



Doctors' Policy Research Group

# **The General Medical Council: Fit to Practise?**

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## Glossary

BMA	British Medical Association
BMJ	British Medical Journal
FTP	Fitness to Practise
GMC	General Medical Council
MDU	Medical Defence Union
MDDUS	Medical and Dental Defence Union of Scotland
MPTS	Medical Practitioner Tribunal Service
MPS	Medical Protection Society
PCC	Professional Conduct Committee
RMP	Registered Medical Practitioners

## Authors' note on data interpretation

Wherever possible, we have used data on the numbers of GMC complaints, tribunal hearings, registered medical practitioners, and so on, deriving directly from the GMC's annual reports and Medical Registers for the relevant year. However, historically, the GMC's annual reports did not adhere to a standard format for the data they provided year-on-year. In addition, the GMC's internal professional committee structures and range of options for disposing of complaints have changed over time. Where we have not been able to find a direct GMC source for a figure for a given year, the source of the quoted figure is given in the text or footnotes. Footnotes also indicate where changes in systems affect interpretation of a trend.

## Acknowledgements

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“The strictest law sometimes becomes the severest injustice.”  
**Benjamin Franklin**

## Foreword

This paper by Hilarie Williams, Christoph Lees, and Magnus Boyd raises important questions around the role of regulation in the healthcare professions. Whilst the paper discusses the impact of the General Medical Council, the issues are of much wider relevance. The horrific revelations around standards of care at the Mid-Staffordshire NHS Foundation Trust have shaken confidence in the quality of NHS care more generally, and raised serious questions regarding the role, power, and impacts of performance management and regulation. In April 2014, the Law Commission published a draft Bill for a unified system of regulation, which was intended to prompt further debate<sup>1</sup>, but it was subsequently omitted from the Queen's Speech in June 2014. In any event, the Bill does not address any of the issues raised in this paper.

It is too easy to adopt a knee-jerk response of assuming that bigger, stronger regulation will make the health system (or any other public service) more effective. The evidence to support this response is very limited, and it is important to investigate the potential impact on professional motivation. Intrusive, formulaic regulation promotes an adversarial approach to disputes, and that serves no-one well. A majority of respondents to the Law Commission's 2013 consultation on professional regulation argued for the removal of the legal concept of an 'allegation' in the context of Fitness to Practise investigations, in favour of a more flexible approach.<sup>2</sup>

The authors highlight the costs of the current system. Not only must doctors pay around £400 a year directly to their regulator, but they can spend more than twice this amount in defence organisation subscriptions to guard against the costs of defending themselves in a GMC investigation arising from their NHS work. The other health professions are facing similar costs: the Nursing and Midwifery Council (NMC) is currently proposing a 20% increase in the annual registration fee.<sup>3</sup> The NMC has said that: "the steep increase was needed to handle the soaring number of fitness to practise referrals against nurses and midwives and to cover the increasing costs of regulation".<sup>4</sup>

The Berwick Review on patient safety concluded that NHS supervisory and regulatory systems should be "respectful of the goodwill and sound intention of the vast majority of staff".<sup>5</sup> The analysis of the impact of the GMC suggests a system that falls well short of this ambition, and which has also failed in its duty to protect patients from the actions of a tiny minority of NHS staff.

Drawing on Le Grand's four models of public service motivation<sup>6</sup>, this system has shifted towards one based on a general mistrust of the health professions. The risk is that an increasingly intrusive regulatory regime will crowd out professional motivation to try to provide high quality patient care. The more controlling the regime becomes, then the greater the risk. This could prove a costly mistake in a time of austerity.

Following concerns over hospital ward staffing levels, attempts by NHS hospitals to recruit additional qualified nurses are facing great difficulty in filling posts. In the long run this will drive up staff costs.

An excessive focus on 'confidence' in preference to 'trust' inevitably increases transaction costs, as a system of rules and regulation is required.<sup>7</sup> Doctors who feel 'guilty until proven innocent' will practise defensive medicine, which is both costly for the NHS and worse for patient care.<sup>8</sup> Furthermore, regulatory models that are designed to promote confidence at the expense of trust can create a false expectation of certainty within the uncertain practice of medicine, and drive out morality.<sup>9</sup>

These are important concerns that affect all aspect of health care, and ones that require careful attention as the debate builds over the development of a unified system of regulation.

