To note

**Doctor and Complainant Survey Action Plans**

1. Our Action Plan for improvements to our fitness to practise procedures, in response to feedback from surveys of doctors and complainants.

**Recommendation**

2. The Strategy and Policy Board is asked to note:

   a. The content of the Action Plan.

   b. Our Action Plan with the survey reports, due to be published in October 2014.
Doctor and Complainant Survey Action Plans

Issue

3 As part of our Research Programme in 2012, a survey of doctors and complainants who had been through our fitness to practise procedures was initiated.

4 The objective was to gather feedback about the fitness to practise process from those who have direct experience of it in order to inform our continuous improvement programme. It is intended that the survey will establish a benchmark by which we can gauge improvement over time.

5 The survey of doctors was initiated first, with 2,363 doctors who had a case that closed approximately twelve months prior to the start of the survey (i.e. in 2010). This was intended to select those doctors whose recollection of the process was still fresh, but who had also had time to reflect on it.

6 169 doctors completed the survey (a response rate of 7%). The survey was conducted from early June to mid-July 2012. The last question of the survey asked respondents if they would be willing to participate in a further qualitative research phase and if so, to leave their details. 113 of these doctors were willing to participate and provided the sample for the qualitative stage. Twenty doctors were then selected to participate in a telephone interview lasting up to one hour.

7 Following completion of the doctors’ survey, work commenced on the complainants’ survey. It was initially intended that a qualitative phase would be followed by a quantitative online survey. However, reflection on an initial stage of qualitative interviews resulted in the decision to have a further phase of qualitative interviews rather than a survey. This was due to the likely response rate, and the difficulty that respondents in the initial qualitative interviews had experienced in distinguishing between commenting on the process as well as commenting on the outcome of their own case.

8 The sample for this project was focused on complainants who were members of the public or patients, and who had submitted and had a complaint taken through to investigation stage and then through to completion of the investigation between July 2012 and September 2013. This resulted in a total potential sample of 895 complainants.

9 We selected a first phase sample of 101 cases and sent them an approach letter. This initial sample comprised a stratified random sample of the available cases, stratified by case outcome categories to ensure that a mix of outcomes would be covered. The letter offered complainants the opportunity to opt in to the research process by making direct contact with Community Research. From the responses to this first mailing, ten interviews were conducted. A second stage of interviews were then conducted, which focused on approaching complainants whose cases had resulted in
a hearing or where some form of action was taken against the doctor’s registration, so that the views of complainants with experience of such cases were adequately covered. During both phases, complainants who made contact with Community Research, to express an interest in participating in the research were re-contacted and an appointment for interview was made. A total of 44 complainants were interviewed, with 10 in the first phase and 34 in the second phase.

Equality data

10 We asked survey respondents to provide equality information, to help us to assess any particular concerns from protected groups, but the response to this request was too low to provide any meaningful data. However, improving our understanding of how doctors and complainants experience our processes and introducing improvements over time should benefit all those who are involved in fitness to practise cases.

Survey Reports

11 We have received reports of feedback to both the doctor (Annex A) and complainant (Annex B) surveys. These reports will be published in October 2014.

12 The feedback has been carefully analysed in order to assess the themes that emerge and to assess where we can take forward improvements in both the short and the longer term.

13 A number of clear themes emerge from the feedback:

a The need for greater transparency, communication and sharing of information with doctors and complainants during our investigation.

b A need to set clear expectations of the fitness to practise process.

c A call for the investigation process to be quicker.

d Concerns about the adversarial nature of fitness to practise hearings.

e Concerns about the management of hearings by panellists.

Action Plan

14 Our Action Plan is at Annex C, which was approved by the Performance and Resources Board at its meeting on 8 September 2014. Given the passage of time since the cases of those who took part in the surveys were completed, we have already made a number of improvements to our procedures that address some of the feedback. For completeness, we have included these in the Action Plan alongside proposals for further improvements both in the immediate and longer term.

www.gmc-uk.org
Supporting information

How this issue relates to the corporate strategy and business plan

This issue relates to Strategic Aim 3 of the Corporate Strategy and Business Plan: improve the level of engagement and efficiency in the handling of complaints and concerns about patient safety.

If you have any questions about this paper please contact: Anna Rowland, Assistant Director - Policy and Planning, ARowland@gmc-uk.org 020 7189 5077.
Exploring the experience of doctors who have been through the GMC’s complaints procedures
General Medical Council

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

Final Research Report

March 2013
Contents
1. Executive Summary ............................................................................. 3
   1.1 Introduction, objectives and methodology ........................................ 3
   1.2 Overall conclusions ..................................................................... 4
2. Introduction, Objectives and Methodology ........................................... 8
   2.1 Introduction ............................................................................... 8
   2.2 Objectives ................................................................................ 8
   2.3 Methodology ............................................................................ 8
3. Key Findings ................................................................................ 12
   3.1 The complaint or referral ......................................................... 12
   3.2 Communication with employer(s) or contractor(s) of services ......... 19
   3.3 The investigation process ......................................................... 23
   3.4 Interim Orders Panel hearing ..................................................... 32
   3.5 Case examiner decision and outcomes ....................................... 33
   3.6 Investigations Committee .......................................................... 37
   3.7 Fitness to Practise Panel (FTP) hearing ........................................ 38
   3.8 Communication during the process ............................................ 52
   3.9 Overall experience .................................................................. 57
4. Conclusions .................................................................................. 61
5. Appendices ................................................................................... 66
   5.1 Respondent Profile ................................................................. 66
   5.2 Research instruments ............................................................... 68
1. Executive Summary

1.1 Introduction, objectives and methodology

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

The objectives of the research were:

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

The methodology consisted of the following 3 stages:

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

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

1.2.1 Survey findings

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

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

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

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

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

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

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

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

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

The common concerns were as follows:

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

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

- The protracted nature of the process.

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

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

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

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

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

1.2.3 Key Challenges for the GMC

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

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

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

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

2.2 Objectives
The research explored perceptions of experiences throughout the FTP process, as well as broader issues of communication and general suggested improvements. The structure of both the quantitative questionnaire and qualitative topic guide were broadly similar, and asked for feedback on the following (where relevant):
- The initial letter informing the doctor of the complaint and the accompanying leaflet.
- Communication with employers/contractors about the complaint.
- The investigation process.
- Interim Orders Panel hearing.
- Case examiner decision and outcome.
- FTP Panel hearing.
- Communication during the process.
- Overall experience.

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

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

<table>
<thead>
<tr>
<th>Project component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive pilot</td>
<td>Testing of the quantitative questionnaire with 3 doctors and 2 medically trained GMC staff</td>
</tr>
<tr>
<td>Research with doctors</td>
<td>Quantitative survey (postal and online) with 169 doctors 20 in depth interviews following up issues raised in quantitative survey</td>
</tr>
<tr>
<td>Research with doctors erased by an FTP panel</td>
<td>5 in depth telephone interviews, based on the online questionnaire, with doctors erased by an FTP panel</td>
</tr>
</tbody>
</table>
Cognitive pilot
In November 2011 the GMC wrote to 51 eligible doctors (i.e. those with a case closed during 2010 and without a subsequent open case) and invited them to participate in a cognitive pilot to help inform the design of the questionnaire for the quantitative survey. Doctors were invited to ‘opt-in’ to the pilot by contacting Community Research. Three doctors opted in. Given this low response, 2 GMC members of medically trained staff with knowledge of the FTP process also participated in the pilot to provide additional feedback.

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

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

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

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

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

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

The last question of the survey asked respondents if they would be willing to participate in a further qualitative research phase, and if so, to leave their details. 113 of these doctors were willing to participate and provided the sample for the qualitative stage. A number of these doctors were then selected to participate in a telephone interview, at a time of their choosing, lasting up to 1 hour.
The 20 qualitative interviews were made up accordingly:

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

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

**Research with doctors erased by a FTP panel**

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

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

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

**Notes on reading the report**

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

The vast majority of doctors who go through the FTP process have not chosen to do so (although some self-referrals do occur). The nature of the process generally means that a doctor has had a complaint made about their practice or a negative event has led the GMC to investigate the doctor. As such, it is to be expected that doctors will not view the experience positively. Whilst doctors were asked to be objective and to feed back on the process...
itself rather than the details of their own case, it should be recognised that, for many, the process and the case will have been a distressing experience. Furthermore, the research focussed on suggestions for process improvement and as such actively sought doctors to be critical.

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

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

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

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

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

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

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

3.1 The complaint or referral

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

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

3.1.1 Clarity of the process and the decision to investigate
The survey began by asking respondents about the initial letter they received informing them of the complaint or referral.

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

Opinion was almost equally divided about whether or not the letter was clear about the process that would follow; 51% of respondents agreed or agreed strongly and 44% disagreed or disagreed strongly that the letter was clear about the process that would follow.
Respondents were then asked an open ended question (allowing them to write their own response) on how this initial stage of the process could be improved. The two most common responses, each with nearly one fifth of mentions (18%) were “keep me informed/ up to date/ copy me in to all correspondence” and “give more information on the different routes and outcomes.”

“A lot more information provided about the stages, and who would be dealing with the complaint at that stage.”

“Clearer understanding of the process/procedure would have helped. Including information on the stages/levels of investigation and action.”

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

“Clearer about the process. Realistic about the timeframe. Clearer communications channels.”

“An initial letter, followed by a telephone call to reassure. The letter isn’t very sensitively worded. Makes you feel guilty from the start.”

---

1 The FTP process has various stages, as will be explored within later stages of this report. Doctors were asking here for greater clarity about the possible stages that might occur.
“A far less aggressive letter would be much better; one that did not make you feel like a criminal and that the GMC had decided against you already.”

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

<table>
<thead>
<tr>
<th>Suggestion</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keep me informed / up to date / copy me in to all correspondence</td>
<td>18%</td>
</tr>
<tr>
<td>Give more information on the different routes and outcomes</td>
<td>18%</td>
</tr>
<tr>
<td>Supply a timeline of the process</td>
<td>16%</td>
</tr>
<tr>
<td>Review the tone of communications</td>
<td>15%</td>
</tr>
<tr>
<td>Earlier vetting of cases / filter out malicious complaints</td>
<td>14%</td>
</tr>
<tr>
<td>Satisfied with this part of the process</td>
<td>13%</td>
</tr>
<tr>
<td>A fairer process / listen to all sides / equal treatment of both sides</td>
<td>11%</td>
</tr>
<tr>
<td>Give more detail on the nature of the complaint</td>
<td>10%</td>
</tr>
<tr>
<td>Provide helpline / contact details</td>
<td>9%</td>
</tr>
<tr>
<td>Don’t assume my guilt from the start</td>
<td>7%</td>
</tr>
<tr>
<td>Stress that this is initial enquiry / Inform that many complaints go no further</td>
<td>7%</td>
</tr>
<tr>
<td>Speed up the process</td>
<td>5%</td>
</tr>
</tbody>
</table>

Base: All survey respondents (169)

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

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

“They gave no indication as to what sort of timescales they’d be working to, so 18 months passed following that initial letter, maybe even up to two years, before it was finally dealt with.”
wasn’t given an indication it would take that long, I wasn’t given any indication as to what it was they were going to be doing, what their procedures were, what information they were looking for etc."

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

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

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

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

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

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

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

“We just assume that if anyone complains about a doctor to the GMC that automatically triggers off an investigation. Clearly it needs the GMC to come off sitting off the fence and say ‘look, we’ve received this complaint and our initial concerns are x, y and z’, a brief summary.”
“The letters had this threatening tone and it seemed that, as soon as somebody complains to the GMC, they sort of swing into action and start looking for things then. It wasn’t a question of ‘has this patient’s complaint any justification? Let’s look through all that’s gone before the Trust and get an expert to look at the answers’. This was ‘oh, here’s a chance to investigate a doctor, let’s see what we can find’. That was the impression that I was given of the way the whole process went, which seems grossly unfair really.”

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

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

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

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

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

“It just said ‘please find enclosed the letter’, basically I think they were just saying here’s a letter, a complaint, read the letter and I suppose what they implied was that if I read the letter I’d
know what the complaint was about. But, as I said, I was barely able to understand the letter and certainly didn’t understand what the specific complaint was about.”

3.1.2 Perceptions of the leaflet and suggested improvements

Process

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

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

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

![Pie chart showing responses to the question: If you saw the leaflet, how helpful was it?](image)

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

Other suggestions included making the leaflet “clearer and easier to understand” (13%) and “more helpful/supportive” (13%). One source of suggested support was an explanation of the number of complaints made to the GMC and their outcomes, in order to provide context or acknowledgement that complaints can be vexatious.
“It is very dry and unsympathetic. It is pro-complainant anti-doctor. It needs to be more reassuring for the majority of excellent clinicians who have been reported. Acknowledgment must be made that vindictive patients will make groundless accusations.”

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

<table>
<thead>
<tr>
<th>Suggestion</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaflet is irrelevant - process is traumatising/harrowing</td>
<td>16%</td>
</tr>
<tr>
<td>Clearer/easier to understand</td>
<td>13%</td>
</tr>
<tr>
<td>Should be more helpful/supportive</td>
<td>13%</td>
</tr>
<tr>
<td>Less generic/impersonal/relate to my case</td>
<td>12%</td>
</tr>
<tr>
<td>More information - procedure</td>
<td>12%</td>
</tr>
<tr>
<td>Leaflet was satisfactory</td>
<td>10%</td>
</tr>
<tr>
<td>Don’t assume guilt from the start</td>
<td>9%</td>
</tr>
<tr>
<td>More information on the detail of the complaint</td>
<td>9%</td>
</tr>
<tr>
<td>More information - timescales</td>
<td>9%</td>
</tr>
<tr>
<td>Inform me of my rights</td>
<td>4%</td>
</tr>
<tr>
<td>Can’t remember/don’t know</td>
<td>10%</td>
</tr>
<tr>
<td>Nothing in particular</td>
<td>14%</td>
</tr>
</tbody>
</table>

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

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

“At this stage the reaction is going to be distress at receiving a complaint, so it’s difficult to provide information that will be reassuring.”
There was also comment that the stress of receiving the letter can make it difficult for any information, however useful, to ‘sink in’.

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

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

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

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

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

3.2.1 Ratings of aspects of communication

### The process

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

All respondents who were employed or working under contract at the time of the complaint were asked about how satisfied or dissatisfied they were that the process of the GMC communicating with their employer(s) or contractor(s) was handled sensitively. Views were mixed with 44% satisfied or very satisfied, but a third dissatisfied or very dissatisfied (33%) and a quarter said that they didn’t know (23%). The qualitative interviews showed
that a number of doctors did not remember anything about providing employer details and communication with their employer, which would explain this high ‘don’t know’ response in the survey.

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

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

<table>
<thead>
<tr>
<th>Satisfied</th>
<th>Dissatisfied</th>
<th>Very dissatisfied</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>39%</td>
<td>14%</td>
<td>19%</td>
<td>23%</td>
</tr>
<tr>
<td>52%</td>
<td>21%</td>
<td>28%</td>
<td>14%</td>
</tr>
</tbody>
</table>

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

3.2.2 Suggested improvements

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

“All communications between the two parties must be copied to the accused doctors, for reasons of transparency.”

“Any correspondence between my contractor and the GMC should have been copied to me which I am sure wasn’t the case.”

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

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

“There was clearly communication which I hadn’t been copied in to...it was quite a surprise when we kind of met in a corridor about something else, he started a conversation about a level a detail which I hadn’t expected. Which I think was slightly uncomfortable in that I was obviously feeling a bit raw about it and it was suddenly coming up in a situation where I wasn’t expecting it to come up.”
One participant commented that he had been allowed to see the correspondence between his employer (a Primary Care Trust) and the GMC and by doing so, this helped to reduce his stress.

