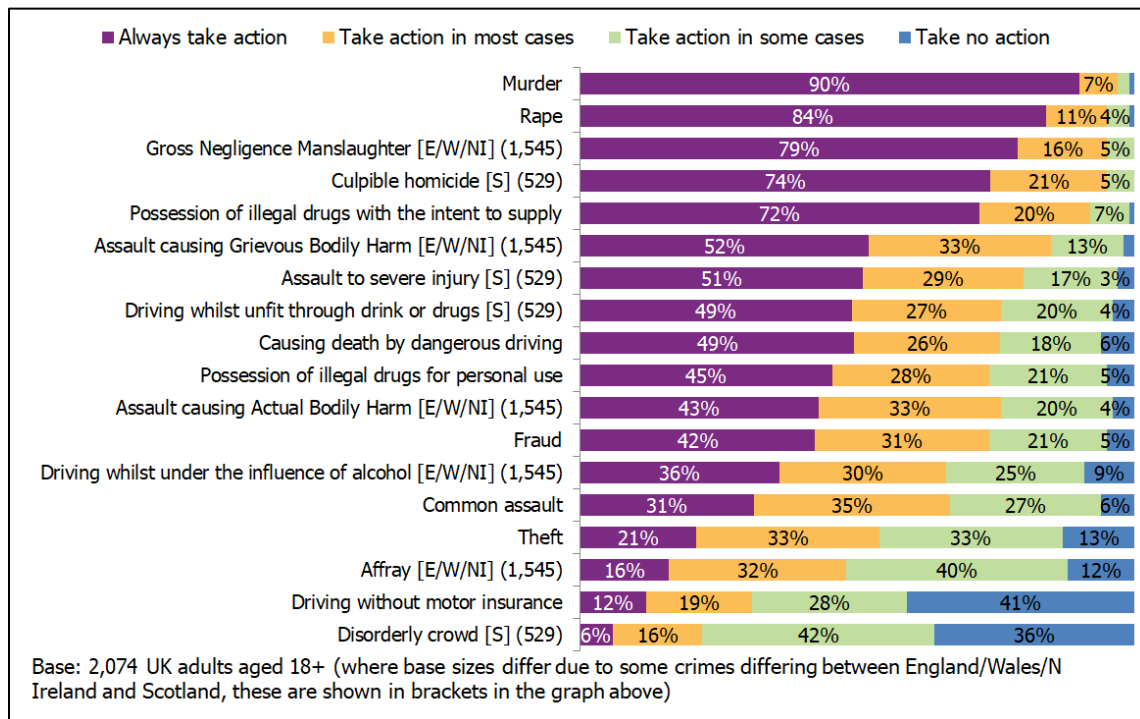
There is more divided opinion on the extent to which professionalism from doctors is expected outside of the workplace. For some patients and the public, a doctor is 'never off duty', and there is an expectation that the GMC will have oversight of behaviour outside of the workplace that could be regarded as 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.

When considering scenarios where doctors have committed potentially criminal acts in a non-work context, the more 'relaxed' view of the behaviours was more frequently expressed. As well as considering whether the doctor has harmed another person, it is expected that the GMC should base its response on whether the criminal behaviour had the potential to affect the doctor's ability to practise safely and effectively, whether there was a pattern of criminal behaviour, or whether the behaviour suggested the doctor was dishonest, aggressive or deceitful in character. A conviction and sentence had no more of an effect on public expectations of regulatory action than the criminal act and the circumstances surrounding it.

### **6.1 Expected regulatory response to criminal offences**

In both the qualitative and quantitative research, participants sorted a range of criminal offences on the basis of the extent to which they expect the GMC to take action where a doctor commits an offence. The offences included in this exercise are shown in Figure 17.

Findings from both qualitative and quantitative research show that participants did not automatically expect the GMC to have involvement where a doctor commits a criminal offence. Indeed, as Figure 17 shows, for a number of offences only a minority of those in the survey felt that the GMC should take action in all such cases. Less than a quarter of respondents believed that the GMC should take action in all cases of theft (21%), affray (16%), driving without motor insurance (12%) and disorderly crowd (in Scotland) (6%).



**Figure 17: Q17 (Doctors are sometimes convicted of crimes. The fact that a doctor faces criminal proceedings does not automatically mean that the GMC will take a particular action. Please indicate your view as to which of the following categories each crime fall.)**

Findings from qualitative research reinforce and explain the ranking of offences and the list of factors that influence participants' expectations of the GMC. Participants felt that the most important consideration was whether the doctor had (intentionally) harmed another individual. As a result, participants said that murder and rape should be of serious concern to the GMC. Death by dangerous driving and 'assault occasioning grievous bodily harm' ('assault to severe injury' in Scotland) were also of higher concern. Participants generally saw affray, driving without insurance and assault occasioning ABH as less of a concern for the GMC (as long as they were a one-off incidence).

In Scotland, there were a couple of differences in ranking compared with the other nations:

- Assault to severe injury was judged as a more serious concern for the GMC (compared with assault causing actual bodily harm in other nations);

*"It shows a disregard for life. If you can go out and harm somebody through rape or through assault to severe injury, are you in the right profession?" (Pre-family, C2DE, Glasgow)*

- Conversely, Disorderly Crowd, in Scotland, was seen as less serious than affray in the other nations.

In nearly all the offences, participants felt that the GMC should take all circumstances into account and investigate thoroughly before deciding how to act. These themes were explored in greater depth through a series of scenarios of doctors behaving in potentially criminal ways while they are outside of the workplace.

As with clinical errors, some participants were sensitive to the risk of losing good doctors through overzealous regulatory response to wrongdoing outside of work.

*"I do think he should be suspended and then given the benefit of the doubt but ever again a strike. Because we could lose a seriously good doctor just for being a bit greedy... So I would give him the benefit of the doubt rather than lose what could be a great doctor." (Family life-stage, C2DE, Northampton)*

## 6.2 Expected regulatory response to potentially criminal acts outside of the workplace

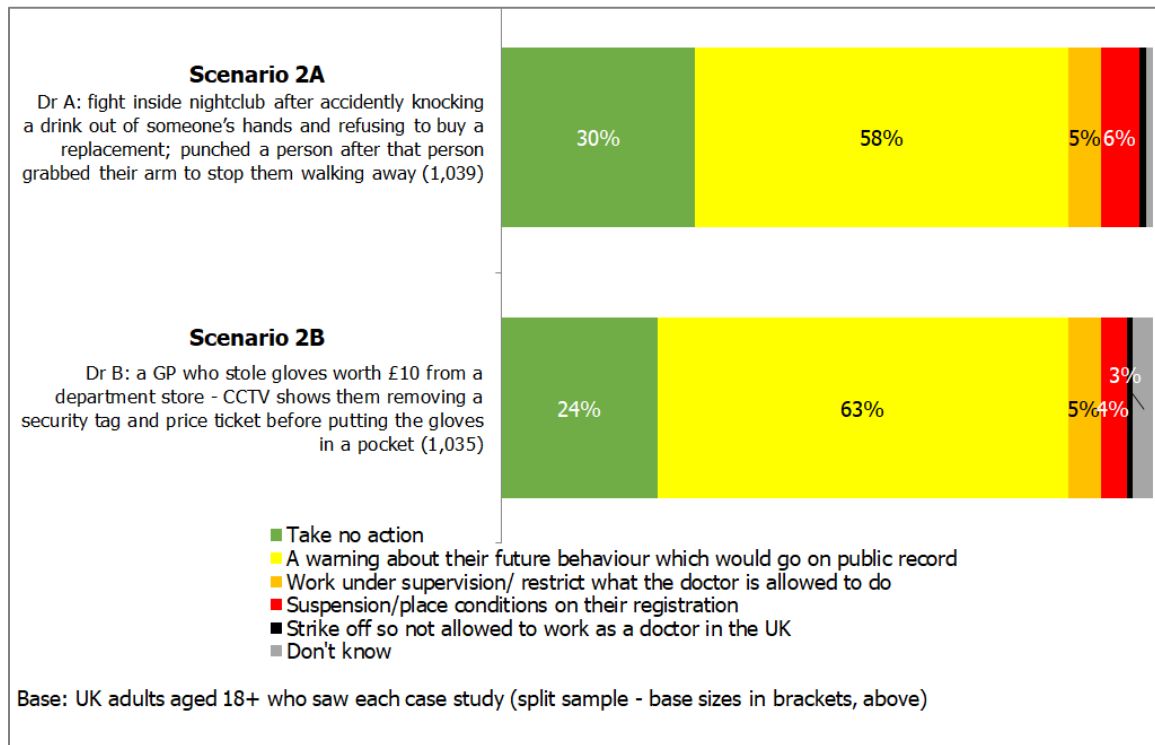
Participants in the qualitative phase of the research considered three scenarios where a doctor had behaved outside of the workplace in a way that could potentially be criminal. These scenarios were as shown in Figure 18:

<b>Scenario 2A</b>	Dr A was on a night out and got into a fight inside a nightclub. The fight started when Dr A accidentally 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.
<b>Scenario 2B</b>	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.
<b>Scenario 2C</b>	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.

**Figure 18: Scenarios of wrongdoing outside the workplace that could potentially be criminal**

Scenarios 2A and 2B were also considered (each by half of the sample) in the quantitative research. Scenario 2C was considered in some focus groups and some bulletin board discussions, but not in the survey.