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## Executive Summary

- In the wake of past scandals, the GMC has tried to reinvent its image. The Council and its disciplinary arm are now dominated by lay personnel. It explicitly claims to protect patients and repudiates any protection of the medical profession.
- The GMC remains funded by mandatory levies on doctors. Annual subscriptions increased 20-fold in real terms from 1970-2010.
- The number of complaints made to the GMC about doctors rose 8-fold between 1992-2012.
- The number of public hearings increased 5-fold between 1992-2012.
- The number of erasures from the medical register increased 12-fold between 1992-2012. For every erasure in 2012, there were 5 suspensions from practice. Three quarters of those were prior to any public hearing.
- Some high-profile successful appeals have occurred against GMC sanctions despite the enormous legal and cost barriers of an individual taking on the GMC. Common themes include inconsistent decision making, excessive delays, flawed evaluation of the evidence and undue weight given to the testimony of the accusers.
- 96 doctors are reported to have died whilst undergoing fitness to practise procedures between 2004 and 2013. It is unknown how many were suicide. A GMC internal investigation that commenced in 2013 has not reported to date.
- The GMC seems to lack openness and insight concerning the failings in their processes. When there is no case to answer after protracted proceedings, it is exceptional for there to be any apology, or explanation about why cases were pursued.
- The GMC acknowledges that there is no evidence of any decline in standards of medical practice to justify its increased activity and no published or inferred evidence exists that the GMC FTP processes improve the quality of medical care overall.
- There is evidence that a culture of complaint and litigation may harm patient interests by fostering defensive medicine and encouraging experienced doctors to leave the profession or switch to low risk practice. A GMC referral is the extreme adverse professional experience for a doctor, so it is disturbing that the GMC appears to give no serious consideration to the impact of its own activity (and deficiencies) on either doctors or patients.



## Introduction

The General Medical Council (GMC) regulates the practice of medicine in the UK, its main statutory basis being the 1983 Medical Act. In the 21<sup>st</sup> century, its professed remit is to 'protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine'.<sup>10</sup> Some see this focus on the interests of patients rather than doctors as a new phenomenon and, having been found wanting in the past, the GMC is anxious to publicise its commitment to patients at every opportunity.<sup>11</sup>

This anxiety has compelling roots in recent history, although accusations that the GMC protects doctors' interests are far from new. Establishing minimum standards of training (the main aim of the original Medical Act of 1858<sup>12</sup>) inevitably privileged those who could qualify, but, in the early part of the 20<sup>th</sup> century, the GMC effectively acted as an enforcer of restrictive practice.<sup>13</sup> Equally, throughout its existence, many doctors have felt let down by a regulatory body that was dominated by elite doctors who had little connection to the bulk of the profession.<sup>14</sup> In 1858, a British Medical Journal (BMJ) correspondent, 'MD' drew a parallel between the impending 1858 Act and Aesop's fable of the frogs that desired a king. Just as doctors had petitioned a largely uninterested government for medical reform, the frogs had importuned the gods for a ruler. When they disdained his offering of the inert King Log, Zeus sent the frogs a stork. The stork was much more proactive – it gobbled them up. 'MD' felt that the medical profession stood in a similar danger of being consumed.<sup>15</sup>

MD was prescient: in contemporary Britain, the GMC's activities are consuming doctors on an unprecedented scale. The Chief Executive – a former BBC journalist – has welcomed the escalation of complaints from doctors' employers and colleagues despite his belief that this does not reflect any fall in standards.<sup>16</sup> Others, however, feel less complacent about the manner in which the GMC's activities have snowballed since the mid-1990s, and how the unintended consequences of its actions have multiplied. In this paper, we analyse how the GMC has arrived as its current state, and how practice by the GMC is threatening the lives as well as the livelihoods of doctors. Most importantly, we consider how, contrary to the declared intention, this may damage the care of patients and lead to expectations that can never be met.

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## 1. How did we get here?

Until the late 20th century, the GMC's operations were relatively peripheral to the lives of most doctors and patients. Periodically, the press reported on a salacious misconduct case, which usually involved drugs, alcohol, and/or inappropriate sexual liaisons. Complaints were relatively few, with only a handful of hearings by the Professional Conduct Committee (PCC) each year. Revised versions of the Medical Act came into force periodically, notably the 1978 Act, which restructured the council so that some members were elected by the grassroots, divided off procedures for sick doctors, and provided for specialist registration. It, and preceding Acts, was ultimately consolidated in the 1983 Act, but there was scant interest outside medical and health-policy circles.

All was to change markedly from the 1990s onwards. Between 1992 and 1995, the GMC took steps to assume powers to assess doctors' performance through the Medical (Professional Performance) Act 1995.<sup>17</sup> Shifts in the GMC's focus reflected a combination of the government's consumerist policies and the media highlighting individual cases of poor practice. Meg Stacey, a former lay member of the GMC, traced the origin of the 1990s' developments back to a celebrated case a decade earlier, but the momentum gathered markedly with the Bristol paediatric heart surgery scandal, which surfaced around the time that Donald Irvine became president of the GMC in 1995.<sup>18</sup> From the first, Irvine signalled the importance he attached to image and the media. When asked by Richard Smith, editor of the BMJ what he saw as the key problems facing the GMC, his reply was: "The first is getting its image and its relationship right with the outside world".<sup>19</sup> Irvine, somewhat controversially, personally superintended the fitness to practice hearings of doctors implicated in the Bristol case, who were found guilty of serious professional misconduct in 1998 amidst a welter of adverse media coverage.<sup>20</sup>