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

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

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

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

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

“There wasn’t any communication between the Trust and the GMC, that I was aware of, because surely if I had been, the Trust would have said actually we’ve been through all this with a fine tooth comb and found that actually this patient is one of
“those peculiar people who just likes to complain and got very angry over things that he didn’t understand.”

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

3.3 The investigation process

3.3.1 Representation

Respondents were asked how they generally interacted with the GMC during the investigation of their case. Multiple responses were possible. As Figure 3.7 shows, half of respondents (50%) said that a representative from a professional organisation handled interactions with the GMC on their behalf and nearly half (48%) said that they interacted with the GMC themselves. Nearly a third (31%) said that a solicitor or barrister handled interactions with the GMC on their behalf.
The qualitative interviews suggested some confusion about the need for representation. For most, the receipt of the initial GMC letter triggered a call to a representative body. However, some doctors failed to appreciate the possible magnitude of the FTP process; they believed an investigation would conclude their innocence and so did not think to involve representation at early stages.

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

### 3.3.2 Rating of aspects of the process

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

Other aspects of the investigation process received a more mixed response. Just over half of respondents (56%) disagreed or disagreed strongly that they were ‘kept informed of progress’ whilst just under half, 42% agreed or agreed strongly.
Nearly 4 in 10 respondents (39%) agreed or agreed strongly that ‘their comments were considered as part of the investigation’, however just over a third disagreed (34%) with a quarter (23%) disagreeing strongly. There was also a comparatively high ‘don’t know’ response to this question (at 1 in 5 or 16%); qualitative investigation suggested that this is because they felt they had no clear way to know for certain, whether or not the GMC had genuinely considered their comments.

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

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

<table>
<thead>
<tr>
<th>Gave you and / or your representative enough time to comment</th>
<th>10%</th>
<th>70%</th>
<th>28%</th>
<th>3%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kept you informed of progress</td>
<td>5%</td>
<td>37%</td>
<td>34%</td>
<td>22%</td>
</tr>
<tr>
<td>Considered your comments as part of the investigation</td>
<td>11%</td>
<td>28%</td>
<td>11%</td>
<td>23%</td>
</tr>
<tr>
<td>Understood the circumstances of my case</td>
<td>9%</td>
<td>30%</td>
<td>18%</td>
<td>39%</td>
</tr>
<tr>
<td>Conducted the investigation in a timely manner</td>
<td>9%</td>
<td>26%</td>
<td>24%</td>
<td>38%</td>
</tr>
</tbody>
</table>

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

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

“He (the assessor) didn’t understand the nuances of the relevant sub speciality and he didn’t... I don’t think he grasped what the patient was complaining about.”

Some respondents raised questions as to whether the GMC had sufficient assessors to ensure the appropriate breadth as well as depth of knowledge. One participant commented about the barriers to becoming an assessor, with
the hours required by the GMC not being consistent with the hours allowed for professional leave by the NHS; this was thought to limit the numbers of assessors and limit the most capable or experienced doctors or consultants becoming assessors.

“They obviously have a need to employ a lot more investigators within multiple subspecialties.”

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

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

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

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

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

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

In the qualitative interviews doctors were frustrated by the inability to talk to case examiners and explain their case. They expressed the desire to have a chance to put their side of the story across and answer questions that the
GMC have as soon as possible. Some used the analogy of a police investigation, where the accused would be interviewed by the police and have a chance, verbally, to explain or defend themselves and thereby influence the focus of the investigation. The same is expected of a GMC investigation. The current system of letters is thought to be inadequate and, instead, a conversation is needed to paint a complete picture and ensure that the case examiners have an adequate/appropriate understanding of the issues.

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

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

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

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

“All I got in that period was, or my solicitor got, the holding emails. They didn’t say what they were looking for, the information they were seeking.”
In the qualitative interviews those that had agreed or agreed strongly in the survey that the GMC “gave you and/or your representative enough time to comment”, nevertheless bemoaned the protracted nature of the overall investigation, and stated that the length of the overall process was, in fact, a cause of dissatisfaction, even though it did mean that there was plenty of time to comment.

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

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

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

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

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

“None of the GMC panel ever went to our Practice to see how we were working.”
In some cases the investigation was thought to rest on a ‘he said, she said’ situation, with a perception that the GMC made insufficient efforts to delve deeper into the issues.

3.3.3 Reasons for not commenting

<table>
<thead>
<tr>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors are asked directly for comment at the outset of the investigation in the initial letter they receive, and are again asked at the end of the investigation. Doctors may also provide comment at any point during the investigation.</td>
</tr>
</tbody>
</table>

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

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

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

<table>
<thead>
<tr>
<th>Reason for not commenting</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was following representative’s advice</td>
<td>38%</td>
</tr>
<tr>
<td>Wasn’t given the chance/ investigation behind closed doors</td>
<td>18%</td>
</tr>
<tr>
<td>My comments were not taken into account/ignored/ twisted</td>
<td>8%</td>
</tr>
<tr>
<td>Concerned that the information could be used against me</td>
<td>8%</td>
</tr>
<tr>
<td>Had previously provided adequate information</td>
<td>5%</td>
</tr>
<tr>
<td>Other answers</td>
<td>20%</td>
</tr>
<tr>
<td>Nothing in particular</td>
<td>18%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3%</td>
</tr>
</tbody>
</table>

Base: All those giving an answer (40)

The qualitative interviews highlighted a number of cases where the doctors had been told by their defence unions or representatives not to speak to the GMC. They had been told that they were risking widening the scope of the investigation and that the GMC could ‘twist things’ and use the doctor’s evidence against them.
“The advice I had from the barrister was to make no comments to the GMC as they tend to go on a fishing exercise to look for faults and try to twist anything said against the doctor.”

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

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

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

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

3.3.4 Suggested improvements

In the survey, respondents for whom the GMC had conducted a full investigation were asked how the investigation and opportunity to comment part of the process could be improved. The most common response to this open ended question, with a quarter of responses (23%) was to ‘speed up the process’. Other common responses included ‘earlier vetting of cases/filter out vexatious complaints’ (17%), ‘impartiality/lack of bias’ (17%) and ‘keep me informed/up to date’ (16%). Responses are shown in Figure 3.10.
As was found in the qualitative discussions, a face to face meeting with the GMC is also called for, by 12% of respondents. 10% call for a review of the selection criteria of assessors and discussion in the qualitative interviews suggest that this means selecting assessors with more suitable skills and knowledge (see section 3.3.2).

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

Base: Those for whom the GMC conducted a full investigation giving an answer (77)
3.4 Interim Orders Panel hearing

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

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

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

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

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

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

“The fact that the IOP is not a fact finding body and the fact that the doctor is not allowed to defend himself is rather surreal.”
“They assume that they’re working on the fact that the accusations are taken as proven which, to a certain extent, I can see in terms of serious cases involving child molestation and murder and that sort of thing, and I suppose the GMC will be saying that they have to protect the public or, more importantly, to be seen to be protecting the public; but in did strike me that there’s very few other situations where you’re guilty until proven otherwise.”

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

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

3.5 Case examiner decision and outcomes

3.5.1 Clarity of the process and the rationale for the outcome

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

Nearly three quarters of respondents (72%) agreed or agreed strongly that ‘the reasons for the decision were clearly explained’ and 6 out of 10 respondents (60%) agree or agree strongly that ‘the supporting evidence was clear’.
Figure 3.11: How far do you agree with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree strongly</th>
<th>Agree</th>
<th>Disagree</th>
<th>Disagree strongly</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>The decision was clearly stated</td>
<td>39%</td>
<td>53%</td>
<td>5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You understood the implications of the decision for you</td>
<td>37%</td>
<td>49%</td>
<td>7%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>The reasons for the decision were clearly explained</td>
<td>26%</td>
<td>46%</td>
<td>17%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>The supporting evidence was clear</td>
<td>29%</td>
<td>31%</td>
<td>16%</td>
<td>15%</td>
<td>9%</td>
</tr>
</tbody>
</table>

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

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

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

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

“The decision making was opaque and that the reasoning just didn’t make logical sense, no proper explanation was given as to why my account was discounted.”
3.5.2 Response to ‘Meeting with Doctors’ initiative

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

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

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

“I think it’s a brilliant idea because in this situation I would have been able to say exactly what I said to you now.”

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

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

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

“It would be useful, I would have thought, if there was some way in which there could be an interaction, right at the outset, so that everybody could understand what the issue is and what
Some doctors thought it was important that they bring representation to such a meeting in case they should ‘incriminate’ themselves.

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

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

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

### 3.5.3 Suggested improvements

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

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

**Process**

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>3.7.1 Representation</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the survey, only 14 respondents had been subject to a full FTP Panel hearing. Of these 14 respondents</td>
</tr>
<tr>
<td>• 11 attended all of the hearing and 3 did not attend at all.</td>
</tr>
<tr>
<td>• 1 represented him/herself, and 12 had representation from a solicitor, barrister or professional organisation.</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>3.7.2 Rating of aspects of the process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whilst only 14 respondents who had been through an FTP hearing responded in the survey, their responses are shown in Figure 3.13, the chart shows raw</td>
</tr>
</tbody>
</table>
numbers, rather than percentages. Results should be treated as indicative only, since the number of responses is so small.

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

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

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree strongly</th>
<th>Agree</th>
<th>Disagree</th>
<th>Disagree strongly</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>The decision of the panel was clearly stated</td>
<td>3</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You were given sufficient notice of the panel hearing</td>
<td>2</td>
<td>10</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You understood the implications of the decision for you</td>
<td>3</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>The reasons for the decision were clearly explained</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>The information leaflet provided with the notice of the hearing was helpful</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>If you attended, both sides were given sufficient opportunity to present their case</td>
<td>7</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>It was explained why a panel hearing was felt to be necessary in your case</td>
<td>7</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>If you attended, the Panel was attentive throughout the proceedings</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>If you attended, the hearing was effectively run</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

Some participants had been surprised by the adversarial nature of the hearing and had found the process and the prosecution unexpectedly aggressive.
“I guess the way it was an adversarial process was the bit that was the real surprise. I guess I’d expected something that was more, that wasn’t such a legal process, it was more of an examination and debate of the evidence using, what I would call common sense.”

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

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

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

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

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

There were complaints about the perceived ineffective time management of the Chair, allowing for numerous recesses or adjournments. This was reported as frustrating for participants who wanted the Panel to be concluded as quickly as possible and there is an expectation amongst some that a hearing would run similar to a ‘9-5’ normal working day. It was also reported as being difficult for doctors who have travelled and who were spending numerous nights away from home, something which they feel adds to the
stress of the ordeal. A few doctors were cynical about these delays, saying that the Panel members, including the Chair, are paid ‘per session’ and so it is in their interests financially to protract the time that the hearing runs.

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

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

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

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

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

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

“The prosecuting barrister had such vile language, as if, ‘you are rubbish’ and I wasn’t rubbish.”
There were a couple of complaints regarding the Chair not being fair to both sides or dominating or influencing the panellists, particularly lay panel members, which is thought to be inappropriate.

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

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

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

**Dissatisfaction with the Panel**

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

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

“In my case, it was a surgical procedure, a complication as a result of a surgical procedure. If a Psychiatrist judges me, a Psychiatrist in my opinion has nothing to do with medicine. How can you ask someone to judge someone else if they’re not
familiar with the speciality?.... you have a medical degree but that doesn't give you any kind of familiarity with what we're talking about.”

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

“It ended up as quite an ordeal for all concerned. One of the panel members was not infrequently asleep during the proceedings, which did not give me reassurance.”

“One of the panellists could be seen dozing fairly frequently, which is not reassuring when it is your livelihood and family home at stake.”

“I said ‘look, they are sleeping’. It was after lunch and I had to give my version of events, my testimony after lunch, and I said to my barrister afterwards ‘did you see that two of them were sleeping’ and she said ‘I saw it and I was raising my voice to wake them up’. I can’t believe that.”

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

“I think the difficulty is, the GMC did appoint a CWOF expert, a GP expert but, to be honest, I didn’t feel that he had a hands on, realistic idea of what they were, he wasn’t a GP in the true sense of the word and that was quite frustrating for us because, certainly during the FTP panel, a lot of my evidence I was trying to explain to the panel what CWOF was and what it did, which just to me seems... because I meant the trouble is there were two lay people and then there was a retired psychiatrist, which obviously none of them had any idea about general practice.”

“He was a knee surgeon who did not work in the NHS and who claimed he’d been trained in shoulder surgery but, in fact, had undertaken no work in shoulder surgery, I think, for the whole of his consultant life. I was annoyed. I was going to complain about him to the GMC but my MDU barrister said it’s not worth the effort, the GMC won’t take any notice because they’re short of assessors.”

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

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

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

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

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

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

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

**Difficult to appeal**

**Process**

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

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

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

**3.7.3 Suggested improvements**

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

The few improvements that were commonly suggested included:

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

“"It should be less threatening and intimidating.""

“They should be more medical members in the composition of the panels.”

“Panel members should stay awake.”

“The barristers could get their acts together beforehand as the start time was held up with their discussions. Again a lot of hanging about. I also feel the whole gladiatorial combative style is too legalistic it is not a court of law.”

“Some respect and dignity.”

“I think then that, when people are cleared or when they’re overturned, then the very least the GMC should... you should get a letter from the president of the GMC. The fact that you did... it finishes, you just walk out of the building, nobody says a word to you and you don’t hear from them afterwards. I mean, it just leaves a nasty taste.”

“They obviously have a need to employ a lot more investigators within multiple subspecialties and there needs to be some national agreement whereby GMC assessors have time away from their normal working practice which is under some national agreement because otherwise you’re going to then be left with semi-retired or private people who are trying to earn some extra money by being GMC assessors as opposed to your hardworking NHS consultant who is strictly limited in the amount time that he can take off.”

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

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

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

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

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

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

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

> “I attended the first half... but I realised ‘what am I doing here, what am I doing here, this is just a farce, it’s just a kangaroo court’.”
There were complaints by these doctors about the time limitations on the hearings, which a couple of doctors felt were profoundly unfair; they thought time limitations were not appropriate in a hearing of this significance.

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

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

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

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

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

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

“You can’t win. They said ‘we think you’re dishonest’ so you’re dishonest because it was my word against the Receptionist and they went to her side but there was no evidence of any dishonesty. In the olden days you had to have criminal level of proof, but they’ve changed it since the Shipman thing… Dishonesty and insight are two big words they can hang any doctor on. You overdosed him and you say you didn’t but we think you did’ and when there is no evidence how can you hang somebody, but that’s the law. So these two things they can just hang you for it, they are a law unto themselves because they can decide.”
There was a common complaint of being made to feel like criminals, not just during the hearing, but afterwards, for example with information being circulated in newspapers. The stress of this was reported as not just affecting the doctors, but also their spouses and families.

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

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

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

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

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

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

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

“No patient died, no patient complained, this Hearing was because of the PCT.”
Dissatisfaction with defence and legal representation

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

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

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

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

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

“They can’t just accept that the advice that the doctors are getting from their legal team is good advice, if there’s some way round that. They should have told my legal advice immediately ‘actually you cannot apply for voluntary erasure.’”
3.7.4 Response to establishment of the Medical Practitioners Tribunal Service (MPTS)

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

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

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

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

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

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

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

“Yes, potentially that could be a step forward. I mean, it would be interesting to see how it actually works on the ground but, certainly, the headline is better than what's going on at the moment.”
“The fact that if politicians have a particular axe to grind under a certain circumstance it will have an effect on the outcome of the hearing. There’s been several very political cases recently, again, I’ve seen other sort of major issues that there’s been a lot of political comment on in advance of GMC hearings, which I’d had concern about politicians making decisions or making statements and accusations in advance of a hearing.”