As shown in Figure 19, the vast majority of respondents felt that the GMC should either take no action or warn the doctor about their future behaviour, under both of these scenarios (88% 2A and 87% 2B). In response to Scenario 2A, a higher proportion of people in Scotland expected no GMC action (36% compared to 30% of the total sample).



**Figure 19: Q4/6: What would you expect the GMC to do in these circumstances (non-clinical scenarios)?**

There was divided opinion in the qualitative research on the extent to which participants expected professionalism from doctors outside of the workplace:

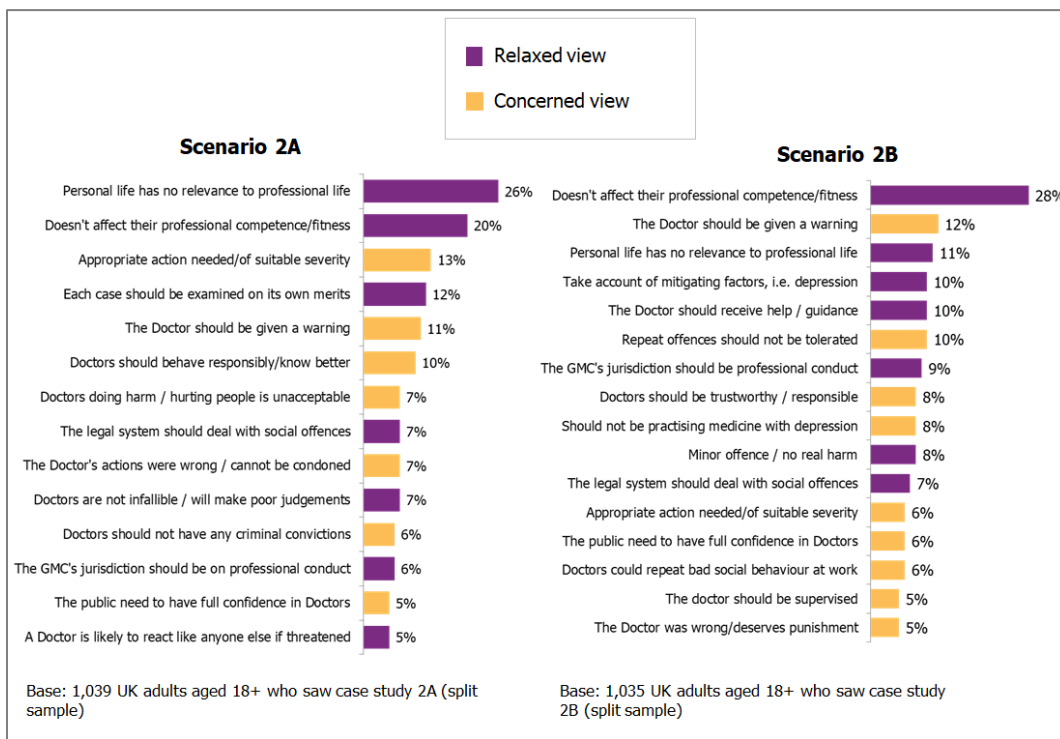
- Some participants felt that a doctor is 'never off duty', that they represent the medical profession even when they are outside the workplace, and they cannot behave in any way that risks bringing the profession into disrepute. Their start-point was that the GMC should have oversight of a doctor's behaviour outside of the workplace.

*"I think it's bringing the profession into disrepute. That's how they look at it. The doctors are meant to be held in high regard."  
(Retiree, ABC1, Newport)*

- Other participants felt that doctors 'are human too', and that they need to be able to 'let their hair' down when not at work. Their starting position was that a doctor's behaviour outside of work is almost never of concern to the GMC. They drew more of a distinction between the function of the criminal justice service and the regulator.

*"I think it's a police matter and if he's prosecuted or not prosecuted, or charged or warned or whatever it should be, I don't think it's anything to do with the GMC." (Retiree, ABC1, Newport)*

A similar division of opinion was observed in the quantitative survey open comments about the non-clinical scenarios, as shown in Figure 20. A more 'relaxed' view of the behaviours in both scenarios was more frequently expressed overall with many expressing the view that what happens in a doctor's personal life has no bearing on their professional life and / or that the scenario does not affect professional competence. It should be noted that this open question was asked after consideration of the full scenarios, including additional 'what if' elements had been considered (e.g. depression as a factor in Scenario 2B.)



**Figure 20: Q8. Having looked at [CASE STUDY 2A / 2B] do you have any comments about why you chose the actions you did and what the GMC should consider in cases like these where a doctor has behaved inappropriately in their personal life? [Response categories with 5% or more]**

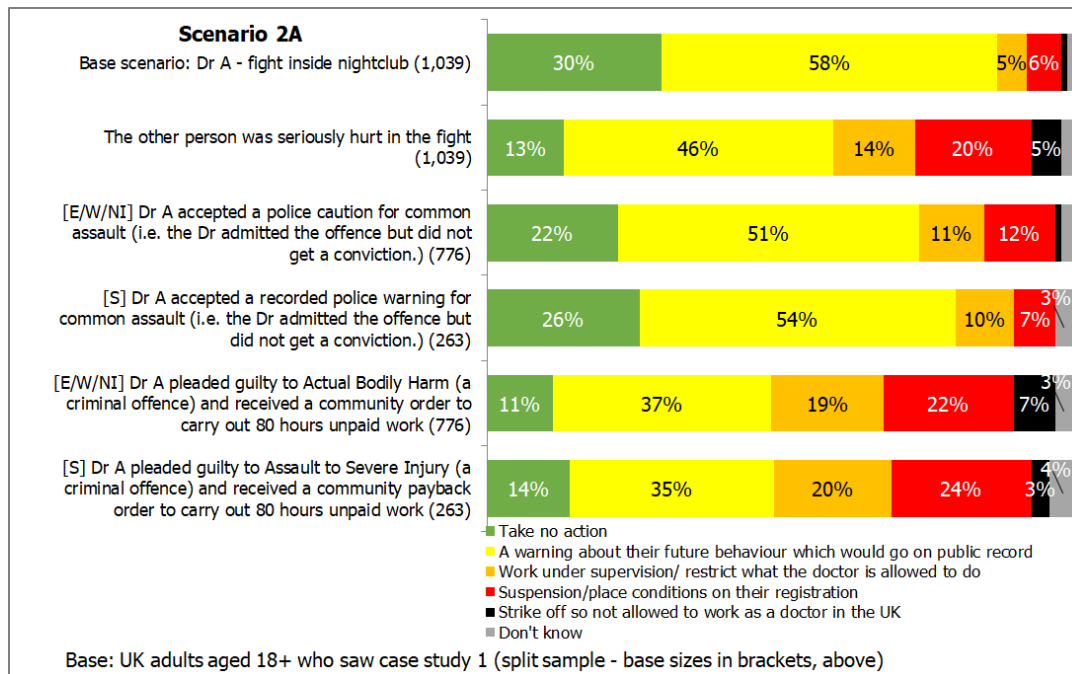
As before, most participants in the qualitative research assumed there were underlying reasons and mitigating circumstances to explain the doctor's behaviour in each of these scenarios. In some cases, these assumptions affected their expectations of the regulatory response.

In the survey, participants also considered the extent to which mitigating or aggravating factors influenced their expectations of regulatory action in these scenarios.

In the nightclub fight scenario (2A), where participants were asked to consider a situation where the other person was seriously hurt in the fight, the proportion of people saying that no GMC action is expected reduced from 30% to 13% and the most frequent action (expected by 46% of the sample) is for the doctor to be given a warning. Stronger actions were supported by smaller proportions of the sample. Only 5% suggest the doctor should be struck off, but 1 in 5 (20%) suggest suspension. These results are shown in Figure 21.

Figure 21 also shows the impact on expectations of GMC actions if the doctor accepts a police caution (or warning in Scotland) or pleads guilty to a criminal offence and receives a sentence of 80 hours unpaid work. Under the scenario of the doctor receiving a police caution / warning, over half of the sample (51% in England, Wales and Northern Ireland and 54% in Scotland) expect that a warning would be given. Very few expect the doctor to be struck off under these circumstances (0% in Scotland and 1% in the rest of the UK.) One in five people (20%) expected a police caution to result in suspension in England, Wales and Northern Ireland while 12% had this expectation in Scotland if a police warning were accepted by the doctor.