Meanwhile, suggestions that the GMC was disproportionately targeting non-UK medical graduates led the council to commission Isobel Allen of the Policy Studies Institute to undertake a study, published in 1996 with a follow-up study published in 2000. Allen found some discrepancies between the referrals of UK and non-UK graduates to the GMC by employers, but the overwhelming interest of her findings was the inconsistency, poor recording, and lack of transparency of the GMC's processes in general. Allen's recommendations included: a need to ensure efficiency and speed; that the reasons for the decisions taken should be recorded formally at all stages; and that these decisions and outcomes be audited. Moreover, all those involved in fitness to practice (FTP) procedures should have a

common understanding of what does and does not constitute serious professional misconduct (SPM).<sup>21</sup>

Allen's work was, however, overtaken by the emergence in 1998 of the activities of the serial killer GP, Dr Harold Shipman, just as the GMC was hearing the cases of the Bristol heart surgeons and medical director. In 2000, Shipman was convicted of the murder of 15 of his patients, but Dame Janet Smith, who chaired the subsequent inquiry, opined that he killed at least 215 and probably over 250.<sup>22</sup> Shipman came to the attention of the GMC in 1976 after he was convicted of forging prescriptions to feed his opiate addiction, but the Penal Cases Committee of the GMC determined against a Disciplinary Committee inquiry. "Shipman was, therefore free to pursue his medical career when and where he chose".<sup>23</sup> Had the medical regulator taken a more stringent line earlier in his career, Shipman's opportunities to go undetected might have been curtailed. The GMC was effectively in the dock along with Shipman, and its efforts to present itself as a reformed organization that had learned lessons fell on deaf ears.<sup>24</sup> In attempting self-preservation, following the reports of the Shipman Inquiry and of the (then) Chief Medical Officer Liam Donaldson,<sup>25</sup> the GMC has greatly increased the role of lay (non-medical) personnel in its committees and staff. Council members are now appointed from 'the great and the good' of the profession and the quangocracy.<sup>26</sup> Ordinary jobbing doctors may, like any other interested party, contribute a comment to the GMC's periodic 'consultations' but few seem to be aware of them.<sup>27</sup> Most importantly for doctors, the burden of proof for professional misconduct cases was, on the recommendations of both Janet Smith and Donaldson, changed from the criminal one of 'beyond reasonable doubt' to the civil one of a 'balance of probability': that is, the threshold for the degree of certainty that the GMC has to establish to prove its case against a doctor has been lowered.<sup>28</sup> That balance of probability is now determined by a panel of 3 members of the Medical Practitioners Tribunal Service (MPTS), a semi-detached judicial arm of the GMC, which was created in 2012 to address the conflicts inherent to its role as investigator, prosecutor, judge, and jury. Only one panellist has to have any medical training and none any legal background, though the panel does have access to a legal assessor.

## 2. What has this meant for ordinary doctors in practice?

Since the 1990s, doctors have been bombarded with guidance by the GMC. Prior to that, the GMC's code of conduct for doctors was fairly simple and straightforward. Apart from the ever-present danger of a clinical mishap, any doctor who observed the usual social mores, who was not a convicted criminal, who did not steal from patients or make sexual advances to them, was fairly safe from regulatory interference (unless, of course, they committed the sin of canvassing for patients). The 'blue book', *Professional conduct and discipline: fitness to practise*, was a slim pamphlet that the council suspected went largely unread.<sup>29</sup> In 1988, urged by the Department of Health, the GMC took the exceptional step of publishing specific guidance on ethics issues in the context of HIV/AIDS. The genie was out of the bottle: guidance came in dribs and drabs, but it gathered momentum until a bumper pack of booklets was issued in 1995. After that, it came thick and fast. Between the mid-1990s and April 2013, more than 50 guidance documents were issued on over 30 areas of practice, and then superseded. At May 2014, the guidance listed on the GMC website amounted to 31 documents, of which 24 were only available online.

Creating guidance has created more opportunities to be in breach of it. Starting with John Major's 'Patients' Charter', politicians of all parties have responded to periodic crises in the NHS with the rhetoric of patient entitlement and choice. The expectations encouraged by this often outrun reality.<sup>30</sup> Together, these have led to a massive escalation in cases dealt with by the GMC, which is mirrored by regulators of other health professionals.