3.8 Communication during the process

3.8.1 Rating of aspects of communication

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

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

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

In the qualitative research, communication problems were a recurrent theme. Participants often expressed feeling they had been ‘kept in the dark’ during
much of the process. They reported being unsure what, if anything, was happening with their case and when their case might be resolved. One doctor who had been erased by an FTP Panel, took the lack of communication from the GMC as an indication that his investigation had been dropped.

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

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

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

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

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

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

“Having to chase it up via my Defence Organisation and you’re feeling that if you’re chasing it up it will prejudice the complaint, so it was slow.”

Whilst there was broad agreement that the tone of letters was professional, in the qualitative interviews there were other criticisms about tone. A common complaint was the communications implying guilt, even at the point of case
dismissal. For example one participant mentioned that their final communication said “on this occasion, there is no case to answer”.

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

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

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

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

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

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

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

The website

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

Figure 3.15: Thinking about the entire process, how far do you agree or disagree with the following
The few qualitative participants who had used the website, had used it to find out more about the processes they might go through and to try and find out about similar cases to theirs, in order to know what to expect. One participant had been directed to specific pages on the website, by their lawyer. They commented that finding this information was difficult and navigation of the website was not easy, overall.

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

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

3.8.2 Suggested improvements

When asked in the survey how the GMC’s communication could be improved, nearly a quarter of responses to this open ended question related to requirements for more information or being kept up to date. The full responses are shown in Figure 3.16.
Figure 3.16: How could the GMC’s communication (written, telephone and web-based) be improved?

<table>
<thead>
<tr>
<th>Suggestion</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Want more information/to be kept up to date</td>
<td>22%</td>
</tr>
<tr>
<td>Don’t assume guilt from the start / imply guilt</td>
<td>12%</td>
</tr>
<tr>
<td>Improve staff - unhelpful/insensitive / lack of knowledge</td>
<td>12%</td>
</tr>
<tr>
<td>Satisfied with this part of the process</td>
<td>11%</td>
</tr>
<tr>
<td>Speed up the process</td>
<td>11%</td>
</tr>
<tr>
<td>A fairer process/ listen to all sides/ equal treatment of both sides</td>
<td>10%</td>
</tr>
<tr>
<td>Want a named contact to deal with / continuity of staff</td>
<td>10%</td>
</tr>
<tr>
<td>Clearer info about procedures/ which stage complaint is at</td>
<td>9%</td>
</tr>
<tr>
<td>GMC lack credibility</td>
<td>8%</td>
</tr>
<tr>
<td>Less adversarial approach</td>
<td>6%</td>
</tr>
<tr>
<td>Earlier vetting of cases/ filter out vexatious complaints</td>
<td>6%</td>
</tr>
<tr>
<td>Inform doctors if the case against them is dropped</td>
<td>4%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>1%</td>
</tr>
<tr>
<td>Nothing in particular</td>
<td>11%</td>
</tr>
<tr>
<td>Other Answers</td>
<td>13%</td>
</tr>
</tbody>
</table>

Base: All that responded (139)

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

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

"Can I suggest that someone reads letters before they are sent out from the viewpoint of a potential recipient? They are legendarily brutal."
Doctors responded positively when told in the qualitative interviews about new guidelines to ensure written communications are more accessible, personal and jargon free.

“More personal, less jargon. Perhaps less threatening might be another (suggestion) because that’s the underlying tone.”

3.9 Overall experience

3.9.1 Single most important thing to improve

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

Figure 3.17: What is the most important thing that the GMC should do to improve the Fitness to Practise procedure for doctors? (open ended)
In the qualitative interviews there was a common call for better vetting or ‘triage’ on receipt of the complaint to filter vexatious complaints or resolve issues that may be easily explained. It was thought that a time investment here, would reduce the number of complaints going through a more thorough investigation process, only to be ‘thrown out’ later on.

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

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

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

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

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

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

“It suddenly felt to me clear that the, and particularly in the FTP panel, that the GMC were trying to get me accused, they were trying to prove that I wasn’t fit to practise.”

3.9.2 Response to the Doctor Support Service initiative

In the qualitative research, The Doctor Support Service pilot was explained and discussed with those who touch on the issue of doctor support. It was broadly welcomed; participants liked the idea of confidential, independent emotional support and this initiative recognises the emotional toll that Fitness
to Practise procedures can take on doctors. Some participants said that it can be hard to talk about and ask for emotional support, but they thought it is something that would have helped them. A few said that they received help from other sources locally, or via their defence body or employer. A few also said that they wouldn't need this service because of these local services, or the support that they had received from their employer and/or family.

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

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

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

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

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

It was also suggested that those who have been through the FTP process and have been cleared still need help returning to 'normal' practice as they have been through a traumatic experience and it may change how they practise in future (i.e. they practise more defensively). It was felt that this service should
be extended to doctors who have been through the process (or if it is available, this fact be promoted).
4. Conclusions
The vast majority of doctors who go through the FTP process have not chosen to do so (although some self-referrals do occur). The nature of the process generally means that a doctor has had a complaint made about their practice or a negative event has led the GMC to investigate the doctor. As such, it is unlikely doctors will view the experience positively. Whilst doctors were asked to be objective and to feed back on the process itself rather than the details of their own case, it should be recognised that, for many, the process and the case will have been a distressing experience. Furthermore, the research focussed on suggestions for process improvement and as such actively sought doctors to be critical. It is unsurprising therefore that the research revealed many concerns about the process and that there was considerable strength of feeling about some aspects of the process. Despite this, there were also some positive messages regarding the process, particularly in terms of the clarity of GMC communications.

4.1 Survey findings

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

Communication with employer
Respondents were divided on perceptions of the GMC’s communication with their employer and there appeared to be some uncertainty about these communications. Almost half (49%) expressed dissatisfaction with regard to how well they were kept informed about communications between the GMC and their employer. Responses suggest that whilst doctors are told that their employer will be communicated with, they don’t know exactly what is being disclosed in this communication. The most common suggested improvement to the GMC’s communication with employers is more transparency and the sharing of correspondence across all parties (53% offered this response to the open ended question regarding improvements).
The investigation process
In terms of the investigation process itself, there was considerable agreement that the GMC gave doctors and their representatives enough time to comment (80%). Other aspects of the investigation process received a more mixed response, with opinion divided on whether or not they were ‘kept informed of progress’ and whether or not ‘their comments were considered as part of the investigation’. Almost two thirds (62%) disagreed that the investigation was conducted in a timely manner and the most common suggested improvement was to speed up the process (23% gave this response to the open ended question regarding improvements).

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

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

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

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

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

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

The common concerns were as follows:

- A perceived lack of clarity within the process and insufficient information, particularly with regard to progress in their case:
  - Doctors reported not knowing what was happening with their case, how and by whom the investigation was conducted, and crucially how long it would take.
  - Communication was seen as infrequent and at certain times during the process, vague.
  - Doctors reported this perceived information shortfall as causing considerable stress.

- The perceived adversarial nature of the investigation and the sense that there is a ‘guilty until proven innocent’ attitude from the GMC:
  - Doctors expected their investigation to be a fact finding mission, but felt the tone of communications conveyed a sense that the GMC starts from a point of presumed guilt, looking for evidence to back this up.

- The protracted nature of the process:
  - Many doctors were surprised and extremely dissatisfied with the length of the FTP process.
  - Doctors tended not to expect a lengthy process and felt that this was not clearly explained at the outset.
  - Furthermore, they reported that they did not know what was happening and why their process was taking so long.

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

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

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

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

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

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

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

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

5.1 Respondent Profile

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

- In the UK, 79%
- In the European Economic Area or Switzerland, 4%
- Outside the UK, European Area or Switzerland, 12%
- Prefer not to say, 5%

Figure 5.2: What is your gender?

- Male, 70%
- Female, 26%
- Prefer not to say, 4%
Figure 5.3: What is your age?

- 65-74, 6%
- 55-64, 28%
- 45-54, 36%
- 35-44, 21%
- 25-34, 7%

Figure 5.4: What is your ethnic origin?

- British: 66%
- Indian: 9%
- Prefer not to say: 5%
- African: 2%
- Irish: 2%
- Pakistani: 2%
- White and Asian: 1%
- Black or Black British: 1%
- Any other Asian background: 1%
- Bangladeshi: 1%
- Any other white background: 1%
5.2 Research instruments

5.2.1 Questionnaire

About this questionnaire:

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

Instructions for completing this questionnaire:

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

This questionnaire should take around 10-25 minutes to complete depending on your experience of the GMC procedures. Thank you in advance for your time.
At the start of the process, the GMC would have sent you a letter acknowledging or informing you of the complaint or referral, the next steps for the inquiry and further information about the GMC processes.

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

<table>
<thead>
<tr>
<th>TICK ONE BOX ONLY PER LINE</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed you about the concerns that had been raised</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Was clear about the decision to proceed with an investigation</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Was clear about the process that would follow</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

2) How could this initial stage of the process be improved?
PLEASE WRITE IN:
3) You should have received a leaflet along with this initial communication from the GMC. If you saw the leaflet, how helpful was it?

<table>
<thead>
<tr>
<th>Option</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Very helpful</td>
<td>[ ]</td>
</tr>
<tr>
<td>Quite helpful</td>
<td>[ ]</td>
</tr>
<tr>
<td>Not very helpful</td>
<td>[ ]</td>
</tr>
<tr>
<td>Not helpful at all</td>
<td>[ ]</td>
</tr>
<tr>
<td>Don't know/ can't remember</td>
<td>[ ]</td>
</tr>
<tr>
<td>Did not receive</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

4) How could the information leaflet be improved?

PLEASE WRITE IN:
SECTION 2 - COMMUNICATION WITH YOUR EMPLOYERS(S)/ CONTRACTOR(S) OF SERVICES

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

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

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

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

<table>
<thead>
<tr>
<th>TICK ONE BOX ONLY PER LINE</th>
<th>Very satisfied</th>
<th>Satisfied</th>
<th>Dissatisfied</th>
<th>Very dissatisfied</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>That the process of communicating with your employer(s) / contractor(s) was handled sensitively</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>That you were suitably kept informed about communications between the GMC and your employer(s) /</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
3. How could this part of the process (communication with your employer or contractor) be improved?
   PLEASE WRITE IN:

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

<table>
<thead>
<tr>
<th></th>
<th>PLEASE CONTINUE TO Q9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>PLEASE MISS OUT Q9-Q25 AND GO STRAIGHT TO Q26</td>
</tr>
</tbody>
</table>
SECTION 3 - THE INVESTIGATION PROCESS

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

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

<table>
<thead>
<tr>
<th>Interaction Type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>I interacted with the GMC myself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A solicitor or barrister handled interactions with the GMC on my behalf</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A representative from a professional organisation handled interactions with the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GMC on my behalf</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A friend, family member or other person handled interactions with the GMC on my</td>
<td></td>
<td></td>
</tr>
<tr>
<td>behalf</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Conducted the investigation in a timely manner</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don't know</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understood the circumstances of the case</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kept you informed of progress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gave you and/or your representative enough time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Considered

TICK ONE BOX ONLY PER LINE
7. If you did not comment on your case can you please explain why?
   PLEASE WRITE IN:

   

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

   

SECTION 4 - INTERIM ORDERS PANEL HEARING

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

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

- Yes, a hearing was held and you attended
- Yes, a hearing was held but you did not attend
- No, a hearing was not held in your case
- Don’t know

PLEASE ANSWER Q14 - 16

PLEASE MISS OUT Q14-Q16 AND GO STRAIGHT TO Q17

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

- A solicitor or barrister
- A representative from a professional organisation
- A friend, family member, or other person
- You represented yourself
- No one
- Don’t remember
10. How far do you agree or disagree with the following statements:

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

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

PLEASE WRITE IN:
SECTION 5 - CASE EXAMINER DECISION AND OUTCOME OF YOUR CASE

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

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

<table>
<thead>
<tr>
<th>TICK ONE BOX ONLY PER LINE</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>The decision was clearly stated</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The reasons for the decision were clearly explained</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The supporting evidence was clear</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>You understood the implications of the decision for you</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

13. What was the case examiners’ decision in your case?

<table>
<thead>
<tr>
<th>TICK ONE BOX ONLY</th>
<th>PLEASE ANSWER Q19 AND THEN MOVE STRAIGHT TO Q26</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your case was closed with or without advice</td>
<td>☐</td>
</tr>
<tr>
<td>A warning was issued</td>
<td>☐</td>
</tr>
<tr>
<td>Undertakings were suggested and agreed</td>
<td>☐</td>
</tr>
<tr>
<td>A warning was refused and an Investigation Committee held</td>
<td>☐</td>
</tr>
<tr>
<td>Undertakings were suggested and refused</td>
<td>☐</td>
</tr>
<tr>
<td>The case was sent to a Fitness to Practise Panel hearing</td>
<td>☐</td>
</tr>
</tbody>
</table>

PLEASE ANSWER Q19 AND THEN MOVE STRAIGHT TO Q26

PLEASE MISS OUT Q19 AND THEN GO STRAIGHT TO Q26

PLEASE MISS OUT Q19 -
14. How could the process of either closing your case, issuing a warning or discussing undertakings be improved?

PLEASE WRITE IN:

15. How could the Investigation Committee process be improved?

PLEASE WRITE IN:
16. What was the decision of the Investigation Committee?
TICK ONE BOX ONLY

<table>
<thead>
<tr>
<th>Decision</th>
<th>Please Miss Out Q22-25 and Go Straight to Q26</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your case was closed</td>
<td><img src="" alt="Tick" />](image)</td>
</tr>
<tr>
<td>A warning was issued</td>
<td><img src="" alt="Tick" />](image)</td>
</tr>
<tr>
<td>Your case was sent to a Fitness to Practise Panel Hearing</td>
<td><img src="" alt="Tick" />](image)</td>
</tr>
</tbody>
</table>

PLEASE CONTINUE TO Q22
SECTION 6 – FITNESS TO PRACTISE PANEL HEARING

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

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

<table>
<thead>
<tr>
<th>Option</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes all of it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, some of it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No not at all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Option</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A solicitor or barrister</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A representative from a professional organisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A friend, family member, or other person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You represented yourself</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No one</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t remember</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
18. How far do you agree or disagree with the following statements:

<table>
<thead>
<tr>
<th>TICK ONE BOX ONLY PER LINE</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
<th>Don’t know</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>It was explained why a panel hearing was felt to be necessary in your case</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The information leaflet provided with the notice of hearing was helpful</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>You were given sufficient notice of the panel hearing</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>If you attended the hearing was effectively run</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>If you attended, both sides were given sufficient opportunity to present their case</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>If you attended, the Panel was attentive throughout the proceedings</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The decision of the panel was clearly stated</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The reasons for the decision were clearly explained</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>You understood the implications of the decision for you</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
7) How could this part of the process (Fitness to Practise Panel) be improved?

PLEASE WRITE IN:
**SECTION 7 - COMMUNICATION DURING THE PROCESS**

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

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

20. How could the GMC’s communication (written, telephone and web-based) be improved?  
PLEASE WRITE IN:
SECTION 8 – OVERALL EXPERIENCE

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

22. Please provide any additional comments you may have.
   PLEASE WRITE IN:
SECTION 9 - ABOUT YOU

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

23. Where did you earn your Primary Medical Qualification?

<table>
<thead>
<tr>
<th>Option</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the UK</td>
<td>□</td>
</tr>
<tr>
<td>In the European Economic Area or Switzerland</td>
<td>□</td>
</tr>
<tr>
<td>Outside the UK, European Area or Switzerland</td>
<td>□</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>□</td>
</tr>
</tbody>
</table>

24. What is your gender?

<table>
<thead>
<tr>
<th>Option</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>□</td>
</tr>
<tr>
<td>Female</td>
<td>□</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>□</td>
</tr>
</tbody>
</table>

25. What is your age?

<table>
<thead>
<tr>
<th>Option</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 24</td>
<td>□</td>
</tr>
<tr>
<td>25 – 34</td>
<td>□</td>
</tr>
<tr>
<td>35 – 44</td>
<td>□</td>
</tr>
<tr>
<td>45 – 54</td>
<td>□</td>
</tr>
<tr>
<td>55 – 64</td>
<td>□</td>
</tr>
<tr>
<td>65 – 74</td>
<td>□</td>
</tr>
<tr>
<td>75 +</td>
<td>□</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>□</td>
</tr>
</tbody>
</table>
8) What is your ethnic origin?