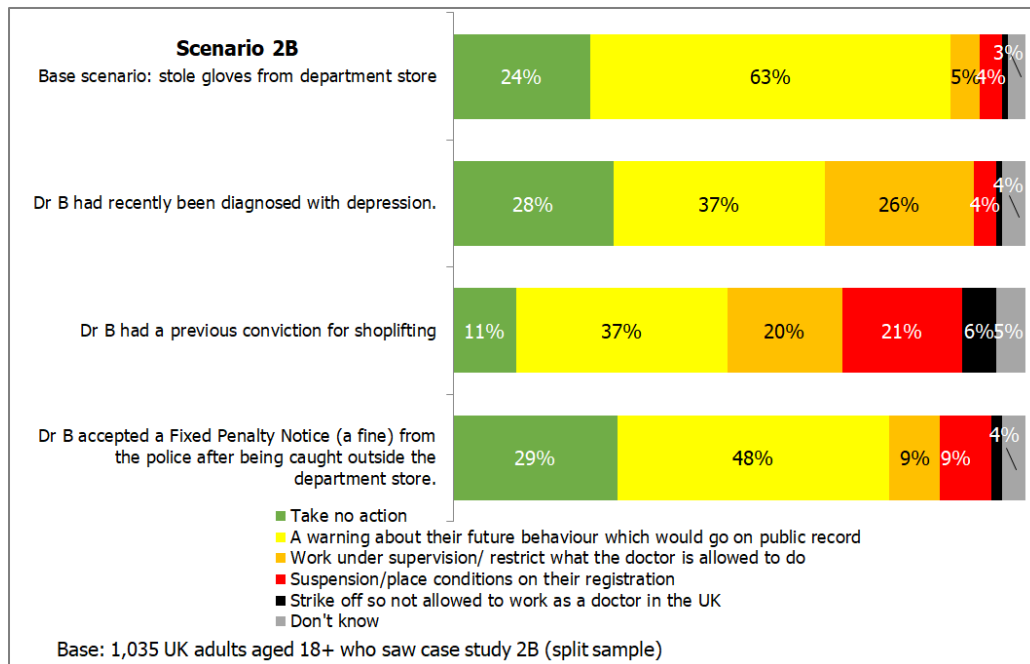
After a guilty plea and sentence of 80 hours of unpaid work, still more than 1 in 10 people felt that no GMC action would be expected (14% in Scotland, 11% in the rest of the UK.) The range of expectations is more split under this aspect of the scenario with almost a quarter (24% in Scotland and 22% in the rest of the UK) expecting that the doctor would be suspended and an increased, albeit still small, minority (7% in England, Wales and Northern Ireland) expecting that the doctor would be struck off.



**Figure 21: Q4. What would you expect the GMC to do in these circumstances? Q5. What would you expect the GMC to do in Dr A's case if .....**

As shown in Figure 22, in the shoplifting scenario (2B) the inclusion of the possibility that the doctor in question had been suffering from depression considerably reduced the proportion of the sample expecting a warning to be the resulting GMC action in this case. Whilst this remained the most popular course of action (37%), a much increased proportion of the sample would then expect the doctor to be asked to work under supervision or restrictions (26%).

A harsher approach was expected in response to the suggestion that the doctor had a previous conviction for shoplifting. Still only a small minority expected that the doctor would be struck off if this were the case (6%), but more than 1 in 5 expected this to result in suspension (21%). The acceptance of a fine for the offence clearly softened the expectations of many within the sample. Under this aspect of the scenario 77% of respondents expected either no action to be taken (29%) or for a warning to be given (48%). However, a higher proportion of the sample, than was the case with the original base scenario, expected suspension (9%) or supervision / restrictions (9%).



**Figure 22: Q4. What would you expect the GMC to do in these circumstances? Q5. What would you expect the GMC to do in Dr B's case if .....**

In the qualitative research, several factors altered participants' expectations of regulatory action in these scenarios:

- Causing (serious) harm to others:** where a criminal act out of the workplace causes significant harm or death, participants expected the GMC to take action. They felt that 'do no harm'/ 'primum non nocere' is a central tenet of medical practice, and as such, it applies to a doctor's life outside of work too. As a result, if the doctor caused grievous bodily harm in the nightclub fight scenario, or caused death by dangerous driving, many participants called for stronger action;

*"I wouldn't want to be seen by a doctor who's got a criminal record, especially one with... blood on their hands because they've killed." (Bangladeshi women, Leeds)*

- Implications for the doctor's performance or patient safety:** where an activity outside of work has a knock-on effect on a doctor's ability to practice safely and effectively, participants expected greater GMC involvement. Examples included: if the doctor was still over the limit when they went to work (in the reckless driving scenario); if a surgeon damaged their hand when they punched someone (in the nightclub fight scenario); if the doctor is stealing from individuals (especially vulnerable individuals), patients or the NHS;
- Repeated offences:** if the doctor had a history of any of the offences in the scenarios, participants expected more involvement from the GMC. They were

concerned that this could point to aggressive tendencies, lack of trustworthiness or a reckless attitude in wider life, and that this might affect the doctor's work and patient safety;

*"[The doctor should be struck off for repeated shoplifting offences] Because any illegal action shouldn't be condoned. In whatever walk of life you are. If you can't make a good decision about what is thieving or not, can he make a good decision about what's wrong with me? ...I think, when you sign up to become a doctor, you sign up to be an honest, upright person to be valued as a member of the society." (Retiree, ABC1, Newport)*

*"We all make mistakes, don't we, so this could just be a one off. As long as he doesn't keep doing it and... it doesn't affect his profession, so it doesn't affect any care or treatment that he's given to the public. He just needs to learn not to do it again." (Family life-stage, C2DE, Northampton)*

- **'Poor character':** some participants felt that the GMC should look at other signs that the doctor lacked judgment, was dishonest, lacked an ability to control their impulses or temper, or was deceitful (e.g. attempting to cover up wrongdoing or blame others). Even where offences happened outside work, participants were sensitive to these factors, suggesting they might spill over into doctors' work life and affect their ability to act in patients' best interests.

In the qualitative research, other factors had less of an effect on participants' expectations of regulatory action:

- **Mental health issues:** few participants felt that a doctor's mental health issues (such as depression, bereavement, addiction) should be taken into account when the GMC decides on actions where a doctor commits an offence. Many switched their expected action to 'supervision' if a doctor in the scenario was depressed or bereaved. However, they expected this supervision to be initiated by the employer as a means of supporting the doctor, rather than as a regulatory action. They felt that mental health issues should only be considered by the GMC where they affected the doctor's fitness to practise.
- **Conviction and sentence:** the nature and severity of the offence decided most participants' expectations of regulatory action, not the presence of a conviction or nature of a sentence.

## 7. Breaching professional boundaries

### Summary:

Responses to scenarios on potential breaches of professional boundaries vary depending on individual's judgements about whether the behaviour has fallen below expected professional standards. For example, there was divided opinion over whether a relationship between a doctor and patient was 'allowed' or not, and therefore a spread of opinion regarding the expected GMC response.

Scenarios involving posting patient anecdotes on Facebook and misuse of NHS funds were clearly seen as wrong. These both called for regulatory action, but more so for misuse of funds as it implied dishonesty (not merely naivety) – a characteristic incompatible with what is expected of a doctor.

In the qualitative research, participants in most of the focus groups considered a scenario where the doctor's actions had potentially contravened the professional boundaries expected to be adhered to by doctors (professional boundary is defined as "the boundary between what is acceptable and unacceptable for a professional both at work and outside work"<sup>4</sup>). Participants in the quantitative survey did not consider this scenario.












The scenarios considered were rotated between different groups (i.e. not all groups considered all scenarios), and are shown in Figure 23:

<b>Scenario 4</b>	Dr K, a practising GP for 30 years, had a 'sexual and emotional relationship' with a patient lasting for several months.
<b>Scenario 5B</b>	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.
<b>Scenario 5C</b>	Dr P was using NHS resources to provide blood tests for private patients.

**Figure 23: Scenarios of actions outside of work that challenge professional boundaries**

<sup>4</sup> [http://shura.shu.ac.uk/1759/1/Prof\\_Boundaries\\_FINAL\\_REPORT.pdf](http://shura.shu.ac.uk/1759/1/Prof_Boundaries_FINAL_REPORT.pdf)

Participants' responses to these scenarios in the qualitative research are shown in Figure 24<sup>5</sup>.

Scenario	No action	Warning	Supervision / retrain	Suspend	Strike off
4 (Sexual relationship)					
5B (Facebook post)	-				-
5C (misuse of funds)	-				-

**Figure 24: Approximate spread of initial expectations of regulatory action in response to behaviour that potentially breaches professional standards (based on responses from participants in 3-4 of the qualitative focus groups).**

Participants' responses were partly determined by the extent to which they felt that the action contravened professional standards:

- All expected regulatory action against Dr K using NHS resources for private clients, as they felt that this was a clear breach of standards;
- There was some debate over whether Dr M had breached confidentiality by posting the story of their patient's OCD behaviour on Facebook, though all agreed that the doctor should not have done this and that he needed to face a sanction;
- Participants were divided about whether Dr P's relationship with a patient was 'allowed' or not, and this influenced their position about whether the GMC should become involved in the case.

*"The GMC can't be the love police." (Pre-family, C2DE, Newport)*

*"That's why I've struck him off because, like the teacher/pupil relationship thing, it's a no-no." (Empty nesters, C2DE, Belfast)*

Participants stressed the importance of understanding the circumstances around these cases in order to decide an appropriate regulatory action. The factors they considered important for the GMC to consider were different for each scenario as outlined below.

<sup>5</sup> Please note, this diagram is intended to show the spread of responses, rather than represent specific numbers of participants.

#### **Scenario 4 – sexual relationship with a patient**

A minority of participants felt that the patient-doctor relationship is sacrosanct, and any romantic relationship would be a breach of trust. They felt that the doctor-patient relationship must end before a romantic relationship can start, or the GMC should take action. Other participants wanted to understand more about how the relationship started and whether the client was vulnerable in any way. If consensual and initiated by the patient, they felt this was not a matter for the GMC.