Table 1: Complaints to GMC 1992-2012, total numbers and as a percentage of registered doctors

Year	Number of registered medical practitioners (RMP)	Enquiries / Complaints to GMC (% of RMP)
1992	143,224	1,300 (0.9%)
2002	221,250 <sup>31</sup>	3,943 (1.8%)
2012	252,566	10,347 (4.1%)

In 1997, 2,653 enquiries were received about doctors, 44 cases were brought before the PCC, and there were 3 interim order hearings.<sup>32</sup> In 2012, 10,347 enquiries were received and 208 doctors appeared before the new MPTS (of

whom 146 were found 'impaired'). Thus, over 15 years, the number of doctors subjected in some way to GMC processes quadrupled. Conduct tribunal hearings quintupled, although the 2012 figure was actually lower than the 2011 peak of 242.<sup>33</sup> This small reduction was amply balanced by the meteoric rise of interim order panel hearings. These reached 784 in 2012, with 543 sanctions being applied (69%).<sup>34</sup> Interim orders effectively place a doctor on remand, either completely suspended from practice or with disabling restrictions, pending full investigation of the complaint(s) made against them.

Guidance for doctors has not only increased in volume, but the quality and nature of that guidance has also changed to become more onerous and wide-ranging. Clause 65 of the GMC's current version of 'Good Medical Practice' states that doctors must: "make sure that your conduct justifies your patients' trust in you and the public's trust in the profession". Whilst superficially incontrovertible, this guidance does not care to restrict or delineate "your conduct" – so that, in effect, it applies to *any* conduct in *both* a doctor's private life as well as a doctor's working life. This is despite responses to a poll by the GMC in 2011, which were overwhelmingly against the GMC regulating doctors' lives outside medicine.<sup>35</sup> The Court of Appeal has acknowledged that doctors "hold a position where higher standards of conduct can be rightly expected by the public".<sup>36</sup> The result is a situation that invites the risk of individual GMC employees and MPTS panellists applying their own personal morality in sanctioning a doctor for acts that would attract no sanction in law.

Following a consultation in 2011, the GMC has piloted a system in which some doctors are invited to agree to a predetermined sanction. This has the consequence of there being no public examination of the evidence.<sup>37</sup> This is a relatively inexpensive way for the GMC to dispense with the less severe categories of alleged misdemeanor. This approach was apparently favoured by the BMA and Royal Colleges, but individual doctors who responded to the consultation were concerned that, faced with an expensive public hearing, the risk of adverse publicity, and the further 12-18 months of disruption to the life of a doctor, a case might simply be settled in this way out of expediency. It is not dissimilar to accepting a police caution, irrespective of the rights and wrongs of the charges, in order to avoid the adverse impact on employability, salary, and reputation of being found guilty at trial. Some have seen it as a form of 'plea bargaining', although it was made explicit that the sanctions would not be negotiated.<sup>38</sup>

Table 2: GMC complaints, hearings and sanctions by selected years

Year	No. of registered medical practitioners (RMP)	Enquires <sup>39</sup> (% of RMP)	PCC/FTP hearings <sup>40</sup>	Erasures from medical list	Suspensions from practice	Interim order hearings	Interim suspension <sup>41</sup>
1974	96,766	847 (0.9%)	39	3	8	N/A	N/A
1982	115,455	966 <sup>42</sup> (0.8%)	36	5	6	N/A	N/A
1992	143,224	1,300 <sup>43</sup> (0.9%)	43	4	13	N/A	N/A
2006	240,328	5,085 (2.1%)	303	54 + 3 VE*	96	259	104
2007	244,537	5,168 (2.1%)	256	60 +2 VE	79	346	152
2008	247,530	5,195 (2.1%)	204	42	75	329	132
2009	231,415	5,773 (2.5%)	270	68 +3 VE	77	427	156
2010	239,292	7,153 (3.0%)	326	73 +7 VE	108	489	144
2011	245,918	8,781 (3.6%)	242	65 +1 VE	93	489	158
2012	252,566	10,347 (4.1%)	208	55 +2VE	64	784	207

\*VE = Voluntary Erasures; there are no data for voluntary erasures for the 1970s-90s.

### 3. GMC and the Media

The damage to a doctor's reputation as a result of a GMC investigation and/or Fitness to Practise hearing is not merely confined to the profession. The GMC does not work in a vacuum, and yet it has taken scant regard of the impact of its increased public recognition on the reputations of doctors subjected to its procedures.

The intrusiveness of today's reporting, the techniques of modern news gathering, and the speed with which inaccurate and unfair allegations can be published to a global audience, mean that these are becoming increasingly determinative for how an individual doctor approaches a complaint that has been made about him or her to the GMC.

A snap-shot of the long term changes affecting the British media was captured by a study at Cardiff University in 2007<sup>44</sup>, which found that, although there were fewer journalists, they were producing three times as many pages as 20 years ago, and only 12% of stories were being properly checked. "The everyday practices of news judgment, fact checking, balance, criticising and interrogating sources that are, in theory, central to routine day to day journalism practice, have been eroded."<sup>45</sup> The implications for doctors are serious. Journalists are increasingly reliant on what is already in the public domain or their archives, and on what they are fed by the news agencies. There are now fewer journalists with the specialist knowledge and contacts to properly report the issues that surround medical stories. Complexity, detail, and accuracy are compromised. Important but complicated issues are not covered and if a story looks like it will require lots of time or work it is less likely to be investigated. This problem is particularly acute in the reporting of the GMC's Fitness to Practice adjudications. A journalist who does not understand such rulings or who is unfamiliar with the background to the complaint can easily and inadvertently defame the doctor involved.