<table>
<thead>
<tr>
<th>Asian or Asian British</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Bangladeshi</td>
<td>□ Indian</td>
<td>□ Pakistani</td>
</tr>
<tr>
<td>□ Indian</td>
<td>□ Pakistani</td>
<td>□ Any other Asian background, please specify,</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Black or Black British</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Black or Black British</td>
<td>□ African</td>
<td>□ Caribbean</td>
</tr>
<tr>
<td>□ Black or Black British</td>
<td>□ African</td>
<td>□ Caribbean</td>
</tr>
<tr>
<td>□ Any other Black background:</td>
<td>□ Any other Black background:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chinese or any other ethnic group</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Chinese</td>
<td>□ Any other background, please specify</td>
<td></td>
</tr>
<tr>
<td>□ Any other background, please specify</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mixed</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ White and Asian</td>
<td>□ White and Black African</td>
<td></td>
</tr>
<tr>
<td>□ White and Black African</td>
<td>□ White and Black Caribbean</td>
<td></td>
</tr>
<tr>
<td>□ White and Black Caribbean</td>
<td>□ Any other mixed background:</td>
<td></td>
</tr>
<tr>
<td>□ Any other mixed background:</td>
<td>□ Any other mixed background:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>White</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ British</td>
<td>□ Irish</td>
<td></td>
</tr>
<tr>
<td>□ Irish</td>
<td>□ Any other white background:</td>
<td></td>
</tr>
<tr>
<td>□ Any other white background:</td>
<td>□ Any other white background:</td>
<td></td>
</tr>
</tbody>
</table>

Prefer not to say | □

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

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

Yes ☐
No ☐

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

<table>
<thead>
<tr>
<th>Full Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Email address:</td>
<td></td>
</tr>
<tr>
<td>Landline telephone number:</td>
<td></td>
</tr>
<tr>
<td>Mobile telephone number:</td>
<td></td>
</tr>
</tbody>
</table>

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

GMC FTP Survey: Depth interview draft discussion guide

27th July 2012

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

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

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

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

The interviewer will:

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

**NOTE TO INTERVIEWER:**

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

7. **The complaint or referral**

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

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

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

- Is there anything else that would help improve things?

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

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

- In your questionnaire response, you indicated that you were particularly satisfied/ dissatisfied with xx aspects of the communication with your employer/ contractor(s). Why did you give those ratings for this part of the process?
• Do you have any views on how employers are informed about the complaint?

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

• Is there anything else that would help improve things?

9. **The investigation process**
Thinking now about the investigation process…

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

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

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

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

• Is there anything else that would help improve things?

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

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

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

• In your questionnaire response, you indicated that you were particularly satisfied/dissatisfied with xx aspects of the IOP hearing. Why did you give the select those ratings for the process?
• You said that the process could be improved by xxx. Probe for further information on the suggested improvement (and focus on how this could be achieved).

• Is there anything else that would help improve things?

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

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

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

• Is there anything else that would help improve things?

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

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

• Would you have found this helpful in your case?

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

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

12. Fitness to Practise Panel hearing
On the questionnaire you indicated that Fitness to Practise Panel hearing was held in your case…
• You indicated on the questionnaire that a FTP hearing was held but you did not attend. Why did you elect not to attend?

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

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

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

• Is there anything you would like to say about the hearing in general? (POSSIBLE PROBES - BE CAREFUL NOT TO LEAD THIS: practical arrangements, the panel, decision making)

• Is there anything else that would help improve things?

FOR DISCUSSION WITH ALL WHO HAVE BEEN THROUGH FTP HEARING:

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

It was set up to:
• provide better separation between the GMC’s complaints and investigation functions and adjudication, and
• to take over responsibility for the day to day management of hearings, panellists and their decisions.

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

• Do you think this change (and the separation of investigation and adjudication) represents an improvement?
• Why/why not?
13. Communication during the process
Thinking about communication during the entire process…

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

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

IF RESPONSE IS NEGATIVE:

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

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

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

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

- Is there anything else that would help improve things?
14. Suggested improvements
Thinking about the whole experience, I want to focus now on the single thing that would improve the process for other doctors experiencing it in future…

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

- Is there anything else that would help improve things?

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

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

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

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

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

15. Final thoughts
- Is there anything else you feel we should have covered?
- Are there any aspects of the process that worked well and you feel should not change?
- Overall, what aspects of the process were you most dissatisfied with? Why?
Thank for their time.
Exploring the experience of public and patient complainants who have been through the GMC’s Fitness to Practise procedures
General Medical Council

Exploring the experience of public and patient complainants who have been through the GMC’s Fitness to Practise procedures

Research Report Draft 3

July 2014
1. Executive Summary

1.1 Introduction and Objectives
In 2011, the GMC highlighted a need to conduct research to better understand the experience of both doctors and complainants who have been through fitness to practise (FTP) procedures. An initial research project with doctors was completed in 2012/13. This report presents findings from subsequent research undertaken with complainants. The GMC defines three types of complainant: patients and the public; persons acting in a public capacity (PAPCs) and others. This study has focused solely on the experiences of patients and the public.

The research explored perceptions of experiences throughout the FTP process, as well as broader issues of communication and suggested improvements. The structure of the interview guide asked for feedback from complainants on the following aspects of the process (where relevant):
• How did complainants hear about the GMC?
• Who did they complain to first?
• Views on the ease of making a complaint.
• Whether they received any (advocacy) support.
• Tone of voice in GMC correspondence.
• Did individuals feel they were adequately informed of progress?
• Perceptions of the extent to which decisions are explained and supported by a rationale.
• The extent to which individuals felt supported throughout and after the process.

1.2 Methodology
The sample for this project was focused on complainants who were members of the public or patients and who had submitted and had a complaint taken through to investigation stage and then through to completion of the investigation between July 2012 and September 2013. Qualitative in depth telephone interviews were conducted in two phases. During both phases, complainants were first sent a letter by the GMC and given the opportunity to opt-in to the research by making contact with Community Research. Those who did so were re-contacted and an appointment for interview was made. The final achieved sample was as follows:
• Phase 1 -10 interviews
• Phase 2 - 34 interviews

The opt-in recruitment methodology means that it is not possible to provide profiling information about respondents. In total, 5 respondents reported that their case had resulted in a panel hearing and provided some feedback about this experience.
1.3 Overall Conclusions

Despite the fact that complainants were actively being asked, within this research, to concentrate and focus on possible process improvements there was a good deal of positive feedback about the GMC’s process, including:

- The clarity of communications (other than with regard to the final outcome letter and supporting documents.)
- The initial speed with which the receipt of a complaint is acknowledged.
- The responsiveness and professionalism of Investigations Officers was widely praised, although there was some inconsistency.
- The hearings process being well organised and good support being offered at this stage.

Nevertheless, the research has highlighted a large number of issues that the GMC will need to consider. Key points are summarised below.

Submission of the complaint
Suggestions for improving the process for submitting complaints were as follows:

- Allowing complaints to be admissible when submitted verbally, or to have someone from the GMC (or from an independent advocate) to help complainants put their written complaint together.
- Making it clearer that complainants should submit any and all evidence at the outset.
- Making it clear and explicit that complainants may not be contacted again until the outcome of the investigation.

The investigation itself
Suggestions for improving the investigation element of the process were as follows:

- Speeding up the process.
- Allowing for more complainant dialogue and involvement within the investigation process, including:
  - Telephone calls or meetings to discuss and ask questions following initial evidence gathering.
  - Allowing complainants to provide a considered reaction to the doctor’s response to the complaint and to the expert report.
- Greater transparency with more automatic sharing of full expert reports and doctors’ responses to allegations.
- Provision of external, independent advocacy support, to help complainants navigate their way through the process more successfully.
**Case Examiner decisions**

Suggested improvements for the case examiner decision communication included:

- Improvements to the communications at this stage, including:
  - Making letters easier to understand, with less jargon.
  - Wording the letters more sensitively or sympathetically.
  - Including a summary of the key points contained in the annexes.
- Being warned that the decision is imminent in order to allow complainants to prepare themselves.
- Being told the outcome over the phone and being called proactively by the Investigation Officer at this stage to discuss the outcome.

**Communication**

Key improvements with regard to general communication were as follows:

- More communication from the GMC giving updates on the case, what is happening next and ideally what timescales are involved.
- More interactive communication. Phone calls are called for to ensure that the complainant is kept in the loop with the developments.
- Written communication having a more sympathetic tone and better reflecting the emotion and stress the complainant might be experiencing.

There was almost unanimous support for wider introduction of the current pilot meetings at the start of the investigation process. Many, though not all, also welcomed the idea of a further final meeting after the conclusion of the case.

Given the relatively small number of respondents taking part in this research who had experienced a panel hearing it is recommended that the GMC and the MPTS considers undertaking further, more targeted research to gain more feedback from complainants and witnesses about how such hearings might be improved.
2. Introduction, Objectives and Methodology

2.1 Introduction

In 2011, the GMC highlighted a need to conduct research to better understand the experience of both doctors and complainants who have been through fitness to practise (FTP) procedures. An initial research project with doctors was completed in 2012/13, with the final report being presented to the General Medical Council (GMC) in March 2013.

This report presents findings from subsequent research undertaken with complainants. The GMC defines three types of complainant: patients and the public; persons acting in a public capacity (PAPCs) and others. This study has focused solely on the experiences of patients and the public. This research will be used, alongside the research conducted with doctors, to help inform the development of potential changes to the FTP procedures. It is proposed that both elements of the research might be repeated periodically to track trends and identify areas for further improvement.

2.2 Objectives

The research explored perceptions of experiences throughout the FTP process, as well as broader issues of communication and suggested improvements. The structure of the interview guide asked for feedback from complainants on the following aspects of the process (where relevant):

- How did complainants hear about the GMC?
- Who did they complain to first?
- Views on the ease of making a complaint.
- Whether they received any (advocacy) support.
- Tone of voice in GMC correspondence.
- Did individuals feel they were adequately informed of progress?
- Perceptions of the extent to which decisions are explained and supported by a rationale.
- The extent to which individuals felt supported throughout and after the process.

2.3 Methodology

An iterative approach

The methodology for this project was iterative. At the outset, it was intended that an initial qualitative phase might be followed by a quantitative online survey, as had been the case in the research with doctors.

Learning from the initial phase of qualitative interviews, suggested that complainants found it very challenging to separate feedback about the GMC’s process, from feedback about the details of their case. They required a good
deal of guidance and support. The response rate to this initial phase was in the region of 10%. In response to these two observations, it was decided that a quantitative survey would not be the right approach for the remainder of the project. This was for two main reasons - a tick box survey (even one that is well designed and allows room for open comments) was felt to be unlikely to ensure that complainants focus on process and differentiate this from feedback about their case. Secondly, the likely achievable sample size based on a 10% response rate was unlikely to result in a sample great enough to provide a robust quantitative result. It was, therefore, agreed to take a purely qualitative approach for the remainder of the project.

**Sample selection, mailing and opt in process**

The sample for this project was focused on complainants who were members of the public or patients and who had submitted and had a complaint taken through to investigation stage and then through to completion of the investigation between July 2012 and September 2013. These dates were selected, as representing a good compromise between ensuring that the complainants would have a reasonable memory of the events, whilst being sufficiently long ago for patients to have had time to reflect on the experience. Selecting cases within these dates resulted in a total potential sample of 895 complainants.

A first phase sample of 101 cases was selected and sent an approach letter by the GMC. This initial sample comprised a stratified random sample of the available cases, stratified by case outcome categories to ensure that a mix of outcomes would be covered. The letter offered complainants the opportunity to ‘opt in’ to the research process by making direct contact with Community Research. From the responses to this first mailing, 10 interviews were conducted. However, only one of the respondents in this first tranche of interviews had been through a Fitness to Practise hearing. In addition, the majority of complainants included in this first phase had experienced a case where little or no action against the doctor had been taken.¹

Following this first stage a project plan was agreed to conduct between 15 and 25 further qualitative interviews in order to complete the project, but with a view to keeping this decision under review. It was felt to be important to try to focus the second stage interviews, if possible, on cases that had resulted in a hearing or where some form of action was taken against the doctor’s registration so that the views of complainants with experience of such cases were adequately covered. In order to maximise the chances of conducting interviews with such complainants, the second stage mailing was conducted in two parts. The first

¹ Of course, cases resulting in a panel hearing are relatively few and the majority of cases the GMC investigates result in no further action against the doctor, so this result is not surprising. Ref. GMC’s annual statistics - [http://www.gmc-uk.org/publications/23525.asp](http://www.gmc-uk.org/publications/23525.asp)
comprised all cases that had resulted in a panel hearing and/or ‘positive’ outcome from the complainant’s point of view (i.e. some form of action being taken against the doctor.) Once interviews with this cohort had been exhausted, a subsequent mailing was conducted with the remainder of the available sample.

When 14 interviews had been completed in the second stage, further discussion was held between Community Research and the GMC about whether to continue interviewing further complainants. The decision was made to continue conducting further interviews for the following reasons:

- Whilst the feedback being gathered from interviewees was relatively consistent, and therefore new interviews were unlikely to uncover much further insight, the occasional new piece of learning was still being gained.
- Only one additional interview with someone whose case had gone to a panel hearing had been undertaken and it was, therefore, felt important to continue interviewing, in the hope that feedback from further such cases would be uncovered.

Qualitative interviewing
During both phases, complainants who made contact with Community Research, to express an interest in participating in the research were re-contacted and an appointment for interview was made. All interviews were conducted by one of two senior researchers. Interviews followed a semi-structured discussion guide, which was amended slightly between the two phases of interviews (both versions of the discussion guide may be found at Appendix 1.)

Since recruitment was undertaken on an opt-in basis the researchers were not able to cross reference information held by the GMC about the complainant or about their case.

All interviews were audio recorded and just over half of the interviews were fully transcribed. In the first phase, all 10 interviews were transcribed in full. As interviews progressed, during the second phase, the researchers made detailed notes of any new learning points. Interviews that raised significant new points of learning were selected for full transcription. All 5 interviews where the complainant had experienced a panel hearing were also fully transcribed. All interviews, whether transcribed or not, were included in the analysis process.

Final Sample Mix
The final achieved sample was as follows:

- Phase 1 - 10 interviews
- Phase 2 - 34 interviews
The opt-in recruitment methodology means that it is not possible to provide profiling information about respondents. In total, 5 respondents reported that their case had resulted in a panel hearing and provided some feedback about this experience.

In the second phase of interviews, participants were asked to report the final outcome of their case. Outcomes as reported by participants cannot necessarily be relied upon as an absolutely accurate reflection of how the GMC may have recorded the case outcome. Nevertheless, the final sample did contain a range of reported outcomes, including cases where no further action was taken against the doctor; cases where advice was given; cases where warnings were given; a case where a doctor was suspended and cases where undertakings were applied. Only one of the cases appear to have resulted in a doctor being erased from the register, some other cases did result in the doctor no longer practising either because of voluntary erasure, the doctor leaving the country or taking early retirement. Whilst it is clearly impossible to judge whether the range of interviews comprises a representative sample of complainants, we are confident that a wide range of case outcomes has been covered.