If there is any sign that the doctor had abused their position or trust, then participants expected the GMC to take strong action.

Participants considered a scenario where the doctor had accessed patient records to contact the patient. This was considered unacceptable and worthy of strong regulatory action. Several participants also felt that this could affect trust in the medical profession – it reminds patients how much information doctors have access to and the potential for abuse.

*"It takes the trust away. You realise how much trust you're putting in this doctor when I don't think you've realised before. You don't really think how much information they have. They've got your home address, they've more often than not got your e-mail and phone number." (Pre-family, C2DE, Newport)*

#### **Scenario 5B – Facebook post of patient's OCD behaviour**

All participants considered that posting information about a patient's case on Facebook was unacceptable. Many participants felt this showed naivety and poor judgement on the part of the doctor. They thought they should have been aware that once something is posted online, it can be shared far and wide (even if posted on a blog aimed at other medical professionals). Some participants were also concerned that this shows a lack of empathy for the doctor's patient, and that other patients could be unwilling to share sensitive information to them in the future. Participants could not think of any mitigating factors for the GMC to consider in this scenario.

*"A total disregard of anybody, his customers, his fellow doctors. He's got no respect whatsoever, I think he should go." (Empty Nester, C2DE, Belfast)*

*"It doesn't really make a difference if [the doctor] mentions the patient or not, because if you were another patient would you feel comfortable telling that doctor your personal things?" (Pakistani man, Birmingham)*

**Scenario 5C – Use of NHS resources for private patients**

All participants who considered this scenario expected some kind of regulatory action, though there was little consensus over the level of sanction required. Some participants saw this as a lower level transgression than others as it did not directly harm patients. Participants expected stronger action where the doctor was repeatedly using NHS resources for private patients than if it was a one-off. They also drew a distinction between mistaken and intentional misuse of resources. Ultimately, they expected the GMC to thoroughly investigate the circumstances surrounding the case and to look at the doctor's character as a whole (e.g. were there any other signs of dishonesty or abuse of position?) in order to decide an appropriate sanction.

## 8. Overarching themes

### Summary:

For most members of the public, there appear to be two main components for a clinical error to be considered criminal – the act, and its effect.

- The **act** needs to be intentional, deliberate or reckless.
- The **effect** needs to be an outcome of grave and lasting harm or death.

Any attempts by a doctor to cover up, falsify or blame others for clinical errors also led to the public seeing criminality.

Cases of clinical errors and wrongdoing may do little to affect most people's confidence in the medical profession. The public tends to believe that the vast majority of doctors are there to do good, albeit that there are concerns about doctors' ability to provide the best care in the context of an under-resourced system.

The public starts with little knowledge of the GMC and its work to regulate doctors, and few have cause to question confidence in the regulator. There was a split in opinion on the impact of lenient regulatory action on confidence in the GMC. Some trusted the GMC to have thoroughly investigated the evidence, and to make the best decision regarding a doctor's ongoing fitness to practise. Others felt more lenient action than expected would cause them to doubt the GMC, and reinforce underlying assumptions, held by some, that the regulator would 'protect its own'.

### 8.1 When does a clinical error become a criminal act?

Participants in the bulletin board and respondents to the quantitative survey were asked directly to consider what factors lead a clinical error to become a criminal act. Within the quantitative survey there was a strong emphasis on deceit and dishonesty, including any attempts to cover up or to blame others.

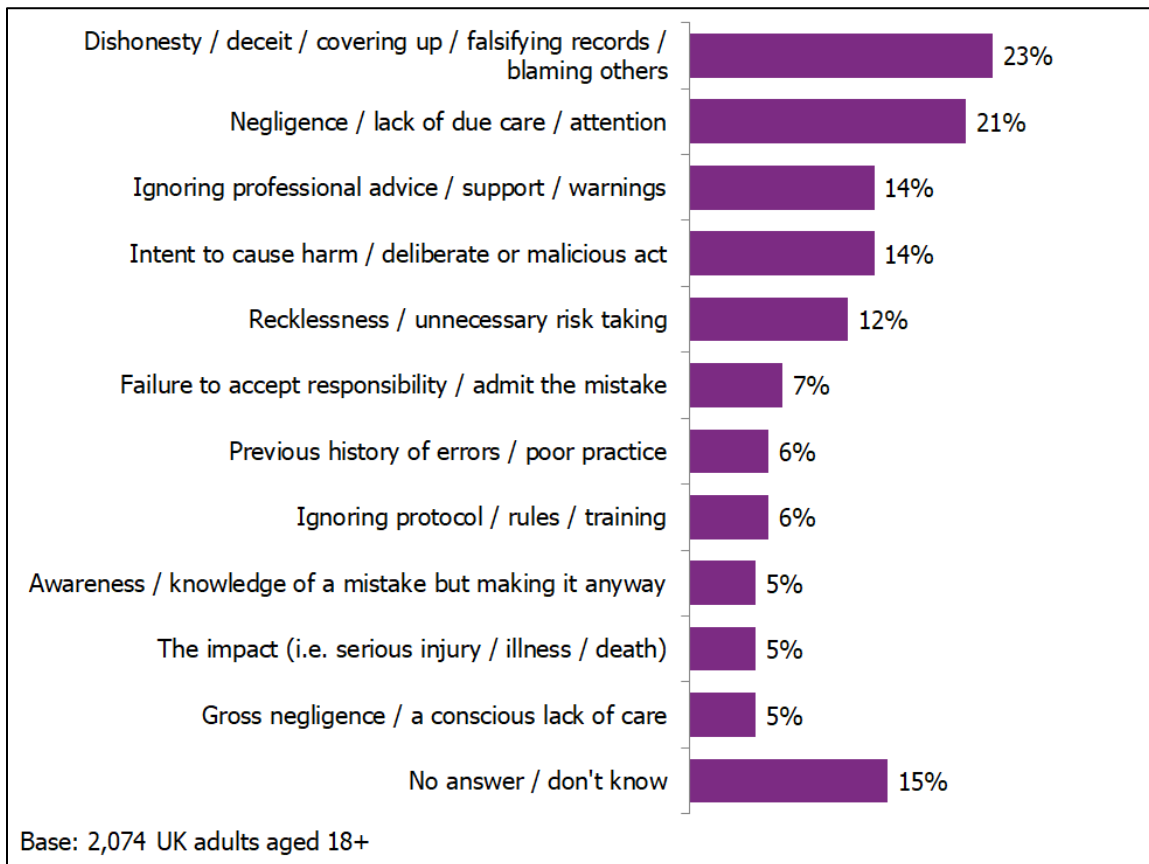
*"A deliberate act to put the blame on someone else, or falsify records, shows that the doctor was aware of their actions and trying to get out of it. They might then take similar actions in other events. How many times have they done this and 'got away with it'?" (Survey respondent)*

In addition, there were many mentions of negligence, lack of care, recklessness and / or evidence of a disregard of any advice, support or previous warnings that the doctor may have received. The sense that clinical errors had been repeated and that the doctor had knowledge or awareness of the error, but made it regardless was also common in the survey responses.

*"If the action constituted wilful negligence by the doctor, who was aware of the risks yet pressed on regardless." (Survey respondent)*

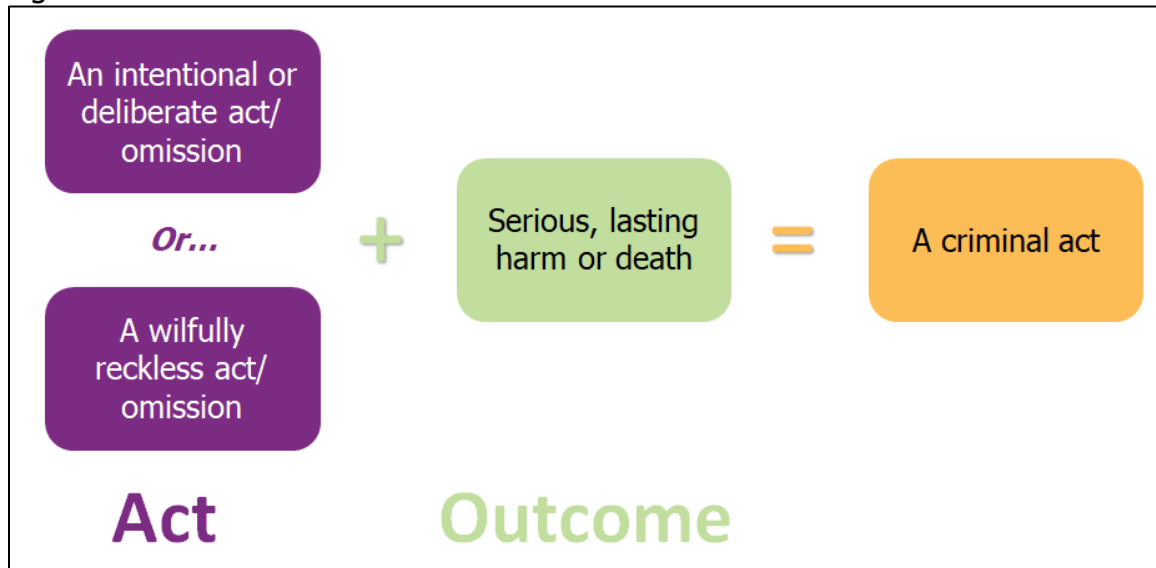
*"Falsifying records or trying to cover up the mistake in any way. A clear lack of concern or interest in the patient, as witnessed by other healthcare professionals at the time. A clear dismissal of warnings and concern from other healthcare professionals that the current course of treatment was incorrect. A pattern of repeated behaviour by the doctor that has resulted in death/injury to a number of patients which have been proven to be as a result of poor care by the doctor." (Survey respondent)*

Figure 25 summarises the varied responses given to this open question within the survey. A significant minority of respondents (15%) said they did not know, or gave no response in answer to this question; younger respondents (under the age of 35) were more likely to say they did not know or to give no response (23%).