In the post-Shipman environment, the press pays increasing attention to allegations concerning medical practitioners. Such intrusion is easily justified on the grounds of social responsibility and public interest. The trust that doctors hold in society means that medical stories make good copy. Human interest stories drive sales. Life, death, health, wealth and welfare are the immutable ingredients of such stories. Add a salacious twist, a dash of poor practice – and the editorial cocktail is complete. The reporting of doctors involved in complaints to the GMC, at both a local and national level, is especially vulnerable to the journalistic error of confusing the public interest with their own interest.

Doctors have not one but both hands tied when they try to defend themselves in the media. Frequently, the source of a story will be a patient who is not bound by any level of confidentiality in what they say to a journalist – which, in turn, allows the journalist to report the views and opinions of that patient unfettered. Whilst the right of free speech is vital to society at large, it does provide scope for exploitation when the doctor is unable to correct any inaccuracy or distortion, either prior to or after publication, without breaching client confidentiality. In addition, the GMC has warned doctors that: “Disputes between patients and doctors conducted in the media ...may undermine public confidence in the profession, even if they do not involve the disclosure of personal information without consent”.<sup>46</sup> Websites have been set up to encourage patients to sell their stories and journalists may not be able to verify what they have been told. In one case, a psychiatrist working in a highly specialized field of child protection was pilloried by national newspapers and then referred to the GMC at the instigation of a woman who, in the words of the MPTS panel chair, had “a long and complex history of mental illness, familial difficulties, alcohol abuse and personal problems”. The psychiatrist was completely exonerated, but, by then, after five and a half years under investigation by the GMC, he had left the profession. He commented: “it’s a high price to pay for protecting other people’s children”.<sup>47</sup>

The GMC is dealing with complaints against doctors in an environment in which medical opinion is challenged in public more often and via an increasing variety of media. The Internet and social media have provided a number of ‘rating’ websites and forums dedicated to the medical profession and its specialisms. Despite such forums often being poorly moderated and providing the opportunity for posting criticism anonymously, the GMC has refused to rule out the use of anonymous comments on ratings websites as evidence in Fitness to Practise hearings.

Furthermore, the GMC has been known to scrutinize a doctor, based on nothing other than media reporting of his or her conduct – regardless of whether a complaint has been made by an individual or not.

This is all the more worrying as McGivern and Fischer, in their report of interviews with people involved with or affected by regulatory transparency, quoted a medical member of the GMC saying: “if you’re a doctor who’s been criticised in the press... the GMC are very unlikely to find for you. It’s definitely trial by media”.<sup>48</sup>



## 4. Revalidation

From the end of 2012, 5-yearly revalidation requirements were put in place for all registered doctors. This new system is far more detailed than any other similar process that we can find in any developed country. Its infrastructure is almost entirely provided by the NHS. This has added to cost-pressures and creates difficulties for those without regular NHS employment, including those recently retired from full-time posts who might otherwise plug gaps in NHS cover and teach or mentor younger doctors. The principle of revalidation is that it appraises doctors against the requirements of the GMC's 'Good Medical Practice' guidance. A detailed discussion of revalidation is outside the scope of this paper but it has undoubtedly added to the pressure on medical practitioners and affected their view of the GMC. Although revalidation was first mooted in the 1970s, it is widely perceived that the Shipman case was a principal catalyst for its resurrection in the 1990s, and just as widely perceived that Shipman would have revalidated with ease.<sup>49</sup> A recent survey for the GMC, geared to gauging perceptions of fairness for ethnic minority doctors and non UK graduates, found that only half of respondents thought that revalidation would have any value for patient safety.<sup>50</sup>

## 5. The cost of medical regulation: GMC subscriptions

All this activity has been expensive. Whilst the NHS is bearing substantial costs for the infrastructure of revalidation, most costs for the GMC are met by mandatory subscriptions from registered medical practitioners. At the end of the 1970s, doctors were charged £10 per annum to maintain their registration. By 2010, the obligatory retention fee had risen to £420 – an inflation rate that makes the rise in UK house prices look tame. It then fell back to £390 per annum in 2012. This was achieved by cutting the number of panelists who hear a case down from 5 to 3, reducing use of external lawyers, and saving on printing and postage – as guidance is no longer sent out to those who are regulated by it.<sup>51</sup>

The medical defence organisations (MPS, MDU and MDDUS) that fund legal advice and representation for their members have been obliged to escalate their subscription rates to maintain cover. For doctors undertaking NHS practice only, civil litigation awards are, in the main, covered by Crown Indemnity, and in this case, as opposed to private practice, the major cost to defence organizations is their member being the subject of a GMC enquiry or process. The defence organisations no longer publish their subscription rates but, as an indication, an NHS consultant physician is currently paying in the region of £1,000 per annum, largely in case she is referred to the GMC (or is sued for a ‘Good Samaritan’ act).