**A note about reading this report**

Whilst complainants were asked to try to be objective and to feed back on the process itself rather than the details of their case, it should be recognised that, for many, the process and the case will have been a distressing experience and remain inextricably intertwined. Furthermore, the research focussed on suggestions for process improvement and as such actively asked complainants to be critical. It is unsurprising therefore that the research revealed many concerns about the process.

In addition it should be noted that the GMC has changed some aspects of their process and communication since the time that complainants included in this sample experienced the process. It is not possible to be certain of which versions of the GMC’s communications individual complainants may have seen.
3. Expectations of the Process

3.1 Motivations
Complainants tended to mention one, or more, of three motivations when approaching the GMC to complain about a doctor:

- To seek some form of justice (for example, in relation to the death or injury of a family member).
- To gain answers to outstanding questions in relation to a medical incident or issue.
- To protect other patients.

Clearly, the GMC does not share all of these motivations and whilst some complainants did (or had come to) understand this fact, others remained dissatisfied based on an ongoing misunderstanding of the role and remit of the GMC. These misunderstandings did not necessarily arise because (objectively) the GMC's communications do not explain its remit, rather it appears that complainants do not necessarily absorb, retain or understand the reality of the GMC’s position. Many complainants’ initial expectations are never likely to be fulfilled by the GMC’s process and it is therefore perhaps unsurprising that, for some complainants the process ultimately proves unsatisfactory.

“I feel there has been no justice for my son.”

“These three things were the main questions I wanted answers to...and I felt that I didn’t really get an answer to those points, and I still haven’t got that now.”

3.2 Barriers
Complainants did not make the decision to submit their complaint lightly. Firstly, this was because they anticipated that the process would be quite a significant undertaking for them, often including having to recall and recount experiences that had been emotionally distressing. A number of complainants identified that they had been in a delicate emotional or physical condition at the time of contacting the GMC and some complainants discussed deciding to wait a while before making a complaint until they felt better able (emotionally and/or physically) for the undertaking.

“When you make a complaint about anyone it’s a hard thing to do, it’s not an easy thing to do...I found it really hard because I was frightened.”

“I waited a year because I was so wrapped up in pain and grief, so I left it a whole year.”
Secondly, complainants often commented that they felt that making a complaint against a doctor was an extremely serious step. They understood that it would have an impact on the doctor and their career. However, when asked if they had hesitated before making the complaint, most said that they had not. They had felt strongly that it was something that they wanted to do, or something that needed to be done (e.g. for future patient safety).

“I had no hesitancy about reporting him at all because he was telling lies about people.”

Some complainants had decided independently to make the complaint to the GMC, however many had been encouraged by others, including friends and family as well as other health professionals. Receiving encouragement from medical or other health professionals seemed particularly impactful – there was a sense that if other doctors (or nurses) think that the doctor in question has done wrong, then their case is strong.

“I’m not sure I would have done it without him {a friend who was a doctor}. I thought about it and I thought perhaps I’m making too much fuss but he assured me that, no, this was worth going on with…. I would not have known really where to go or where to start.”

3.3 Expectations

Most expected the GMC to be an independent, fair and impartial organisation at the outset.

“So I think we probably went to the GMC with hope and a certain expectation that we were dealing with a very independent professional body who would objectively look at all the evidence.”

For some, however, this view shifted as a result of the process and outcome of the investigation.²

“But I did honestly believe that the GMC would be impartial and would do the right thing, and they haven’t…but the problem is you don’t know that at the time, its only really when you get to the end of the process that you become fully aware that actually they did nothing.”

A minority of complainants said that, even at the outset they had thought that the GMC might not be impartial, but rather tended to side with doctors (a perception they reported having taken from the media or from others they had spoken to). Despite this, they had decided to make a complaint to the GMC as

² See Section 5.3.2 with regard to the perception of GMC bias amongst some complainants, at the end of the process.
they felt their case to be sufficiently strong to overcome this perceived imbalance.

In terms of the process, complainants were frequently unsure what would happen and how long it would take, prior to submitting their complaint. The common assumption was that their involvement in the process would consist of:

- Form filling or writing an initial letter about the complaint.
- Sending in documentation and further evidence.
- Answering questions (most assumed this would be undertaken verbally and after the doctor has responded to the complaint and additional evidence might have been gathered.)

“What I expected was for me to make a complaint and then to have an answer, to speak to somebody maybe on the phone or face to face and then for it to be followed up.”

“I thought there would be an opportunity to have a face to face meeting, I didn’t realise that wouldn’t happen.”

At the outset, most expected that the complaints process would take some considerable time. They commented that the GMC may have to gather information from a number of sources, which might take time and there was a general sense that such a bureaucratic process, involving the NHS, would not be expeditious. However, even those who expected that the investigation would take a relatively long period of time were still often surprised by the actual length of time the process took.

“I knew it would take months rather than weeks.”

“I thought it would take about 6 months. I didn’t expect it to take longer.”

“There was an awful lot to investigate and it was a doctor’s reputation, they obviously had to be very, very careful.”

A few complainants mentioned looking at the GMC website for an indication of what the process might entail. They said that they found the website a useful source of information at that time.

“I remember looking up the procedure and everything on the Internet so I knew how in a way it was going to be done. So that was helpful.”

A number of complainants expected, from the outset, that their case would go to a formal hearing. Some assumed that this happened in all cases that were
investigated, or they thought that their case was sufficiently serious (e.g. involving a death) to automatically warrant a hearing.
4. Feedback on the Process

4.1 Before approaching the GMC

4.1.1 Previous and parallel actions
Some of the participants in this research had made complaints to other bodies, before they approached the GMC and some did so concurrently. Other bodies included GP practices, NHS Hospitals and Trusts, the Health Service Ombudsman as well as linked cases to other health professions regulators. One or two respondents had also previously or concurrently taken legal action against the doctor who was the subject of their complaint. One complainant’s case had also been investigated by the Health and Safety Executive. Some of these complainants had decided to approach the GMC because they were unhappy with the outcome of their prior avenues of complaint. In some cases they were advised (for example by a lawyer) to take the case to the GMC, alongside the action they were already taking, as doing so might improve the chances of a positive judicial outcome.

Where separate or parallel investigations did take place there was some evidence that this caused frustration and confusion, particularly where the ongoing investigations of one body led the GMC to delay their investigations, or vice versa. One complainant had assumed that he didn’t need to complain to multiple sources, because he thought that they would work together and the relevant regulatory bodies would be contacted and involved as and when necessary.

“They were all separate investigations and one would not act if the other one was acting, it was just really frustrating.”

“That also caused a lot of confusion because the Health Authority tried to tell me I couldn’t complain to them and the GMC at the same time, which was wrong, but I was advised to go through them in the first instance which made the whole thing very drawn out and it ended up taking nearly three years.”

“I assumed that when we put complaints in at the xxxx hospital it would automatically be dealt with, it would go through and be dealt with by a higher body, an overseeing body, but this didn’t happen so it was down to us.”

In addition, there was a feeling that the various investigating bodies should share information, in order to minimise the burden placed on complainants.

“It went from the PCT to the Ombudsman and then they had to start and do their investigation, which took two years or more, and then it got
passed to the GMC and they had to start all over again. It was all taking too much time, people were at risk.”

Conversely, a benefit of having made a prior complaint, for example, to a PCT was that much of the material and evidence had already been collated and therefore submitting the complaint to the GMC was a less time-consuming task.

4.1.2 Awareness of the GMC and what prompted complaints

Many complainants had known of the GMC prior to making a complaint, but levels of knowledge and understanding varied considerably. A number of participants were health professionals themselves who knew the GMC as the regulatory body for doctors and so felt confident that the GMC was the appropriate route for their complaint. Those who had made previous or parallel complaints to other bodies, such as Trusts or GP surgeries, were sometimes signposted to the GMC by these bodies as a potential next stage, if unsatisfied.

Others had heard of the GMC, perhaps in the press, and knew only a little about them, but perhaps not enough to be immediately confident that the GMC was the correct route for their complaint.

“I did a search on them because I had heard of them before but I was unclear exactly what they did. I knew they had some involvement in regulation of doctors so I searched them and found the complaints procedure on their website.”

A few had not heard of the GMC themselves and had found out who to make their complaint to via a recommendation or through their own research.

“I asked around a little bit but there happened to be a visitor in the hospital when my wife was in the ward, she heard me talking and she said ‘I know where the right place to write is’ and she told me. It was, in fact, a place in Manchester.”

“I didn’t really know that you could complain to the GMC to be honest. There was nothing in the doctor’s surgery to say ‘if you have a problem.’ It didn’t say anything about GMC or taking it further.”

In summary, complainants had been prompted to approach the GMC in a number of ways:

- Recommendations by others, frequently health professionals (and often family or friends.)
- Signposting by other complaint routes (e.g. following complaining to an NHS body some were told that they could approach the GMC as a next step.)
• Signposting by other professionals, including solicitors, Patient Advice and Liaison Services, Independent Complaints Advocacy Service.
• Their own research online.

“My friend used to be a nurse, her husband is Chief Medical Officer and she made me. Well, she didn’t make me but she suggested to me that I should complain to the GMC about it.”

“During this time (of complaining to the hospital)... we went online and you can search for doctors and their records, and we found out this particular doctor was on a five year warning, ... it was open to the public, luckily we found that so then I thought I would write to the GMC about this doctor.”

One complainant felt that her expectations had been raised inappropriately by the GMC. When she made the initial phone call she was really unsure about whether or not to progress the complaint, but the person on the phone said it was potentially a very serious complaint and the doctor could get ‘struck off’. It was because of this that she pursued the complaint (at significant cost and upheaval). Ultimately, the case examiners decided in the doctor’s favour and she felt that this possibility should have been flagged more clearly at the start.

4.2 Submitting the complaint

4.2.1 Ease of submission

Most complainants said that they found the process of submitting their complaint relatively straightforward.

“It was pretty self-explanatory. I think there were a couple of things I looked up on what I needed to do and I was able then, through that, to send them all my paperwork.”

Most had completed a form, although some had written a letter. Some had completed a form after submission of an initial letter. A number of complainants had phoned the GMC initially to make the complaint and had then been asked to complete a form. Most accepted this, but a few did comment that it had taken them considerable courage to phone the GMC and that then being asked to complete a generic form was disappointing.

“My understanding is, the only reason you would contact the GMC is to make a complaint, and just to get someone to take your name and your address and ‘we will send you out a complaints form’, a generic complaints form which in itself is sort of telling you from the very onset how you’re being dealt with.”
“I had to fill a form in. And that, if I think about it, was quite quick after they received my letter, which was quite lengthy as you can imagine. No, I have no faults at all.”

Views about ease of submission were connected with how able complainants felt to express themselves in writing. A number of complainants commented that in their job/professional capacities they often had to write expansive letters or reports and so felt comfortable writing up their complaint. A few commented that having made complaints to other bodies, they had gone through the process of writing up and summarising their complaint previously, which made submitting their complaint to the GMC easier.

“I found it okay but I’m used to paperwork and doing things like that, through my job I do report writing and things like that.”

“It’s not difficult for me because that’s the sort of work that I do, I work in an office and I’ve got a background but I think somebody else might have found it a lot more difficult than I did. I’m used to writing letters, do you know what I mean?”

However for some, the process of trying to express and summarise, in writing, what they often saw as complex issues was more difficult. The difficulty was often compounded by their emotional or physical state at the time of making the complaint. Even those who found the process of writing up their complaint relatively straightforward, often commented that they were concerned that others might not find it so (particularly those less experienced at writing letters).

“I feel sorry for people who have had things worse than us, anything that’s gone wrong, if they haven’t got time like I had and letter writing abilities and computers and stuff, they’d just fall by the wayside. We feel quite guilty how we managed to pin them down but we certainly had to work at it, but if we hadn’t got these things at hand I couldn’t have done it. And it would be even more daunting for someone.”

“It was very emotional writing it and I’m quite articulate and I’m thinking there are people with genuine complaints against doctors who wouldn’t have been able to cope with the paperwork.”

“If I hadn’t have been a nurse I probably wouldn’t have known what the process was or how to get there, how to start the ball rolling.”

Some received help in developing their submission from family or friends and a couple had received more formal help (from ICAS and from a solicitor).
"I’d contacted ICAS at the time, they helped me with my complaint... They gave me tips and things what I should do, how I should go about it. So that obviously helped me.”

Most also commented that they found the process of submitting supplementary documentation straightforward. However a couple of complainants commented that the amount of photocopying required and the subsequent recorded delivery postage was difficult and costly (with one request for reimbursement by the GMC).

“He asked for all the paperwork, I think that was at my own cost actually. That was a bit miffing, that I had to send all the paperwork over at my own cost.”

4.2.2 Receiving acknowledgement
Complainants tended to be very positive about this part of the process. They often spontaneously commented that the initial response to their complaint had been very quick and the letter clear. They had been impressed by the responsiveness of the GMC and it gave them high expectations for the rest of the process.

“They must have thought there was a case for what I had actually written and very quickly they wanted more information and that they would take my case up.”

“When I submitted my complaint that was absolutely fine. I received an email and I think a phone call from a gentleman saying that they’d received it, I think it was a letter as well.”

4.2.3 Suggested improvements - submitting the complaint
Some found the process of submitting their complaint in writing very onerous, costly and time-consuming. There were suggestions for complaints to be admissible when submitted verbally, or to have someone from the GMC (or from an independent advocate) to help complainants put their written complaint together.

“I do think that maybe I should have had somebody help me in the respect that I could have worded it better. How I worded it, it didn’t come across too good. It helps sometimes if you have the right words to make it sound a bit more... to get your point across.”

A number of complainants commented that it should be made clearer that they should submit any and all evidence at the outset and that the initial submission
might be their one and only chance to put their argument across. A few complainants explicitly stated that they had not submitted all possible supporting evidence with their initial complaint. This was for one of two reasons, either:

- Because they did not recognise the relevance of the additional evidence they held (and only recognised this once they had seen the doctor’s response or the expert report by which time it was too late to make further submissions) or;

- Because they had assumed that they would be much more involved in the investigation, for example through dialogue or questioning following the doctor’s response and during which time they would have the opportunity to put forward their supplementary evidence.

“I wrote to them and said ‘you didn’t look at the evidence...you haven’t even asked me for the evidence.’”

As will be explored further in Section 4.3, not being questioned or asked to feed in to the investigation process was a significant cause of dissatisfaction for many complainants. The GMC making it clear and explicit that complainants may not be contacted again until the outcome of the investigation (and explaining why this is the case) might help manage this dissatisfaction and ensure that complainants do submit all the evidence they hold at the outset.

4.3 The investigation process

4.3.1 Initial communications and expectations

Most were satisfied with the initial communication from the GMC confirming that their complaint would be subject to an investigation. Complainants frequently remembered the letter outlining the name and contact details of their Investigation Officer. They welcomed having a named point of contact and someone who they could speak to if and when they had any questions or concerns.

“You’re given a person’s name who you can always ring if you have queries which, whenever I did ring, absolutely brilliant, no problems at all, very courteous, and professional actually.”

“When the guy did respond he was very helpful and he did put everything that he’d said in writing. And then I had a contact name to speak to, he was the one that rang and said we are going to investigate this further.”

However, not all complainants recalled having this information in their letter and they were subsequently much less satisfied as a result.
A number of complainants did recall, and were very positive about, the factsheet that the GMC sends at this time. Some also mentioned the Investigation Officer explaining the process to them directly (either within the letter or in subsequent communication). Complainants were particularly satisfied when they had had this personal explanation.

“It was quite long, I think it was about three sides of A4 and it described quite fully and very clearly and very well the outcomes there might be as a result of an inquiry of the complaint. Yes, it was very simple to understand, it wasn’t all wrapped up in medical jargon.”

There was widespread satisfaction at the speed of this communication, in the main, and generally at this point of the process complainants were both hopeful and expectant. For most at this stage, the GMC had represented themselves as professional and responsive, giving strong hope for a positive and timely resolution of their case.