**Figure 25 Q16 - In your view, what factors would turn a mistake in the treatment of a patient, resulting in their death, into a criminal act by the doctor? [Answers with 5% or more mentions]**

These factors were echoed in the qualitative research. For the majority of participants to the bulletin board, there were two main components for a clinical error to be considered criminal – the act, and its effect. This is summed up in the Figure 26:



**Figure 26: Majority view on components of a criminal act in the case of clinical errors**

### **The Act**

To expand, most participants in the bulletin board felt that an error needed to be more than 'an accident' or a 'genuine mistake'. Many people felt that 'it is human to make a mistake', even in medicine, and more was needed to criminalise an error. The majority felt that – for an act to become criminal, it must be:

- Intentional, deliberate, on purpose, setting out to cause harm; or
- Wilfully 'reckless', 'clear negligence', easily avoided, deliberately endangering others, or deliberately choosing to ignore protocols or risks. Some suggested this should be objectively determined based on what 'the person on the street' would consider reckless.

*"If the act was on purpose or was a mistake because the doctor had been out all night partying, or even the doctor is chatting to friends and colleagues and not really concentrating on his patient, then that would be a criminal act." (Carer, Bulletin board)*

*"I think overall, the first factor is whether the act was intentional. Clearly this wouldn't be human error. Secondly, would the typical 'man on the street' consider the act to be so reckless that it is beyond the scope of just an error?" (Person with long-term health condition, Bulletin Board)*

*"When it is so careless and thoughtless beyond people's expectations of a doctor." (Complainant, Bulletin Board)*

*"If an act was just seen as 'cutting corners' or laziness then this would also amount to a criminal matter." (Person with long-term health condition, Bulletin Board)*

### **The outcome**

Participants also said that the error needs to have led to harm for it to be considered criminal. Most participants said the harm was to be grave and lasting to be criminal, for example: patient death, loss of a limb, lasting disability or illness.

*"[Amongst other things, an error becomes a criminal act] When somebody's life has been ruined, threatened, or ended!" (Complainant, Bulletin Board)*

*"If the mistake or series of mistakes leads to a patient becoming more seriously ill, if a patient loses a limb or if a patient dies as a result." (Carer, Bulletin Board)*

However, it should be noted that a minority of participants felt that any error that results in grave and lasting harm should be considered criminal. This 'hard-line' attitude was present in all three bulletin board groups and was also evident in participants' responses to the scenarios. A minority of participants who had made a complaint following a clinical error also held this view (though not all participants who had made a complaint against a healthcare professional).

*"As I said we are all human, but a Dr has a very responsible job, lives are at risk and therefore mistakes cannot go without some sort of action being taken especially if the mistake results in death or in our case with our daughter, close to death and lifelong problems." (Complainant, Bulletin Board)*

Some participants suggested that other factors need to be considered before deciding whether the act and outcome are criminal. These echo the factors participants suggested should influence the regulatory response, and include:

- A one-off error compared with a series of mistakes, or several separate incidents of the same error;
- The doctor's response - attempts to cover up the error or blame others compared with quickly noticing and accepting responsibility for errors;
- 'Institutional' factors, such as hours, level of support, staffing levels might mitigate against criminality.

## **8.2 Confidence in the medical profession and the GMC**

### ***8.2.1 Impact of the Research Process***

In the qualitative research, most participants started with little or no knowledge of the GMC, their purpose or their activity. In addition, participants could recall little about doctors involved in wrongdoing or clinical errors, and mostly attributed the cases they were aware of to 'one or two bad apples'.

Through the course of the research, participants came to understand more about the GMC's role and about the nature of cases it needs to consider. As a result:

- They came to appreciate the complexities and nuances of these cases, and the circumstances in which they happened. They realised that cases are often not what they first seem, and that this complexity cannot be conveyed in a newspaper headline;
- Their consideration of regulatory responses raised questions, particularly in relation to how the GMC comes to decisions about sanctions, and who makes decisions.

The research process, therefore, informed discussions about the impact of wrongdoing and regulatory action on confidence in the medical profession and in the GMC.

### ***8.2.2 Impact of wrong-doing on confidence in medical profession***

Even after deeper reflection, the cases of clinical errors and wrongdoing did little to affect most participants' confidence in the medical profession. Instead, for most participants, considering these cases in depth reinforced their starting attitudes towards the medical profession, i.e.:

- The vast majority of doctors are working hard, with the best of intentions;
- Incidences of wrongdoing are isolated to 'a few bad apples';
- System pressures often form the background to clinical errors and increase the risk of harmful errors occurring.

As a result, most participants felt that these cases would make them doubt the individual doctor involved but would not lead them to doubt the medical profession as a whole, and did not affect their trust in their own doctors.

However, there were some small signs of an unsettling effect of some cases of errors and wrongdoing:

- Clinical errors scenarios reinforced perceptions of an overstretched NHS, where errors are more likely because of understaffing, overworking, and overstretched resources. As a result, some participants felt more nervous about using secondary care, and A&E in particular, after considering the clinical error scenarios;

*"If I'd known and that A&E was down the road, I wouldn't go. I'd probably take a taxi further to a different A&E to be fair." (Pre-family, ABC1, Glasgow)*

- Some cases of wrongdoing emphasised the potential for abuse of power (e.g. access to personal details). For a minority, this sowed some seeds of doubt in their minds as they considered the potential for wrongdoing.

*"It takes the trust away. You realise how much trust you're putting in this doctor when I don't think you've realised before. You don't really think how much information they have. They've got your home address, they've more often than not got your e-mail and phone number." (Pre-family, C2DE, Newport)*

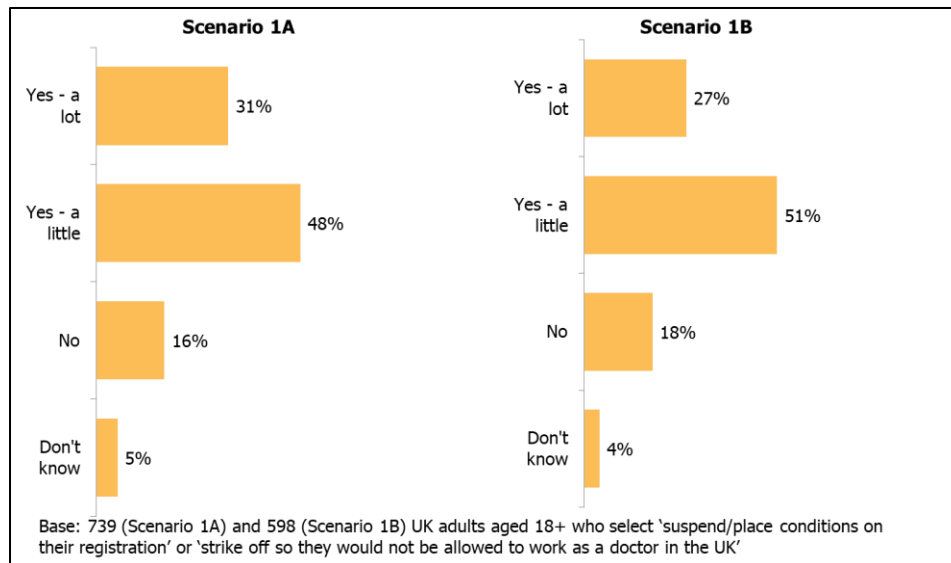
However, it should be noted that participants' focus was on their confidence in doctors' ability to provide the best care *in the context of an under-resourced system*, not on confidence in the medical profession *per se*.

### ***8.2.3 Impact of GMC regulatory action (or lack thereof) following clinical errors on public confidence in the medical profession***

Within the survey, where respondents expressed an expectation that the doctor would be suspended or struck off in response to the base clinical scenarios, they were asked whether, if the GMC took a lesser action, this would undermine their confidence in the profession. Figure 27 shows the response which suggests that this would be the case for many and for almost a third (31% Scenario 1A; 27% Scenario 1B) it would undermine their confidence 'a lot'. It should be noted, however, that this reported negative impact on confidence in the profession was prompted by the question, rather than being raised spontaneously by respondents.

In contrast, the qualitative research suggested that stronger or more lenient regulatory action does not greatly affect confidence in the medical profession. Confidence in the medical profession was based on other factors. One of these factors was a basic assumption that doctors are a regulated profession, but this was not in-depth knowledge of how the profession is regulated or of possible sanctions for wrongdoing.

However, it is possible that if members of the public became more aware of cases of wrongdoing and of GMC regulatory action, this might change. However, the qualitative research suggests this is unlikely given the strong foundation of trust in the medical profession discussed in the previous section.