Year	GMC annual retention fee	Effective £ in 2013 adjusted for interest* *( <a href="http://www.whatsthecost.com/cpi.aspx">http://www.whatsthecost.com/cpi.aspx</a> )
1970	£2	£22.33
1980	£10	£30.98
1990	£30	£51.59
2000	£135	£178.30
2010	£420	£451.23

For doctors who do experience a complaint, the financial costs are most extreme if they lose their livelihood through suspension or erasure. But financial impact can be very significant even for doctors who are ultimately found to have no case to answer and who have not been subject to interim orders. Funding defence lawyers and expert witnesses can cost hundreds of thousands of pounds. For upwards of two years, accused doctors are frequently unable to move jobs, obtain a new job,

or renew a contract. They may lose private practice, and be effectively unable to apply for clinical excellence awards. This is principally for two reasons: (1), that there appears to be no presumption of innocence in the context of a GMC enquiry, and (2), any doctor being investigated is obliged to tell all employers or potential employers that they are subject to an investigation.

Those obliged to attend hearings (now only held in Manchester and sometimes lasting several weeks) incur considerable travel and accommodation expenses, which can run into thousands of pounds. If they have family caring responsibilities, the impact is even worse. Some of these doctors have been prevented by interim orders from earning a living for more than a year before the hearing, but there are no compensation arrangements for those who are found to have no impairment.

## 6. What effect do disciplinary processes have on doctors?

What is incalculable, however, are the mental and physical health costs for doctors, and the ultimate health and financial cost to the public, in either the loss of highly skilled doctors, or in changes in their practice to a defensive mode in which patients are over-investigated or high-risk interventions and the sickest patients are avoided.

In 2013, attention was drawn to suicides associated with GMC proceedings. The regulator revealed, in response to a Freedom of Information request from the campaign group doctors4justice, that 96 doctors had died since 2004 whilst subject to investigation. This is disproportionate to the expected death rates, and the regulator undertook to review the deaths but has yet to report.<sup>52</sup> Although the number that took their own lives was not revealed, there have been many cases where doctors have been suicidal during complaint procedures.<sup>53</sup> McGivern and Fischer quote a GP referring to a colleague who “got a letter from the GMC one morning... On the day she needed to attend, she hung herself”.<sup>54</sup> It is self-evident that suicides are symptomatic of a much higher prevalence of psychiatric morbidity. Samanta and Samanta quote a study of 105 doctors who had been suspended through one or other disciplinary routes<sup>55</sup>. “One third required treatment for medical problems directly attributable to the suspension, one third had sought psychiatric help and about half declared that a family member, usually the spouse, have suffered ill health as a consequence”.

## 7. The concept of the ‘second victim’ and its implications

It is now appreciated that in healthcare, adverse events give rise to a second victim: the first, the patient and family; the second, the practitioner. Professionals involved in adverse events may suffer from considerable psychological morbidity and there can be knock-on effects on their colleagues and on subsequent patients as well.<sup>56</sup> Complaints and litigation are not necessarily part of the ‘second victim’ phenomenon but, when they accompany adverse events, they are liable to compound the effect. US research suggests that fear of litigation leads to a high rate of defensive practice, including amongst those who do not have direct experience of medico-legal matters.<sup>57</sup> UK and Australian studies echo this and report that doctors who have contended with claims and complaints often consider giving up medicine or reducing hours. Although they may improve their subsequent communication, they also report becoming more distant and negative about patients.<sup>58</sup> GMC complaints are not all linked to malpractice litigation (although those coming from patients tend to be), but they carry a threat to a doctor that goes well beyond the likely impact of civil claims. It is reasonable to infer, therefore, that, in the current climate where doctors in some specialties now have a high risk of being investigated by the GMC - often for protracted periods - there are profound implications for patients and health care systems as well as for the individual doctor. The director of the London-based Practitioner Health Programme, which has supported many doctors going through GMC investigations, has recently commented that the GMC is “traumatising” doctors and may be harming patients.<sup>59</sup> It is plausible that, given the huge upswing in complaints, litigation and GMC referral, the fundamental practice of medicine has changed. Unless the right questions are asked, it will not be obvious why, or whether more has been lost than gained.