Those complainants who had to give consent to access to their medical records were also satisfied with how this process was handled, with no concerns being raised about this part of the process. All such complainants reported that they understood why this was necessary and were happy with how the GMC handled this request.

“I think I got fairly prompt attention to start with, initially, they wrote and asked me this and that. First of all, like you say, things like permission to see my wife’s medical records and the likes. All that was done fairly straightforward, I don’t have any complaints there.”

4.3.2 The Investigation Officer

Satisfaction levels with regard to the investigation process seemed to depend, in part, on the complainant’s perceptions of their Investigating Officer, both at the point of initial communication and throughout the course of the investigation process. Those who were more satisfied with the investigation frequently reported that their Investigating Officer adequately explained to them:

- **What would happen during the investigation:** including what their involvement might be, for example the ability for the complainant to see and respond to the doctors’ response.
- **How long it might take:** including why things take time (such as obtaining hospital records.)
- **What the GMC can do and what it can’t do:** for example the GMC can’t answer specific questions relating to their case.

As well as clearly setting expectations about the process, Investigation Officers were frequently praised for being responsive, polite and sympathetic (to a point,
whilst maintaining a professionally impartial stance). There was mention of Investigation Officers being very helpful once contacted, responding quickly and effectively to questions or concerns raised by complainants, including answering questions about what was going on with their case at that time.

“He was an easy guy to talk to … a nice bloke doing a difficult job, so he came across to me very well.”

“The person that it went to initially, the Investigation Officer, was very good at keeping in touch and letting us know, and I could ring her at any point and ask her what was happening.”

“I phoned up after a few months and said ‘can you tell me what’s happening, has anything been resolved yet?’ and they replied… they were very good at replying… and they said ‘we’re very sorry, but not all our investigations have been carried out yet, but we will let you know as soon as we can what has happened’.”

“I was very impressed by the Investigation Officer because I had phoned him on a couple of occasions and he was very helpful, he did his best and if he said he was going to contact me, he would and then he would put it in writing. That always happened. I felt he was very good at his job.”

“He phoned, or I phoned him to explain something and he would say if you need any additional information just phone me. I couldn’t fault him, I thought he was very efficient.”

However, although there were very many examples of good experiences with Investigation Officers, there were also some examples of poorer experiences. There were a few mentions of complainants not knowing who their Investigation Officer was at the outset and not having a named point of contact at the GMC.

There were also mentions of complainants not being able to reach their Investigation Officer (complainants trying to contact, but not hearing back, or hearing back from someone else at the GMC) and dealing with multiple people at the GMC.

“I had this contact, this name, and this telephone number who I could contact with anything but, after that initial one, when I phoned up I never got to speak to that person again, it was just somebody telling me that it was all in hand and that he would email me or whatever, but he never did.”
There were also mentions of Investigation Officer sickness causing delays, without the case being taken over by someone else, or Investigation Officers leaving the GMC without complainants being notified of the name of the person now handling their case (and having to chase the GMC before they could find out who was their new point of contact).

“I do remember thinking that the actual investigation officers that deal with the complaint changed constantly. There were lots of different members of staff actually dealing with it, so the point of contact were constantly changing which made communication quite difficult.”

“It actually sat on somebody’s desk... about 6-10 weeks... and apparently a member of staff was off sick and it was just sat, in a heap of files on somebody’s desk, nobody’d looked at it or done anything with it.”

4.3.3 The investigation process

Many complainants expressed considerable dissatisfaction with the investigation process, which centred around four main themes: time taken; insufficient complainant involvement; perceived inadequacy of the investigation and perceived lack of transparency. Each of these themes will be examined in turn below.

• Time taken

The most mentioned cause of dissatisfaction was the much longer than expected length of time taken from start to finish. Whilst there was some understanding of the fact that investigations do take time, complainants were generally not prepared for just how long their case would take to resolve.

“I imagined it would be quite quick, I was shocked to find that... it seemed to be years. I don’t know, perhaps I hadn’t really thought about the time, but it did go on an awful lot.”

“It (time taken) came as a surprise because I don’t think they ever said in a letter ‘this will take some time’ or anything like that. They just said they would investigate and they would let me know when it had been resolved. But I don’t think they ever said this could take months, because I think then I wouldn’t have been surprised that it did take so long.”

The protracted time scale was reported to be a considerable cause of stress for complainants, who were anxiously awaiting an outcome. Some complainants were waiting for the GMC’s outcome before launching further action against the doctor (e.g. legal action), which might carry time limitations and so they needed a more timely resolution from the GMC.
“I began to think perhaps I’ll never hear, they’ve lost me somewhere. I suppose I do wish I had known why it had taken so long because, heavens above, it was a long time for the doctor as well, not knowing what was going to happen.”

Some complainants felt that they had to remember the details of their case whilst the investigation was ongoing and so it remained at the forefront of their minds. They reported being unable to ‘move on’ from their experience whilst the investigation was ongoing and thus, the longer the investigation took the harder it became, on an emotional level.

“The length of time it all took made it difficult. Because you are living and going over what actually happened constantly. You are having to recall it and keep it at the front of your mind.”

“Also, for us, because it took so long we had to hold as many details about what happened on that day as we could, because we knew we were going to have to give evidence, we could never let go of it, we had to keep it as fresh as we could.”

There was mention that the longer the investigation, the weaker the complainant’s case became as memories of events became more obscured.

“I think that the big thing really that probably helped the doctor concerned avoid the proper penalties for what he did, was the sheer length of time that elapsed between the incident and the hearing, and in that time there were sufficient opportunities for very minor details that one may recollect being ever so slightly wrong.”

Complainants tended not to understand why the investigation took as long as it did. Concerns about length of time were compounded by lack of communication both in terms of a lack of direct explanation about delays, and a general quietness from the GMC, which caused complainants to assume that nothing at all was happening with their case. This had ultimately led some complainants to believe that the GMC must be under-resourced.

“We were just left high and dry for months.”

“I just got the impression that they were a little bit under resourced.”
“They did write to me in the meantime and said ‘we’re very sorry it’s taking a long time but we want to investigate it,’ and I wondered if anyone else had complained as well and that’s why it was taking a long time.”

**Insufficient complainant involvement**

Another key cause of dissatisfaction with the investigation process was the perceived lack of complainant involvement in the investigation. There was a general expectation that, at a minimum, complainants would be asked questions once evidence (such as the doctor’s response) is collected to try and explain any inconsistencies in the different parties’ perspectives. Many complainants expected that when an expert was appointed to review the case, this expert would naturally get in touch with them to hear ‘their side of the story’ and ask questions to get to the bottom of the case. Some had the expectation that medical experts called to advise upon the case and/or the medical case examiner would even conduct a physical examination of the complainant (where this was perceived to be relevant.)

“How do you know what the patient is saying is true, unless they physically examine you?”

The lack of further questioning of the complainant produced the impression, for a number of complainants, that the investigation was cursory and superficial and did not adequately or thoroughly interrogate the evidence. Complainants had an expectation that the investigation would work along similar lines to a criminal investigation where all relevant witnesses might be called and questioned in detail, prior to a decision being made about the veracity of the evidence presented.

“They never asked for anything else - literally what you put on that form and send off, that it was they’re basing the complaint on.”

“They failed to investigate...They never came back to me to ask me a single question.”

Some complainants wanted to, or had been told that they could, respond to the doctor’s response to their initial complaint. Those that did so had really welcomed this opportunity. A few complainants were particularly disappointed that they had not had this opportunity, since the doctor had decided not to respond to the complaint at all. This situation both confused and angered complainants, whose expectation tended to be that a doctor would be compelled to respond when a complaint is made about them.
“She wouldn’t take part in it, she said ‘I’m not doing it,’ and they let her get away with it...she just sat and said ‘no comment’ to everything. She should be held accountable by somebody.”

- **Perceived inadequacy of investigation**
  As outlined above, some complainants were dissatisfied that relevant medical experts or the medical case examiner had not contacted them and consequently this led to a perception that their case had not been thoroughly investigated.

  Furthermore, some complainants expressed dissatisfaction about the content of the investigation conducted by the medical expert. They had drawn this conclusion either from extracts of the report (appended as part of the outcome letter) or when they had requested and seen the full report. Some complainants even felt, when reading the expert report (or extracts thereof), that the expert had not properly grasped the basis of their complaint. A couple of complainants also commented that the expert’s investigation had little or nothing to do with their complaint and they did not understand why this was the case.

  “I was dissatisfied with the way they conducted the investigation, with the importance they’d placed on the medical records and the way they didn’t take into account what I was complaining about.”

  “It (the annex) didn’t address the issues that I had. I didn’t feel that my case was taken into account.”

  There was mention by one or two complainants that the expert appointed was inappropriate (i.e. from a different discipline or background from the doctor being complained about).

  Other concerns about the experts stemmed from the quality of the written medical expert’s report (or excerpts of the report) with some mentions of poor writing, typos, grammatical errors and a mention of an error in the name of the patient concerned in the investigation. These errors, when seen, had a significant impact on the complainant’s perception of the adequacy of the investigation; causing them to question the quality of the expert used and thus the quality of the investigation conducted.

  “It was littered with spelling and grammatical mistakes. They called my husband a doctor when he wasn’t.”

  “It makes nonsense reading. Stupid spelling. Very badly written.”
“There’s spelling mistakes, grammar mistakes just those sorts of things are bad enough. On the front of the report there was a reference to someone else’s report…I queried that with the Investigating Officer and she said ‘that just would have come from someone else’s report’ and I was like ‘what? do you think that’s all right?’”

There was considerable concern from complainants whose investigations drew heavily from hospital or doctors’ notes. There was a perception that notes alone (even if they contained gaps, inconsistencies or had been falsified) were not properly interrogated by the GMC; but instead were taken at face value, and held as more important than the evidence of the complainant. A couple of complainants commented that, if they had known what was contained in the notes, they could have submitted additional evidence to counter some of the points therein, but they were not given an opportunity to do so.

“I’ve now had the opportunity to view the expert report… he’s clearly based his opinion on the information available to him in my Mum’s hospital medical notes, without taking notice of the facts and concerns raised in my complaint. It’s clear from reading his report that much of what actually happened to Mum was not recorded in her medical notes, or even worse, in some instances has been mis-recorded giving an inaccurate record of what happened.”

One complainant pointed to the fact that the initial complaint form asks – ‘did anyone else see or hear the things you’re complaining about?’ This, in the complainant’s view, raised the expectation that other witnesses listed on the form would be approached and interviewed. This had not happened, according to the complainant, and was seen as a clear indication that the investigation was superficial and cursory.

“You kind of think they’re going to use that information, but they didn’t.”

Those complainants who started with the expectation that there would be a hearing tended to be extremely aggrieved that this did not happen. Some said that they wanted to face the doctor and contest their case. Others said that a hearing would have been a much more thorough form of investigation, with cross examination and full interrogation of the doctor’s version of events.
• **Perceived lack of transparency**

There was a sense amongst some complainants that the GMC was not sufficiently transparent during the investigation process, which fed into a perception amongst some that the GMC was not impartial in its investigation, but was rather trying to protect the doctor under investigation. This view tended to be based upon:

- Complainants not being kept informed about what was happening during the investigation.
- There being, in the complainant’s view, little or no proactive communication from the GMC.
- The GMC not automatically sharing the doctor’s responses or the expert’s report.

A couple of complainants had requested the expert report and had been denied access to it. One complainant had only gained access to the expert report after submitting a Freedom of Information request to the GMC.

“I was also told at the beginning that once the doctor was told that I had made a complaint against her, that any response she had that they would let me have, and I never heard anything about that.”

“And they all talk about transparency, that seems to be one of the key words at the moment, but there’s no transparency .... none at all.”

“I wrote back to them for the expert report and I had to do an FOI request – that was just nonsense, they knew I wanted it.”

Some complainants commented that the GMC did share information when asked, but complainants had to ‘know to ask’. If they didn’t ask they simply wouldn’t get access to much information that might be highly pertinent to their case. Complainants perceived that they were not routinely told what information they were entitled to receive, or how they might feed further information into the investigation process.

“I was never advised by any of the Medical Council people that I could get a copy of his notes, which I certainly could and did. I only found that out because I’d got connections that helped me to find out.”

“I remember she did tell me that when the case was finished and the doctor did receive a warning on his record that I would be able to ask for the paperwork under the Freedom of Information Act, and I was told who to contact and when I contacted them, I think I
had to do it in writing, and I got a letter back to the effect that they couldn’t release it.”

“I wanted the main report. I am still waiting because the GMC have a policy. Their policy is that the person’s main report can only be released by that person. But X is dead and I can’t see the main report.”

It should be noted that some complainants praised their Investigation Officer for proactively giving them the full range of relevant information related to their case. However, there appears to be some inconsistency of practice within the GMC on this point, since not all complainants reported that this had been the case.

4.3.4 Support
Participants were asked if the GMC mentioned or discussed support available to them from other sources, such as Victim Support. Many had no recollection of being offered any external support (despite the fact that standard letters from the GMC to point out this service) and many such complainants also said that this is something that they would have welcomed, if it had been offered.

Some complainants did recall and had been surprised by the mention of Victim Support; saying that this service didn’t seem relevant to them because they did not perceive themselves as ‘a victim’, or because they assumed that Victim Support provided support for victims of crime, rather than people who may have a complaint about a doctor. A number of complainants also reported feeling that what was offered was a counselling service, which was not what they needed and they would have preferred access to advocacy support.

“I wasn’t writing to them as a victim, I was writing to them about this particular doctor. So they kind of turned me into a victim really which I wasn’t very impressed with.”

One complainant had noted the e-mail address of the support service as ending with ‘@gmc-org.uk’ and therefore questioned whether the support provided was genuinely independent of the GMC.

Many complainants, in fact, spontaneously mentioned a need for external support, in the form of some kind of external and independent advocate. There was a requirement for help in navigating the complaints process; someone who is firmly “on their side.” Some commented that the doctor received professional external help (e.g. from their Unions or their solicitor) and that the complainant was at a disadvantage for not having a professional adviser, with a knowledge of the GMC’s systems and processes, to advise them.
“It would just be nice to feel that you have got a person to talk to, you have this one person who is your person. The guy that I spoke to within the GMC was from the Investigations Unit but obviously he works for the GMC, it would have been nice to have another point of contact to mull things over with.”

“Somebody a bit more independent who’s going to listen to you saying ‘I’m thinking about moving forward with this’, somebody who’s just going to listen to you.”

Such complainants suggested the need for a number of different types of support, including:

- Assistance with making the initial complaint, including helping to draft letters. Whilst some were confident in conveying the complexities of their complaint in writing, some did feel less confident and wondered if there was a more effective way of putting across their complaint. With the benefit of hindsight complainants wondered whether they might have profited from the help of someone who could put together the complaint in the most appropriate (and effective) manner. Such an advocate could also help to ensure that they put forward all of the necessary evidence.
- Supporting them in any interaction with the GMC: including any meetings.
- Keeping them updated: including finding out the details of what was happening with their investigation; advising as to whether the timescales are reasonable and (if appropriate) pushing for a speedier resolution by the GMC.

One complainant mentioned that as a result of complaining about their Investigation Officer, they had received an alternative contact for support (provided by Witness Support). This complainant said that this individual had made a big difference to her and was extremely helpful in terms of proactively keeping her up to date with progress on her case and thereby helping to ease anxiety. This complainant felt strongly that this service should be routinely available to all complainants.

“About a year went by and a very nice lady from the GMC help service called and asked me how I was getting on. She contacted the GMC on my behalf. That lady rang me every month and talked to me. Asked me how I was getting on.”

Another interviewee had taken her complaint to the Health Service Ombudsman with the help of support from ICAS. Because of this ICAS had also provided
support during the GMC investigation and this complainant felt that the provision of this independent advocacy service had been invaluable.