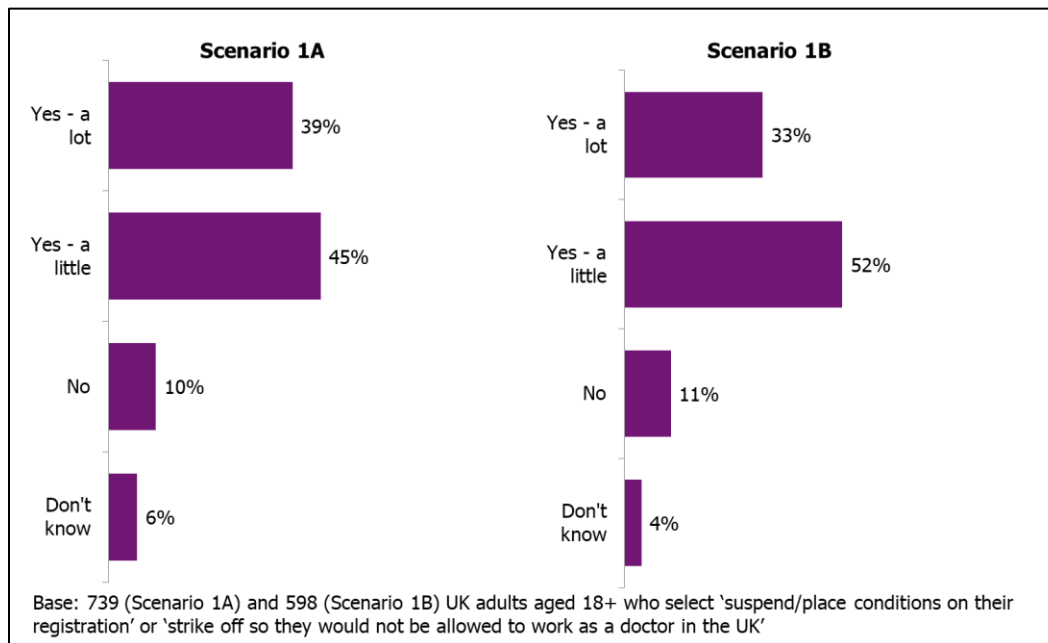
**Figure 27: Q9a/ Q11a. If the GMC did not [suspend/strike off] but decided on a less severe action, and this was their general approach in similar cases, would this undermine your confidence in the medical profession as a whole?**

### **8.2.4 Impact of GMC regulatory action (or lack thereof) following clinical errors on public confidence in the GMC**

In both the qualitative and quantitative research, the impact on confidence in the GMC, if it took more lenient action than anticipated following a clinical error, was considered.

Within the survey, where respondents expressed an expectation that the doctor would be suspended or struck off in response to the base clinical scenarios, they were also asked whether, if the GMC took a lesser action, this would undermine their confidence in the GMC itself. Figure 28 shows the response which suggests, that confidence would be undermined for many: only 1 in 10 people said that 'no' their confidence would not be undermined (10% Scenario 1A; 11% Scenario 1B). Again, it should be borne in mind that, within the survey, this reported effect on confidence in the GMC was prompted by the question, rather than being raised spontaneously.

As already shown, understanding of the GMC was generally quite limited. Most participants in the qualitative research held few preconceived ideas about the regulator. In the online survey only 3% felt that they knew 'a great deal' about the GMC with a further 14% saying they knew 'quite a lot' – the remaining 83% knew no more than 'a little bit' about the GMC and over a quarter had never heard of the GMC at all. A few qualitative participants had questions about how the GMC reached decisions, and assumed that it was likely to be 'on the side' of doctors. A small minority of bulletin board 'complainants', who had had previous contact with the GMC, held negative views about the GMC and did not trust its decisions.



**Figure 28: Q9a/ Q11a. If the GMC did not [suspend/strike off] but decided on a less severe action, and this was their general approach in similar cases, would this undermine your confidence in the GMC?**

Finding out more about the GMC raised questions for some participants, including:

- How do cases come to the GMC's attention?
- How does it link in with local procedures (such as incident reporting and complaints)?
- Who is on decision-making panels – is it the panel all doctors? Some assumed that it would be made up of 'doctors protecting their own' or 'doctors marking their own homework'.
- How long do sanctions last, and what impact do they have on doctors?
- Is there a higher body to hold the GMC itself to account?

For some participants, these questions raised doubts about thoroughness and effectiveness. In particular, they questioned how the GMC could monitor the actions of *all* doctors and take action on *all* errors or wrongdoing. They worried that some cases would slip through the net or be 'swept under the carpet'. This concern was perhaps exacerbated because participants had little understanding of other mechanisms for holding doctors to account, such as supervision, revalidation, incident reporting, and local complaints processes.

In the qualitative research, there was a split in opinion on the specific impact of more lenient action on participants' confidence in the GMC:

- Some participants said that they would trust the GMC to have thoroughly investigated the case, and that they were the experts on whether a doctor

could continue practising and with what restrictions if so. To a degree, these participants wanted to trust the GMC, as the issues are too involved and complicated for them as members of the public to analyse and decide on;

- Other participants said they would lose faith if the GMC took a lesser action than they expected, and that this would reinforce underlying assumptions that the regulator would 'protect its own'.

Even in the context of more lenient regulatory action following a GNM/ CH conviction, some participants held that there were exceptional circumstances where a doctor could continue to practise, and that the GMC would know best (however, they still felt they might not trust that individual doctor). Other participants could not countenance the idea of a doctor practising with a GNM/CH conviction. They would assume the GMC was 'toothless', ineffective, 'untrustworthy' or even 'corrupt' if it allowed a doctor to continue practising.

It should be noted that several participants in the qualitative research expected the GMC to adopt a disciplinary approach with regards to wrongdoing. They expected the GMC to 'hold the doctor to account' for their actions and to punish them. For some, it was important to demonstrate accountability to the public and the family of the victim of a clinical error. As a result, if the GMC took more lenient action than they expected, these participants felt the GMC was failing the family and the public, and not performing effectively as a regulator.

Several participants called for greater transparency from the GMC, explaining to the public their function, how they make decisions, and emphasising the interplay between the regulator, the criminal justice system, employers and the families of patients who have suffered harm or died.

## Appendices

### Appendix 1: Rapid Evidence Review

Prior to the research, Community Research completed a rapid review of the available evidence. The team used this evidence to inform the sample design and materials such as the scenarios and accompanying 'what ifs'. The rapid evidence review is included below.

#### 1. Context

In March 2018, the General Medical Council (GMC) announced an independent review to "*consider gross negligence manslaughter [GNM] and culpable homicide [CH] (in Scotland) in relation to the perceived vulnerability of the medical profession to charges of GNM/CH.*"<sup>6</sup> The instigation of the review followed concern within the profession regarding two recent high profile cases involving doctors; namely Dr Bawa-Garba<sup>7</sup> and Mr Sellu<sup>8</sup>.

The review, which will be reporting in early 2019, is focused on considering how the GMC should handle such cases in future. In particular it is focused on considering the relationship between the criminal processes for GNM/CH and the professional regulatory process. Whilst not revisiting the two cases in question, the review is also considering the wider questions and issues that were raised by those cases. One focus of the review is on the requirement placed on the GMC to promote and maintain public confidence in the medical profession and how this should be put into practice, particularly where a doctor has been convicted of a criminal offence.

The GMC's indicative sanctions guidance states that the main reason for imposing sanctions is to fulfil the statutory objectives in section 1 of MA 1983. It says the following about maintaining public confidence: "*Patients must be able to trust doctors with their lives and health, so doctors must make sure that their conduct justifies their patients' trust in them and the public's trust in the profession ... Although the Tribunal should make sure the sanction it imposes is appropriate and proportionate, the reputation of the profession as a whole is more important than the interests of any individual doctor.*"

The final legal judgement relating to the Bawa-Garba case states that "*public confidence in the profession must reflect the views of an informed and reasonable member of the public, or the statement of Holgate J in Wallace v*

---

<sup>6</sup> The full terms of reference for the review can be found at: <https://www.gmc-uk.org/-/media/documents/terms-of-reference-for-gnm-review-pdf-73991039.pdf>

<sup>7</sup> <https://www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/supporting-a-profession-under-pressure/responding-to-the-case-of-dr-bawa-garba>

<sup>8</sup> <https://www.judiciary.uk/wp-content/uploads/JCO/Documents/Judgments/r-v-sellu-sentencing-remarks.pdf>

*Secretary of State for Education [2017] EWHC 109 (Admin), [2017] PTSR 675 (at [92] and [96(v)]) that public confidence in the profession must be assessed by reference to the standard of "the ordinary intelligent citizen" who appreciates the seriousness of the proposed sanction, as well as the other issues involved in the case"*<sup>9</sup>

The GMC has, therefore, commissioned some research on behalf of the independent review to explore how the public believes the GMC should respond to specific behaviours/acts/omissions by doctors, particularly when these behaviours/ acts/omissions have also been subject to action through the criminal justice system. This rapid evidence review has been conducted to inform the design of this research programme, in particular to aid the sample design and to inform the development and use of scenarios. Scenarios, based on tailored, anonymised real-life cases or hypothetical cases are a valuable, tried and tested tool used to prompt in-depth discussion with participants. They help bring the research to life given that research participants can, sometimes, find it difficult to discuss issues in the abstract.