## 8. To what standard is the GMC working?

The GMC has been repeatedly criticized in recent years through professional journals and court rulings for failures to discharge its disciplinary functions in a manner that does justice to doctors. The *BMJ* has featured many cases in which the High Court has overturned decisions made by one or other of the GMC's panels. Noteworthy (but only selected) examples of doctors whose erasure from the register has been revoked, following High Court judgments, include the following cases:

Professor David Southall was accused of research misconduct, when he was in fact the victim of a carefully orchestrated campaign. He was also subject to a protracted string of GMC hearings and was eventually struck off over child protection work in 2007. This decision was later reversed in 2010, on appeal to the High Court, where it was ruled that the GMC's deliberations had 'fallen into error'.<sup>60</sup>

Dr Yaacoub, a GP, was found guilty of multiple counts of sexual misconduct with a wheelchair-bound patient, in the absence of any apparent corroborating evidence, and was struck off. The case is reported as relying solely on the testimony of the accuser. This decision was later reversed, but left his reputation and livelihood in tatters. No contrition was shown by the GMC, which maintained that a blessing offered by the doctor, a Coptic Christian, marked a departure from professional standards. Mary O'Rourke QC, Dr Yaacoub's defence lawyer, added: "As a result of these false allegations by this witness he has suffered a loss of reputation, profession and income".<sup>61</sup>

Professor Walker-Smith, the head of Paediatric Gastroenterology at the Royal Free Hospital, London, and an author of Dr Andrew Wakefield's study on the link between MMR and autism, was struck off by the GMC in 2010. In a subsequent High Court appeal in 2012, the judge described the GMC's "inadequate and superficial reasoning and, in a number of instances, a wrong conclusion". Professor Walker-Smith was restored to the medical register.<sup>62</sup>

Applications to the High Court have also increased in the wake of the extreme rise in interim order suspensions and the restrictions referred to above. It may be logical to restrict practice prior to a full FTP hearing in those cases where there is good evidence to suggest a doctor might seriously jeopardise patient care, but interim orders have been applied regardless of whether the alleged misconduct relates to medical competence. Reporting in January 2013 on the fifth successful

High Court challenge to interim orders in four months, the *BMJ*'s legal correspondent noted: "Judges' criticism in the spate of judgments suggests that interim order panels can be too heavy-handed in cases where patient safety is not an issue, and too ready to suspend doctors on the ground of public interest pending the hearing of allegations against them".<sup>63</sup> The GMC has also been severely criticised in High Court judgments that concerned interim orders where there might have been risk to patients if the original allegations had been well-founded. Once the GMC had applied interim orders, it failed to evaluate evidence and progress investigations, leaving accused doctors, their livelihoods and reputations in almost perpetual limbo. In one case that has come before the High Court on two occasions, the first judge criticised delays of which a large part "could be explained 'only by inactivity on the part of the GMC for prolonged periods'". The second judge commented on a "lack of urgency as astonishing as it is regrettable", and added that it appeared that such delays were common.<sup>64</sup>

In another recent case, a Trust allegedly made vexatious claims to the GMC about a whistle-blower. The GMC imposed interim conditions on the doctor in such a way that his career was 'sterilized'. The High Court judge went so far as to comment on the GMC's conduct of the case: "This is an astonishing allegation for a responsible body to make against a doctor", and concluded in relation to the GMC's prosecution of the case: "The claimant's conduct of the investigation has been deplorable".<sup>65</sup> In this case, the Trust was subsequently put into special measures, but the effect of its treatment on the doctor has had profound implications for him.

These, and other cases, are characterized by a poor understanding of what constitutes evidence and an abuse of legal process. It is not unreasonable to pose the question of whether such deficiencies in process would be encountered or tolerated in the discipline of the criminal courts. Yet, the ultimate sanction for a doctor can feel like 'a life sentence'.

Significantly, the High Court judgments are almost certainly merely the tip of the iceberg. It is extremely expensive to pursue appeals, so very few doctors will have the financial resources to undertake this course – let alone the emotional reserves, following protracted GMC procedures. The defence organisations are only likely to fund appeals for the most blatant cases of injustice as test cases, and, in any event, some half of doctors do not have defence society funded – or any other – legal representation when undergoing GMC procedures.<sup>66</sup> The medical member of the GMC interviewed by McGivern and Fischer, who referred to trial by media, also commented explicitly that a presumption of guilt was applied.<sup>67</sup>

The GMC certainly appears to operate a default assumption that complainants are correct and honest in their representations. In the extraordinary and deeply disturbing recent case of Dr Yaacoub (described above), the GP was subjected to allegations of sexual misconduct by a patient he had visited on an out-of-hours call. He was suspended from practice and then erased from the register, despite there being no objective evidence for the allegations and there being evidence of extreme unreliability in the witness. After the case was appealed and re-heard, the doctor was exonerated. The most notorious cases of the GMC being manipulated by vexatious complainants have been in the field of child protection, notably the case of Professor David Southall (also referred to above). Southall was the victim of an orchestrated campaign that led to his being struck off. He was eventually reinstated to the medical register after appeal but the various cases made against him took 14 years. Among the many flaws in GMC thinking that were exposed by Southall's case, one regarded proportionality. At one point, Southall faced sanction for having retained a letter about a child in his office filing cabinet, even though this had no impact whatsoever on the child's wellbeing.<sup>68</sup> Southall's experience of a lack of proportionality and an inappropriate credence being given to complainants is echoed by another of McGivern's interviewees. A GP was subjected to a malicious complaint from a convicted sex offender whom she had suspected of abusing his daughter. The GP had every aspect of her practice opened to investigation, regardless of its relevance. She was left advising other doctors to put safeguarding themselves above all other considerations in a consultation.<sup>69</sup>