“We responded with the help of ICAS, who were very, very helpful to us.”

4.3.5 Suggested improvements – the investigation

The most common suggestion for improving the investigation process was to speed up the process. Most complainants appreciated that investigations have to take a certain length of time, because of the inevitable processes involved with collecting information. However many complainants still held the opinion that there must be a way to shorten the time taken.

Another common suggestion for improvement was more complainant dialogue and involvement within the investigation process, including:

- Telephone calls or meetings to discuss and ask questions following initial evidence gathering.
- Allowing complainants to provide a considered reaction to the doctor’s response to the complaint and to the expert report.

There were frequent complainant calls for greater transparency with more automatic sharing of full expert reports and doctors’ responses to allegations.

There were also requests (outlined above) for external, independent advocacy support, to help complainants navigate their way through the process more successfully.

4.4 Interim Orders Panels and doctors’ suspensions

The discussion guide did not specifically ask about Interim Orders Panels (IOPs)\(^3\), since this is not an aspect of the process with which complainants are usually concerned. However, IOPs were proactively raised by two complainants who had serious concerns about the doctor’s continued practice whilst the investigation was ongoing, particularly with investigations taking a considerable time to conclude. These complainants expressed extreme dissatisfaction at their exclusion from the IOP process. In both these cases the initial motivation for the complainant in bringing the complaint before the GMC was to protect other patients and to prevent the doctor from repeating their behaviour or actions.

\(^3\) At any stage of the process, a doctor may be referred to an IOP hearing. This panel does not make findings of fact, but rather considers the potential risk to patient safety of a doctor remaining in practice while the GMC investigates. It has the power to suspend or restrict a doctor from practising temporarily while the investigation continues if the panel decide this is necessary to protect patients.
Having no ability to submit evidence to the IOP and having no opportunity to attend or gain feedback from the IOP hearing caused a good deal of distress to these complainants.

“Like the Interim Orders Panel, I did write and say ‘I really disagree with your decision on this’ but I didn’t have any sway. I couldn’t do anything about it.”

“When it went before the Interim Orders Panel, we weren’t allowed to know why they hadn’t done anything with it.”

“We were getting more and more desperate, because this GP was still working.”

4.5 Case examiner decisions and outcomes

There was a mixed response to the communication relating to the case examiner decision which depended partly on whether or not participants were satisfied with the outcome; those unhappy with the outcome of their case tended to be more dissatisfied with communication, including the clarity of the decision and the rationale. Those who were satisfied with the outcome were, perhaps unsurprisingly, less concerned about the clarity and rationale.

“It said everything it needed to say but I think the whole crux of it was, I didn’t really agree with the outcome.”

Some complainants were surprised when they received the letter; they had not had communication with the GMC for some time and felt unprepared for this communication. A few said that they had expected some communication with the GMC to prepare them for the fact that their investigation was nearly complete.

“When the letter turned I was really scared to open it when I saw the GMC postmark. So maybe, I don’t know, a hint in advance or an email that it was reaching the conclusion.”

“At the time I got the letter because I hadn’t really had good communications, I wasn’t expecting the final letter like that, I was expecting the opportunity, because I knew about London, if there was a Hearing sort of thing. I honestly expected to go somewhere to be able to have my say so that’s why I was quite annoyed with it.”

4.5.1 Clarity of decision and the rationale for the outcome

When participants were asked if the outcome of the investigation was clearly explained, responses were mixed. Of all the communications sent by the GMC, this was the most frequently criticised in the interviews.
A common area of dissatisfaction included the perceived use of jargon (legal and / or medical in nature). A number of complainants said that their final outcome letter was not written in plain English. Or, if the letter itself were easy to understand, the annexes to the letter, including excerpts from the medical expert’s report, were difficult to understand.

“It said ‘the realistic prospect is not met’ – I don’t even know what the realistic prospect test is.”

Some complainants, furthermore, felt that the letter was not worded sensitively and was too short and/ or curt.

“They’re a little bit brusque, they say what they’ve got to say and no more. It didn’t particularly bother me until that last one. Particularly with that last letter, it wasn’t worded very nicely at all. Not that I was waiting for sympathy but you expect a bit of empathy really.”

“I felt it was quite short and very formal, and I remember sitting with it in shock in a way. That’s that, there’s nothing I can do now.”

“Well, they’ve kind of shut the door, or slammed it in my face is how I felt, the way they’ve decided to ‘conclude the case with no further action, if you’d like to talk to somebody about how you feel’. It was a bit brusque really, a bit in your face I felt.”

In addition to concerns about jargon, other common grievances with the annexes included:

- **The use of excerpts:** this was reported by some as being confusing with some excerpts seeming to conflict with one another. Using excerpts from the report, out of context, made the communication difficult to understand.
- **Poor writing:** including reports of typos, grammatical errors and even errors in the names of the individuals / places involved (these seem to have been found in expert’s reports and / or supporting documents rather than in the GMC’s letters, although given that respondents did not have documents in front of them it is difficult to always be certain where such errors were reportedly seen).4
- **Too long:** some complainants reported finding it challenging to pull out the parts most relevant to them (they would have appreciated a summary within the covering letter.)

---

4 See also 4.3.3
• Not complete: some complainants simply objected to being sent excerpts, rather than the full report.

A number of complainants commented that the mention in the decision letter of there being no right to appeal the decision was surprising to them. This complete closure, with no further avenues of redress, coupled with a sense that the letter was short or curt, compounded a feeling amongst some complainants that their views had not been valued in the process and they were left feeling dismissed.

“To be honest, I read the letter and I ripped it up. Because I was quite angry, I felt like I’d been disbelieved.”

One complainant had made a request to see the parallel outcome letter that had been sent to the doctor in their case. On receiving and reading this letter the complainant found that it contained the phrase ‘we do understand that this type of investigation can be stressful.’ This caused considerable anger, since the GMC had not said anything similarly sympathetic in the complainant’s version of the letter.

4.5.2 Contact with the GMC after the case examiner decision
A few complainants mentioned contacting the GMC after receiving the case examiner decision. Some noted that the letter did mention that they could be in touch if they had any questions or concerns. Complainant experiences differed here. Some commented that the GMC contact was helpful in explaining the letter and clarifying points of confusion. However, since they could not change the outcome, some reported that they simply felt more frustrated.

A few of the complainants commented that as a result of their communication after the case examiner decision the case was ‘re-opened’ for further investigation. They may have, for example, commented on something mentioned in the expert report and pointed to further evidence to refute the point made. Complainants in this position felt that if they had had a chance to be more involved in the investigation, for example to see and respond to evidence such as the doctor’s response or the expert’s report, they would have raised the issues at that point and avoided the need for further investigation at this late stage. These participants felt that their experience pointed to a key flaw in the current investigation process (see also section 4.3.3).

4.5.3 Suggested Improvements
Suggested improvements for the case examiner decision communication included:

• Making letters easier to understand, with less jargon.
• Wording the letters more sensitively or sympathetically.
• Including a summary of the key points contained in the annexes.
Complainants who considered the expert report poorly written made broader suggestions about the quality of the expert used.

During the interview it was explained that the GMC is running a pilot project where complainants are invited for a meeting at the end of the investigation to explain the reasons for the GMC decision and to answer the complainant’s questions about the outcome. Many were positive about the idea of a meeting at the end of the process, and indeed some suggested this as an improvement to the process they experienced.

There was also mention of wanting an opportunity to speak to their Investigation Officer. Some had expected to be told the outcome over the phone (or at least to have been told that a decision was imminent in order to prepare them) and some had called their Investigation Officer to discuss the outcome once received. There was suggestion that this communication should be more proactive, rather than the complainant initiating contact.

4.6 Fitness to Practise Panel hearings

Only five of the complainants interviewed had experienced a Fitness to Practise Panel hearing. Complainants who participated in hearings were realistic that their experience was unlikely to be anything other than difficult. Much of the feedback about the hearing process was positive and complainants did say that a good deal was done to prepare them for the hearing session; support them and keep them informed during the experience.

“I think the hearing was organised extremely well, it was very, very good in terms of organisation and the skill levels and experience they had on the panel.”

“We were treated very well, they were very kind to us, very respectful.”

Key points of further feedback from the interviewees can be summarised as follows:

- One complainant raised the point that they had not had (and were not permitted to have) sight of the full written allegations against the doctor prior to the hearing. This was felt to be a major flaw since, on seeing the allegations, the complainant could immediately see that they contained factual errors. This undermined the case against the doctor and could easily have been avoided if the complainant had been allowed to see the full written allegations prior to the hearing.
- The process was perceived, by all who experienced it, to be overly formal and legalistic, which was alienating and very uncomfortable.
- Having the doctor present when giving evidence was particularly stressful and intimidating.
“I don’t really understand why the doctor had to be present in the room because our version of events had already been put into a statement….. I didn’t really understand what the benefit was of having us all in the room together was, and I found it very intimidating, not just because the doctor was there but that his team were there.”

- One complainant expressed concerns over the order in which evidence was heard – the doctor’s expert had time to listen to the complainant’s expert witness and then had time to prepare to refute the evidence, but not vice versa.
- Complainants did not feel prepared for the perceived aggressive nature of the barrister's cross examination or, in one case, the line of questioning that the doctor’s barrister might follow.

“I certainly didn’t feel briefed as to what the line of questioning would be because the questioning wasn’t all in the direction I expected it to be.”

- After giving evidence, one complainant felt they were not kept sufficiently informed of progress, only hearing the result through a subsequent letter.
- One complainant felt that the layout in the hearing room could be improved in order to make the experience less intimidating.

“The layout of the room, I think, for me was one of the things I think they could probably improve upon, you don’t need such a big room, bring the panel a bit nearer, get rid of the microphone and try and put the so-called public gallery not sat behind and quite close to the witnesses.”

- A final but important point was raised by one complainant with regard to the toilet facilities at the hearing venue:

“The toilets at the GMC, the light’s on a timer and I, for reasons, have to spend longer in there than I used to and I had a bit of a panic attack just before the hearing because I was in there and the lights went off. It’s only a little tiny thing but basically the people that go to these hearings are not always going to be tip top health wise. That’s a small thing that maybe they could do something about?”
Some of the above aspects of the hearing process are required by law (e.g. it is a doctor's legal right to be present whilst evidence is being given by a complainant.)

Whilst this limits the possibilities for acting on the feedback provided in terms of changing the hearings themselves, the GMC and the Medical Practitioner Tribunal Service may wish to consider whether, where this is the case, the reasons for hearings being run in the way that they are, might be more effectively communicated to complainants and witnesses.
5. **Feedback on Communication and Overall Experience**

5.1 **Feedback on communication**

Views on communication during the process did vary, with some more satisfied than others. Those who were more satisfied, included those with shorter investigations, or who felt positive about the responsiveness of the Investigating Officer. Some complainants were happier with a letter driven process than others.

Complainants were largely positive about the written communication received (with the exception of the outcome letter which attracted considerable criticism from some). Letters were generally felt to be clear and the tone appropriate.

> “The letters are set out well, they may have taken a little bit of time to carry out the investigation but they did write at the appropriate times in the case and the letters are very well set out as well. You’ve got phone numbers there, contacts, dates, everything there. So the letters are easy to refer to in that respect.”

> “Some official letters can be very much to the point and quite cold but theirs weren’t. I really did feel if I wanted to ring up and talk to somebody that would be fine.”

However, whilst many were happy with the communication, when received, there was a common complaint about insufficient proactive communication. This included concerns about long periods of no communication from the GMC to the complainant during the investigation.

> “It just sort of went silent.”

Some participants in the research only remembered receiving two letters from the GMC throughout – an initial letter saying that they were going to investigate and a letter at the end of the investigation with the outcome. There were also participants who said that very long periods of time (up to 6 months in some cases) went by without them receiving any communication from the GMC about what was happening with their case.

Commonly raised issues around communication included:

- **Little or no proactive communication:** although the GMC may be good at responding when the complainant gets in touch, the GMC were frequently criticised for not periodically contacting complainants on a proactive basis to give them updates. Participants may have received one letter during the investigation to reassure them that their investigation is still ongoing, but they wanted more frequent
communication and even a little more detail about what was actually happening with the investigation at that point.

“*I think you need to be told what’s going on during the process and not just be presented with a fait accompli.... That’s not good enough, you’re involved in it.*”

- **Too much reliance on letters:** many complainants found this approach difficult. They wanted to talk to someone either in person, in order that they might feel better understood and be reassured that the investigation is progressing and is sufficiently thorough. This reliance on the written word led complainants to view the process as too bureaucratic.

  “*It was a bit faceless, a bit blank. The way that you fill the thing in, you thought do they understand what I’m saying and how passionate I feel about what’s going on. All I’ve got is like 76 letters or something left to write what I feel.*”

  “*They should be more open...it’s a crusty old system with a lot of protocol... it needs to be a lot more customer focussed, a lot more down to earth...listen to people instead of all this letter writing.*”

- **Unsympathetic tone:** the GMC’s communications were sometimes seen as overly formal and matter of fact. This was particularly the case in relation to the final outcome letters. Some complainants wanted the GMC’s communications to demonstrate greater empathy for their situation, particularly at an emotionally difficult time.

  “*It wasn’t very caring, I didn’t think really.*”

  “*They never even said ‘condolences’ or anything, even though my daughter had died.*”

  “*It’s like they didn’t really seem to care. It was a really hard time, it put a lot of stress on me and it had been going on for over a year.*”

  “*I expected them to keep in touch with me a bit because of the bereavement I’d had and everything, I thought they would have been that little bit more supportive in the fact that I had to make the complaint, or felt I had to make the complaint, but I didn’t feel that.*”
5.1.1 Suggested improvements
Complainants want more communication from the GMC. Some said that they think the GMC should be in touch every month to two, or every six to eight weeks, giving an update on the case, what is happening next and ideally what timescales are involved.

Complaints suggest more interactive communication. Phone calls are called for to ensure that the complainant is kept in the loop with the developments. Speaking to somebody can help ease the anxiety that complainants can feel about the process and the outcome. Some participants who were positive about the idea of pilot meetings mentioned this idea here, as a suggested improvement in communication.

Complainants suggest that written communication should have a more sympathetic tone and better reflect the emotion and stress the complainant might be experiencing.

5.2 Views about meetings pilots
During the interviews, participants were read a description of the current pilot exercise being run by the GMC where meetings with complainants are taking place (in London and Manchester). This includes both an early stage meeting (to ensure that the GMC has fully understood the complaint) and a meeting at the end of the investigation to explain the reasons for the decision and to answer any complainant questions about the outcome. Interviewees were asked whether they believed such meetings might have been helpful in their own case.

5.2.1 Early-stage meeting to discuss the complaint
Nearly all complainants said that a meeting at this stage of the process would have been helpful and that they would have welcomed it.

Many had spontaneously expressed their disappointment at not having had the opportunity to discuss their case with the GMC and not having had the chance to elaborate, or ensure that the GMC had understood the basis of their complaint.

This was particularly raised by those who felt less confident in their written submission. Complainants also assumed that in such a meeting they would be able to answer questions and point the GMC to any further relevant evidence. They further perceived that this could provide an opportunity to physically hand over any required documentation and that this, coupled with them directing the GMC to other relevant information, might have both speeded up and improved the effectiveness of the investigation process.

“I think the difference between writing things down and actually talking to someone about it face to face, the latter I think the other person can
understand. There might have been things that I didn’t put in, that I might have said.”

“That’s what we wanted… Sitting down and speaking to someone, you can fully understand.”

“Because, in a letter you can miss so much.”

There was also a feeling, from some, that they wanted to be able to express themselves and their concerns orally because this would be helpful for them personally. Some complainants felt that the GMC would have taken their complaint more seriously if the full impact of the doctor’s alleged actions on the complainant could have been explained in person. This, in turn, in the belief of some complainants, would ultimately have resulted in more stringent action being taken against the doctor.