This review is not an exhaustive or academic exercise given its very specific (and focussed) objectives.

## **2. Overall approach**

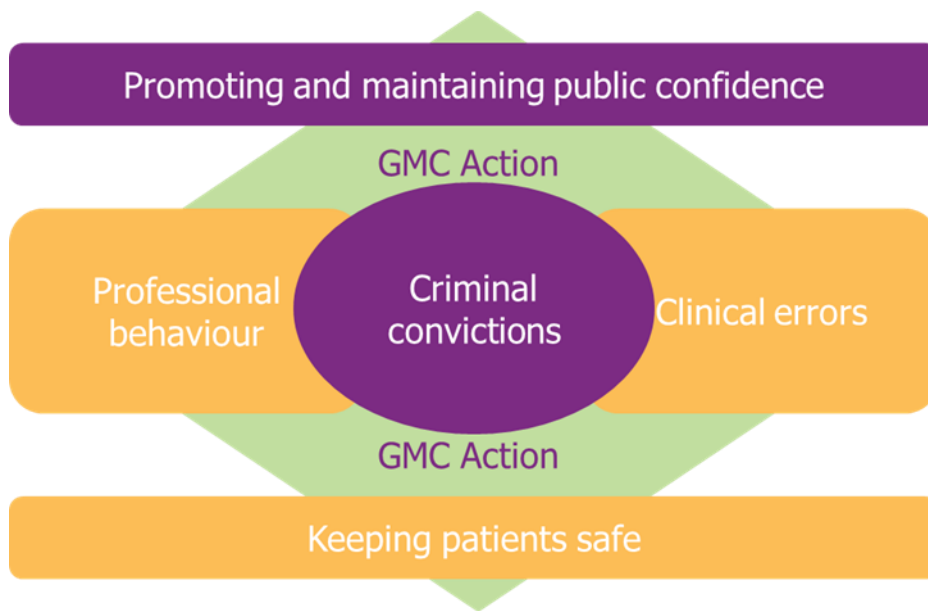
The overall approach has been designed to explore how the GMC should respond to specific behaviours/acts/omissions by doctors, particularly when they have been subject to action through the criminal justice system. In order truly to gauge the impact of a criminal conviction on the public expectation of GMC's response we will look to:

- Explore initial reactions to both unprofessional behaviour and clinical error but maintain and emphasis on clinical error.
- Gauge how participants believe the GMC should respond to such behaviours and errors.
- For relevant cases, introduce the criminal conviction and understanding if, and how, participants' reactions change
- Ensure that we cover a wide array of criminal cases and outcomes i.e. from accepting caution for minor offence through to being found guilty of GNM.

Figure 1 illustrates how we visualise criminal conviction sitting at the heart of the research and how we will, wherever possible, use scenarios relating to professional behaviour and clinical error that could result in a conviction.

---

<sup>9</sup> <https://www.judiciary.uk/wp-content/uploads/2018/08/bawa-garba-v-gmc-final-judgment.pdf>



*Figure 1: Overview of research*

We appreciate thought processes relating to these issues are 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<sup>10</sup> 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%).

A report by Sheffield Hallam University on behalf of the General Social Care Council<sup>11</sup> exploring professional boundaries with registrants, students and educators found that there was a wide level of responses and differing degrees of certainty with some participants finding it easier to come to a conclusion than others. The report notes 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 know from our previous research on the concept of trust for the Food Standards Agency<sup>12</sup> 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.

<sup>10</sup>[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](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

<sup>11</sup>[http://shura.shu.ac.uk/1759/1/Prof\\_Boundaries\\_FINAL\\_REPORT.pdf](http://shura.shu.ac.uk/1759/1/Prof_Boundaries_FINAL_REPORT.pdf)

<sup>12</sup><https://www.food.gov.uk/sites/default/files/media/document/trust-deliberative-forums-research-fsa-2018.pdf>

This means that we have designed a research approach that allows for time and space for an exploration of nuanced opinions through a series of scenarios. We will conduct longer than average group sessions (of 2 hours rather than the standard 90 minutes), with individual activities to ensure we hear from individual participants as well as the group.

### ***3. Agreed approach to sampling and recruitment***

The research objectives indicated that there was a need to explore the views of the 'general public' as a whole, as well as more specific patient groups.

Evidence from the Kings Fund<sup>13</sup> suggests that age and recency of personal experience can impact on perceptions of trust. In light of this, groups will be conducted by lifestage (in order to explore if age does influence attitudes). Within these age groups, there will also be a mix by recency/frequency of visits to a doctor. According to the BMA, the average member of the public sees a GP six times a year; double the number of visits from a decade ago<sup>14</sup>. Other sources indicate that age and gender both influence the frequency of visits; with older people and women more likely to visit the GP most often.<sup>151617</sup> This has, therefore, been factored into the recruitment specification to ensure an appropriate mix by frequency/recency of contact with a doctor within each group.

There is little evidence relating to the impact of socio-economic group on confidence in health professionals although one study mentions differences in attitudes relating to those with private insurance<sup>18</sup>. However, we will conduct homogenous groups with those from higher and lower socio-economic groups as it is generally considered best practice within market research. It ensures that those from a higher socio-economic group, who have benefited from higher education and/or are financially better off do not dominate conversations and/or intimidate participants who might be less articulate and who may have a very different world view. It also facilitates analysis as it means that we can clearly identify the views of different socio-economic groups.

---

<sup>13</sup> <https://www.kingsfund.org.uk/blog/2015/12/public-trust-doctors-nurses>

<sup>14</sup>

<https://www.bma.org.uk/-/media/files/pdfs/.../press%20briefings/general-practice.pdf>

<sup>15</sup> <https://bjgp.org/content/68/670/e370>

<sup>16</sup> <https://files.digital.nhs.uk/publicationimport/pub01xxx/pub01077/tren-cons-rate-gene-prac-95-09-95-08-rep.pdf>

<sup>17</sup> <https://bmjopen.bmj.com/content/3/8/e003320>

<sup>18</sup> <https://qualitysafety.bmj.com/content/13/2/92>

Whilst we can find little evidence in the UK about the impact of ethnicity on attitudes other than this study<sup>19</sup>, there is fairly extensive research from the US<sup>20</sup> that being from a minority ethnic group can have a bearing on views. Some people from minority ethnic groups will be included in the 'general public' groups but we will also conduct some separate groups with these audiences in order to explore their views in detail. As a way of prioritising, we will focus on those minorities with both relatively high populations in the UK and poorer health outcomes, namely Bangladeshi, Pakistani and Black Caribbean communities. For example Indian and Chinese populations are well represented in the UK but are less likely to be at risk of health exclusion<sup>21,22</sup>.

We will conduct single gender groups for the Bangladeshi and Pakistani groups as this tends to be best practice for conducting group discussions with Muslim communities<sup>23</sup>.

There are other audiences that it will be interesting to explore the views of specifically as we can hypothesize that these audiences could have a different view of the issues given their experience of or their ongoing relationship with healthcare professionals:

- Those patients who have made a complaint about a health practitioner.
- Those patients with long-term conditions.
- Informal carers (as defined as 'people who look after a relative or friend who needs support because of age, physical or learning disability or illness, including mental illness' (Department of Health 2005a<sup>24</sup>). This 'looking after' can be in the shape of active support, supervision or social interaction, all of which are provided by informal carers in a non-professional capacity. We suggest that only those carers who look after someone for 20 hours a more per week are included as evidence suggests that this level of care is likely to have more of an impact on carers than lower levels<sup>25</sup>.

Because the GMC is a regulator across the UK, both the qualitative and quantitative research will be conducted across the UK, with some fieldwork in each of the devolved nations and sufficient quantitative responses in each country. This is particularly important in terms of Scotland, given the different legislative framework. According to a legal briefing, "*In Scotland there is no offence of gross negligence manslaughter. The equivalent offence is involuntary*

---

<sup>19</sup> <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3657663/>

<sup>20</sup> <https://www.futurity.org/physicians-race-trust-1079492-2/>

<sup>21</sup> Parliamentary Office of Science and Technology: Ethnicity and Health Number 276', 2007

<sup>22</sup> [http://www.ons.gov.uk/ons/dcp171776\\_318773.pdf](http://www.ons.gov.uk/ons/dcp171776_318773.pdf)

<sup>23</sup> <https://www.kirklees.gov.uk/involve/document/ResearchBME.pdf>

<sup>24</sup> Department of Health 2005a

<sup>25</sup> <https://www.npi.org.uk/publications/income-and-poverty/informal-care-and-poverty-uk/>

*culpable homicide. There has been no successful prosecution of a doctor involving this offence. Culpable homicide is committed where the accused has caused loss of life through wrongful conduct, but where there was no intention to kill. However the mens rea for the offence is undefined and is to be inferred from the circumstances of the accused's actions. The only guidance is that the mens rea of "criminal recklessness in the sense of a total indifference to and disregard for the safety of the public" is an essential element. The essential elements of involuntary culpable homicide are uncertain and unpredictable."*<sup>26</sup>

#### **4. Scenario development**

In terms of the specific 'behaviours/acts/omissions' of interest, the research brief indicates that the GMC would like this research to consider public expectations with reference to a doctor:

- making one or more serious errors whilst working;
- engaging in behaviour that may be regarded negatively (and could be criminal) but is confined to their life outside medicine;
- having a conflict of interest which they fail to declare;
- having inappropriate sexual relationships with a patient;
- breaking professional boundaries (i.e. "the boundary between what is acceptable and unacceptable for a professional both at work and outside work").

#### **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 on indicative sanctions guidance, which included case studies of doctors' behaviour.<sup>27</sup>
- NatCen's research 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.<sup>28</sup>
- Qualitative research conducted on behalf of the Professional Standards Authority explored public, patient and registrant perceptions of dishonest behaviour by healthcare professionals.<sup>29</sup>
- Quantitative research by the Solicitors Regulation Authority which explored public and professionals' attitudes to trust, again using a range of scenarios.<sup>30</sup>

---

<sup>26</sup> <https://www.clydeco.com/insight/article/dr-bawa-garba-could-it-happen-in-scotland>

<sup>27</sup> [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](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)

<sup>28</sup> <https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/patient-and-public-attitudes-to-standards-expected-of-doctors>

<sup>29</sup> <file:///C:/Users/rebec/Documents/dishonest-behaviour-by-hcp-research.pdf>

- Research by Sheffield Hallam University on behalf of the General Social Care Council<sup>31</sup> explored professional boundaries, using scenarios.
- Sessions conducted with registrants by the GMC on the topic of GNM have used the following scenario as the basis for discussion:



Ethical Dilemma -  
v0.1.docx

Community Research has also conducted (unpublished) research using scenarios at deliberative workshops with patients and public as part of General Pharmaceutical Council review of their indicative sanctions guidance and to explore the concept of 'professionalism' on behalf of the General Dental Council. Whilst these projects are not in the public domain, we can apply our learning from these research programmes to this piece of research.

One key distinction between this current piece of work and others cited above are that the latter tend to have a specific focus, for example scenarios relating to different kinds of dishonesty (i.e. fraud relating to the NHS or theft from patients, theft/false expense claims/non-payment of tax not related to their profession, fare dodging) or cases relating to registrants raising concerns. Also, they often concentrate on less serious cases than those relating to GNM.

### **Using scenarios in research**

Based on our previous experience, care needs to be taken when selecting the scenarios for use in research:

- The scenarios chosen need to cover the range of issues but also be prioritised in order not to overwhelm research participants.
- 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 one or two paragraphs.
- Particular thought needs to be given to the phrasing and language used to describe the cases, recognising that how actions/issues are described could influence public perceptions. For example, we note that a phrase used in a relevant criminal case was 'a catalogue of errors'. This type of description may provoke a more emotional response from participants than stating that there was a series of errors. We also note that GNM relates to errors that are 'truly exceptionally bad', which again is a fairly loaded term.

---

30

<file:///C:/Users/rebec/Downloads/UCL%20report%20on%20pre%20consultation%20survey.pdf>

<sup>31</sup> [http://shura.shu.ac.uk/1759/1/Prof\\_Boundaries\\_FINAL\\_REPORT.pdf](http://shura.shu.ac.uk/1759/1/Prof_Boundaries_FINAL_REPORT.pdf)

- Scenarios tend to work well when information is layered on gradually, for example outlining the basic scenario and then discussing related mitigating or aggravating factors.

### **Issues to consider including in selected scenarios**

A review of the types of scenarios used in previous related projects (outlined in Section 4.1) 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):

#### ***Type of cases***

- Whether the case involved vulnerable patients (involving either inappropriate relationships and/or cases relating to medical errors).
- Cases 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; or things that the registrant does in their personal life, for example, shoplifting; possessing a small amount of class B drugs; drunken fights.
- Cases which are influenced by a registrant's medical condition (for example, alcohol and drug addiction).
- Cases which involve social media (for example use of foul/racist language; posting of inappropriate photos or contacting a patient via Facebook etc.).
- Cases relating to series of errors which involve expert advice i.e. exploring how view of an expert on the doctor's actions impacts on public views.

#### ***Criminality***

- Cases that highlight different categories of criminal offence (summary offences i.e. drink driving through to indictable offences i.e. GNM) – exploring if the public distinguish between different categories of criminal offence and what they perceive to be 'serious'.

#### **Systemic/organisational issues**

- Cases which involved mitigating factors related to systemic failure, pressure on resources (e.g. lack of beds), under-staffing, issues with technology (e.g. mobile phone reception; IT systems failure).
- Cases which involved breaches of protocol by numerous staff, for example nursing staff and not just the doctor in question, and the related issues of:
  - The responsibility/accountability of senior colleagues (if the doctor in question is in training or more junior).
  - The exertion of pressure to breach protocol (for example, pressure to backdate patient notes).
  - Usual practice or the culture of the organisation i.e. it was usual practice for things to be done in a certain way which breached protocol.

### ***Doctor's intention/response***

- If the case involved recurrent or ongoing issues or was a first time error/transgression.
- The perceived intention of the doctor – evidence of pre-meditation; objective of personal financial gain or sexual exploitation; wanting the best outcome for the patient and acting in good faith, but making a clinical error as opposed to recklessness or a callous regard for safe practice.
- How the doctor responded to the error/issue coming to light (for example, if they self-reported/fully disclosed; if they lied about the issue when questioned, if they demonstrated insight/remorse; evidence of remediation/behaviour change).

### ***Outcomes/impact on doctors/patients***

- The outcome or consequences for the patient/level of harm, including cases where the patient has died as a result of error or omission.
- The outcome for the registrant – ensuring that research participants explore the balance between public interest/confidence against rights of the registrant, registrant investment in their career and future ability to earn a living.
- The outcome in terms of criminal conviction – particularly exploring if the public feel a criminal offence in itself undermines public confidence or if they take account of any mitigating factors.

In terms of considering **aggravating and mitigating factors** throughout the scenarios, use could be made of the PSA report which has useful hierarchies of seriousness relating to mitigating and aggravating factors. These were inferred from the findings of the qualitative research conducted with patients and registrants and participants did not appear to systemically rate them themselves:



Mitigating factors.PNG



Aggravating factors.PNG

The GDC has also recently published a literature review<sup>32</sup> on Impairment and Serious Misconduct which explores aggravating and mitigating factors, as well as the notion of public confidence.

---

<sup>32</sup> <https://www.gdc-uk.org/about/what-we-do/research>

## Appendix 2: Qualitative sample

### Focus groups

8 focus groups of 10 participants each were conducted. All focus groups were recruited to include a 50/50 split of men and women, and at least 2 participants from Black and Minority Ethnic backgrounds. In addition, the following were screened out:

- Those who had made a complaint against a healthcare professional;
- Those who worked for, or had immediate family who worked for, a regulated healthcare profession;
- Those who worked in market research or journalism;
- Those who had taken part in a market research discussion in the last 6 months.

A mix of socio-economic groups were recruited for the research, defined as follows:

- ABC1 – chief income earner in household holds a high, intermediate or junior managerial position;
- C2DE – chief income earner in household is a skilled, semi-skilled or unskilled manual worker, or is retired, a student or unemployed.

Lifestage	Number of times seen a doctor in last 12 months	SEG	Location
Retired (60+)	More than 5 times = minimum of 6	C2DE	Glasgow
Pre-family (18-35, include at least 2 x 18-20 years)	More than 5 times = minimum of 3	ABC1	Glasgow
Family (with dependent children) (25-55)	More than 5 times = minimum of 5	C2DE	Northampton
Empty nesters (45-64)	More than 5 times = minimum of 5	ABC1	Manchester
Retired (60+)	More than 5 times = minimum of 6	ABC1	Newport
Pre-family (18-35, include at least 2 x 18-20 years)	More than 5 times = minimum of 3	C2DE	Newport
Family (with dependent children) (25-55)	More than 5 times = minimum of 5	ABC1	Oxford
Empty nesters (45-64)	More than 5 times = minimum of 5	C2DE	Belfast

### Mini focus groups

There were three further focus groups with 6 participants each. These groups each focused on a different minority ethnic group, and included people from a mix of socio-economic groups, a mix of ages between 30 and 60, and a range of

lifestages. The same screening criteria were used in relation to industries and complaints regarding healthcare professionals as for the standard focus groups.

<b>Ethnicity</b>	<b>Gender</b>	<b>Location</b>
Pakistani	Male	Birmingham
Bangladeshi	Female	Leeds
Caribbean	Mix	London

### **Online Bulletin Board**

Bulletin Board participants were recruited according to the following specification:

<b>Group type</b>	<b>No. of participants</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Gender</b>	<b>SEG</b>
People with long-term conditions or those who have frequent contact with a doctor*	9	32-51	Mix	5 women 4 men	Mix
People who have made a complaint about a health professional	9	No quota	No quota	No quota	No quota
Informal (non-professional) carers (at least 20 hours per week / 3 hours a day)	8	Mix	Mix	Mix	Mix

\* at least once every 2 months / 6 times in last year.

## Appendix 3: Research instruments

### Qualitative research instruments:



Discussion  
guide.docx



Discussion guide  
SCOTLAND.docx



Online discussion  
plan and content.d

### Qualitative scenarios and 'what-ifs':



Scenarios and what  
ifs.docx



Scenarios and what  
ifs SCOTLAND.docx

### Quantitative survey questionnaire:



GMC Public  
confidence quant que