“It would have given me an opportunity to discuss and to ensure that I was getting over to them what my concerns were. Because I felt at the end of the process they had quite ignored the issues that I’d raised about the doctor and they’d supported him really rather than listening to what I’d got to say.”

“Having a meeting with somebody to actually discuss the complaint would have helped a great deal.”

Some wanted this meeting to be face to face; they wanted to meet the person reviewing their case and thought that a face to face meeting would work best to ensure that they were fully understood. However, some said they would have been equally happy with a telephone conversation. They might not want to travel, for example, or they might be concerned at the formality of a face to face meeting. Some complainants did ask whether a complainant would be able to bring someone along to support them, to a meeting of this kind.

“You are dealing with people … about something that is extremely traumatic.”

5.2.2 Meeting to discuss the outcome
The idea of a meeting at the end of the process received a more mixed response. Some welcomed the idea and would have both requested and attended this meeting, if they had been given the opportunity. Some complainants felt that they did not fully understand the reasons for the investigation outcome, or that they didn’t understand what the outcome meant in practice.
“I would have loved that, in fact I would still love it now.”

Others would have liked a meeting as they understood the outcome rationale, but were nevertheless unhappy with the reasons given and wanted the chance to argue their own perspective. Some perceived this meeting as a chance to change the final decision because they were unhappy with it. Others felt that a meeting at this point, when the decision has already been made, would be too late if they could no longer influence the outcome.

“I think I would have taken it (the meeting to discuss the outcome) actually because I think I would have been arguing my case. I think I would have been saying that’s all good and well but this is how we feel, I would have felt that would have been more of a conclusion rather than just sort of saying this is our outcome and the case is now closed.”

5.3 Overall experience
5.3.1 Single most important thing to improve
Participants were asked, towards the end of the interview, and thinking about their whole experience, what single thing would improve the process for other people complaining to the GMC in the future.

Consistently, the most frequent suggestions related to:
- Speeding up the process.
- More complainant involvement, greater dialogue and opportunities to discuss the complaint.
- More complainant support.

These points have all been covered in some detail at 4.3.3 and 4.3.4.

5.3.2 Other general comments
Cynicism and perceived bias
Some complainants (although by no means all) had been left cynical about the complaints process and the GMC as an organisation. A number of complainants expressed the perception that the GMC is an organisation who would “protect their own” and that doctors had the advantage of professional representation and knew how to “work the system.” Some had thought that the GMC was biased in favour of doctors from the outset, but still hoped that they might have a successful outcome in their own case. Others had started the process optimistic of a fair, impartial investigation, but in their experience had led them to change their mind about this.

“I mean, here I am, the layman, and here they are with legal teams and professionals and insurance companies, they’re all on the other side, aren’t they?”
“I do feel sort of they have the backing of their Union, a lay person isn’t potentially going to be able to...I mean, her response was probably what the Medical Union had said, you say this and this covers you. So as a lay person responding back to that, it was quite difficult.”

“I’m being a bit cynical but it’s very easy for a Medical Union to say we’ve had experience of this before and this is how you should approach it.”

The parts of the process that were perceived to reinforce such perceptions were:

- A perceived lack of ‘forensic’ investigation: there was a feeling that some of the doctors’ evidence is insufficiently scrutinised and, since complainants were often not asked to comment or counter doctors’ arguments, the investigation was considered flawed and biased towards the professional.
- A lack of communication: long periods of time with no communication led some complainants simply to assume that nothing was really happening with their case and that enquiries into the true facts were not being assiduously pursued.
- Reliance on written submissions: this conveyed a sense of bureaucracy and paper shuffling making the investigation seem, to some, like a ‘tick box’ exercise rather than a thorough investigation.

These perceptions appear also to have been partially reinforced by the media, with some spontaneous mentions of high profile cases in which the GMC has reportedly failed to act against doctors who have harmed patients.

**Misunderstanding of the GMC’s role and the meaning of outcomes**

For a number of complainants there was simple disbelief at the outcome of their case. As far as they were concerned there was no question or doubt that the doctor had done wrong and his or her fitness to practise was questionable. This disappointment in part stems from a lack of understanding of the GMC’s role, remit and motivation in investigating complaints against doctors.

There was widespread lack of understanding of the GMC’s actions and what they mean: participants had difficulty understanding why if the GMC say that a doctor’s actions have fallen ‘below standard’, this may not warrant some form of ‘punishment’. Several complainants did not understand the phrase ‘not sufficiently below’ standards, their perception was that being below standard at all must be unacceptable. In addition some complainants did not fully understand the impact on the doctor of the GMC’s final actions (e.g. what goes on their record? Or; what limits are placed on their ability to practise in the future?)
One complainant could not understand the point of writing to a doctor’s ‘employers’ about the advice the doctor has been given by the GMC, when the doctor was essentially self-employed within in a GP practice.

“The advice gets sent to his employer and, considering he is his own employer, it means absolutely nothing…they might as well have written ‘don’t get caught’.”

**Frustration that complaints can only relate to one doctor**

Some complainants raised frustration at the fact that the GMC refuses to investigate multiple doctors in the same case. One complainant felt that the basis of the decisions made on the various doctors that she complained about were conflicting (junior doctors were ‘let off’ because they had insufficient experience, and the senior doctors were ‘let off’ because they had delegated to people they thought had sufficient experience). She thought that if the case had not been treated as numerous separate complaints, each with its own case examiners, but rather as one complaint with the same examiner, the outcome would have been consistent.

One complainant was frustrated that her complaint could not be heard about a whole GP practice. The complainant felt that the entire system at the practice had failed and that no one individual doctor was necessarily at fault on their own, the complainant argued that patients rarely see one single GP all the time nowadays and that there should be a simpler way for a case to be raised about more than one doctor.

“He saw more than one GP at the surgery, but you have to make specific complaints against one GP and, to be honest, I didn’t have the energy.”

**Time frame for accepting complaints**

A couple of participants mentioned that, due to slow recovery from procedures, their decision to make a complaint nearly fell short of the time frame permissible to make a complaint (taken from the procedure date). It was felt that because the outcome (or lack of outcome) from certain procedures can take some considerable time to show, the current timescales allowed to launch a complaint are not always appropriate and should be longer.

“There’s a five years complaints procedure and they take that from the date of the operation….there was some question mark initially as they’ would investigate …I don’t think patients on the day of the surgery or for several month after would necessarily think there was something wrong. It seems very unfair using a fixed date rather than when the patient became aware of how wrong it is.”
6. Conclusions and Recommendations

Despite the fact that complainants were actively being asked, within this research, to concentrate and focus on possible process improvements there was a good deal of positive feedback about the GMC's process, including:

- The clarity of communications (other than with regard to the final outcome letter and supporting documents.)
- The initial speed with which the receipt of a complaint is acknowledged.
- The responsiveness and professionalism of Investigations Officers was widely praised, although there was some inconsistency.
- The hearings process being well organised and good support being offered at this stage.

Nevertheless, the research has highlighted a large number of issues that the GMC will need to consider. Key points are summarised below.

Submission of the complaint

Suggestions for improving the process for submitting complaints were as follows:

- Allowing complaints to be admissible when submitted verbally, or to have someone from the GMC (or from an independent advocate) to help complainants put their written complaint together.
- Making it clearer that complainants should submit any and all evidence at the outset.
- Making it clear and explicit that complainants may not be contacted again until the outcome of the investigation.

The investigation itself

Suggestions for improving the investigation element of the process were as follows:

- Speeding up the process.
- Allowing for more complainant dialogue and involvement within the investigation process, including:
  - Telephone calls or meetings to discuss and ask questions following initial evidence gathering.
  - Allowing complainants to provide a considered reaction to the doctor’s response to the complaint and to the expert report.
- Greater transparency with more automatic sharing of full expert reports and doctors’ responses to allegations.
- Provision of external, independent advocacy support, to help complainants navigate their way through the process more successfully.
Case Examiner decisions

Suggested improvements for the case examiner decision communication included:

- Improvements to the communications at this stage, including:
  - Making letters easier to understand, with less jargon.
  - Wording the letters more sensitively or sympathetically.
  - Including a summary of the key points contained in the annexes.
- Being warned that the decision is imminent in order to allow complainants to prepare themselves.
- Being told the outcome over the phone and being called proactively by the Investigation Officer at this stage to discuss the outcome.

Communication

Key improvements with regard to general communication were as follows:

- More communication from the GMC giving updates on the case, what is happening next and ideally what timescales are involved.
- More interactive communication. Phone calls are called for to ensure that the complainant is kept in the loop with the developments.
- Written communication having a more sympathetic tone and better reflecting the emotion and stress the complainant might be experiencing.

There was almost unanimous support for wider introduction of the current pilot meetings at the start of the investigation process. Many, though not all, also welcomed the idea of a further final meeting after the conclusion of the case.

Given the relatively small number of respondents taking part in this research who had experienced a panel hearing it is recommended that the GMC and the MPTS considers undertaking further, more targeted research to gain more feedback from complainants and witnesses about how such hearings might be improved.
Appendix 1 - Research Instruments

Stage 1 interview discussion guide FINA

Stage 2 interview discussion guide FINA
Doctor and Complainant Survey Draft Action Plan
<table>
<thead>
<tr>
<th>Concern raised</th>
<th>Changes made</th>
<th>Further action planned</th>
<th>Long term changes</th>
</tr>
</thead>
</table>
| The need for greater transparency, communication and sharing of information with doctors and complainants during our investigation                                                                 | **Tone of correspondence**<br>Last year we commenced a fundamental review of the tone of our correspondence to make it simpler, clearer and more sensitive. We reviewed all letters used in fitness to practise.<br>At the end of 2012 we commenced 3 pilot projects:<br>**Communication with patients**<br>The first is a pilot of meeting patients at the outset and the end of an investigation in order to ensure we have understood their concerns, explain how we investigate and explain our decision. Following a very positive independent evaluation, we have decided to implement a substantive UK wide service to continue these meetings in the future from the start of 2015.<br>**Communication with doctors**<br>The second is a pilot of meetings with doctors at the end of our investigation to support better informed decisions about whether a hearing is necessary. This is currently being independently evaluated.<br>**Emotional support for doctors**<br>The third is a pilot of independent, confidential emotional support for any doctor (a service already provided on our behalf for complainants by Victim Support) who is subject to a complaint (a service already provided on our behalf for patients/families involved in a complaint). | **Tone of correspondence**<br>Following feedback we are undertaking further work on the tone of our fitness to practise letters. We are also in the process of reviewing our website and other fitness to practise documents such as guidance to ensure the tone is clear and accessible.<br>Following the comments made in the survey we propose to make the following changes to the first letter that we send to doctors and complainants confirming we are undertaking an investigation:<br>  - Provide a customer care statement  
  - Set out at what stage we will update doctors and complainants about progress with our investigation and when we estimate that will be.  
  - If we have no progress to report at the points we estimated in our first letter, we will send an update with a new estimate.  
  - Be clear that doctors and complainants can ask us for information at any time. | In the longer term we propose to explore new and more innovative ways to communicate with doctors and patients and to speed up cases.                                                                                         |
|                                                                                                                                                                                                                                                                       | **Accessibility to updates about investigations**<br>We propose to look at whether technology offers opportunities for increasing the transparency of our process, for example, by enabling doctors and patients to track the progress of complaints on our website. |                                                                                                                                                       | **Customer care**<br>Introducing a greater focus on customer care including considering additional customer care roles within our fitness to practise procedures. |
|                                                                                                                                                                                                                                                                       | **Earlier face to face communication with doctors**<br>Considering whether there are ways to communicate in person with doctors about complaints earlier in an investigation that would be effective and proportionate. |                                                                                                                                                       | **Sharing information with patients**<br>We also propose to undertake a more fundamental review our approach to sharing information with complainants during an investigation to see if it can be improved in the light of the need to take care not to influence potential witnesses. |
| A need to set clear expectations of the fitness to practise process | **Communication with patients**  
The pilot of meetings with complainants (see above) being piloted since late 2012 seeks to set clear expectations for complainants at the outset of an investigation. | **Better information about investigations**  
We propose that the first letter that we send to doctors and complainants confirming we are undertaking an investigation should contain a process map and an estimate of how long we expect the process to take and what factors we would expect to extend the average timescales. |
|---|---|---|
| **Increased capacity**  
During 2013 and 2014 we have increased capacity and resilience within our operational teams. This has allowed us to meet the increasing volumes of complaints that we have been receiving in recent years and has led to an overall improvement in the timeliness of our investigations. | **Streamlining our procedures**  
Next year the Lean programme will focus on speeding up our investigation process.  
**Making preliminary enquiries to deal with concerns faster**  
We are currently developing proposals for expanding further our use of preliminary enquiries as a way to speed up our handling of complaints.  
**Speeding up the undertakings process**  
We are currently developing plans to establish and implement a clear escalation process for agreeing undertakings to speed up the undertakings process.  
**New legislation to speed up our procedures**  
We are considering those parts of our investigation where delays arise because we are waiting for information from other bodies to develop ideas for reducing those delays, for example, by collecting medical records from health providers rather than requesting them by post. |
<table>
<thead>
<tr>
<th><strong>Concerns about the adversarial nature of FTP hearings.</strong></th>
<th><strong>Emotional support for patients</strong></th>
<th><strong>We provide a Witness Support Service to assist complainants and witnesses in giving evidence to the panels. We have kept this service under review and are currently considering the provision of an on-site representative for the service.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Emotional support for doctors</strong></td>
<td><strong>We are piloting a Doctor Support Service for supporters to accompany doctors to hearings as mentioned above.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Making reasonable adjustments</strong></td>
<td></td>
</tr>
<tr>
<td>Concerns about management of hearings by panellists</td>
<td>Recruitment, training and appraisal of panel chairs</td>
<td>New legislation to speed up hearings</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>-----------------------------------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>We make reasonable adjustments for anyone involved in a hearing that has specific needs where appropriate.</td>
<td>Training for panel chairs</td>
<td>We are pursuing changes to legislation to take forward a modernisation programme for FTP hearings (referred to above) which will assist us in reducing the length of hearings. It will also reduce the adversarial nature of some aspects of the process by introducing powers to deal with some types of cases where all the parties agree to the outcome without the need for a hearing.</td>
</tr>
<tr>
<td>MPTS Chairs’ training in 2014 specifically addressed the witness and experience and included sessions delivered by Witness Support. The management of hearings and the cross examination process is included in training.</td>
<td>MPTS has completely revised the appraisal, recruitment and training process. New Chairs are now appointed on probation and are independently observed in hearings by either the Chair of MTPS or senior staff who have been specifically trained. This process must be satisfactorily completed before chairs are confirmed.</td>
<td></td>
</tr>
<tr>
<td>Quality assurance of panels</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The MPTS Panel Development team review all panel feedback and take action where appropriate. The MPTS Quality Assurance Group reviews all Chairs’ feedback on individual hearings for learning points.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual panel training</td>
<td>Annual training for Chairs, panellists and</td>
<td></td>
</tr>
<tr>
<td>Enhanced performance management for panels</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Chair of the MPTS is introducing enhanced performance management of panellists in order to ensure that panels manage hearings effectively. New systems have been piloted in the interim order panel pool and will be rolled out to all panellists once the IT system is complete - scheduled for the end of 2014. This will include collated 360 feedback and quarterly and annual reviews with a formal appraisal.</td>
<td>Streamlining hearings</td>
<td></td>
</tr>
<tr>
<td>The modernisation programme mentioned above also includes provision for the use of legally qualified chairs in some cases to enhance case management and hearing management. It will also allow hearings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Assessors is mandatory.</td>
<td>such as undisputed reviews to proceed to conclusion without Legal Assessors.</td>
<td></td>
</tr>
</tbody>
</table>