The GMC's own survey of whether various of their functions are perceived to treat black and ethnic minority doctors and non-UK graduates fairly showed that – whereas a majority were 'fairly confident' in the overall regulation of doctors (including registration and revalidation as well as disciplinary measures) – only 27% felt that GMC FTP investigations are fair for all doctors; only 16% felt outcomes of FTP procedures were fair for all doctors; and only 11% believed that FTP outcomes are based on relevant evidence all of the time.<sup>70</sup>

The lack of proportionality evident in the treatment of Southall pervades other cases. In almost all categories of allegations leveled against doctors by the GMC, following their investigations there may be accusations of practice that is fairly standard for those working at 'the sharp end' – usually under considerable pressure, with little or no support for administrative tasks, and little time for anything beyond core clinical practice. Sometimes, a doctor has been subject to serious accusations by a complainant – which are disproved by the investigation –



yet still goes on to face charges relating to trivial matters. A regulatory representative interviewed for the McGivern study “argued that regulators were too focused on ‘minor infringements bringing the profession into disrepute’ which might tarnish regulators and professional image but presented little danger to the public”. Another one compared the regulator to the Inquisition, and stated that “innocence just means that we don't yet know what we are guilty of... Everybody's got something to hide”. Minor infringements are particularly picked up on by allegations centering on communication and respect, whether for patients or for colleagues. Allegations investigated in these domains rose by 69% and 45%, respectively, in 2011. The GMC has commented that this increase reflects patient expectations and perceptions, rather than any deterioration in doctor's communication.<sup>71</sup> ‘Good communication’ is a holy grail in current medical practice, but it is highly subjective. Documentation of it is usually brief, unless writing and recording are to dominate a consultation to an extent that they squeeze out listening to and examining patients. In other Good Medical Practice domains, there is a danger of GMC screeners and case-examiners applying checklists without an appropriate understanding of real-life clinical context, with the result that the charges are incongruous.

The GMC is defensive about appearing overly punitive, and case law has established that punishing doctors is outside their role. They acknowledge that ‘any action taken by the GMC must be proportionate. To act otherwise would be inappropriate and unlawful’.<sup>72</sup> However, the GMC imposes sanctions on doctors that include suspensions from the register for defined periods. While a doctor may well have breached one or more GMC guidelines and been found guilty of ‘misconduct’, unless there is a requirement for remedial training or any rational restriction on practice once the doctor is restored to the register, suspension is self-evidently a punishment. It seems that the GMC believes that the public needs to see that a doctor is being punished, in order to safeguard the reputation of the profession and instil public confidence. This interpretation of their role opens up a vast field in which judgments about what damage has been or may have been done to the profession's reputation, and how important this may be, can seem to be entirely within the gift of the GMC's functionaries. In a recent case, a GP married the widower of one of her patients soon after the patient's death. The parties were in their 50s and 60s, and the new husband (not one of the GP's own patients) had made no complaint. However, an MPTS panel suspended her from practice because they determined that she was in breach of guidance on maintaining boundaries.<sup>73</sup> On the face of it, the outcome appears to have hinged on the GMC's determination to protect confidence in the medical profession (amongst the issues that had been considered were whether or not the neighbours

approved), but, given the acknowledgement of the panel that this would hardly be a recurrent behavior, it is difficult to see the sanction as other than punitive.

In 2012, about a quarter of MPTS hearings found no impairment. In some of those cases, the GMC's prosecution counsel was unable to make a case for the charges made by the GMC, so there was no need to hear the defence. In addition, some cases are withdrawn by the GMC shortly before a hearing. This must reflect failure to analyse cases properly at an earlier stage. Undue credence given to the complainant can be a factor here, but poor handling by case-examiners can also result from a naïve acceptance of prejudicial advice from expert witnesses commissioned by the GMC. These may be conflated if the expert witness's interpretation of his/her role is to support the prosecution case. Decisions on whether to proceed to a FTP hearing, following the investigation stage, are made by GMC case-examiners. These are either lay-people, or medically qualified. However, the medical case examiners do not necessarily have any expertise in the area of practice under question. In the words of a recent advertisement, they "take on a large and diverse caseload".<sup>74</sup> Moreover, the same advertisement stresses that applicants must have "the strength of character and resilience to stand by those decisions", which suggests that there is an imperative not to back down once a decision has been made, regardless of what evidence may then come in from the defendant. Case-examiners are heavily dependent on reports commissioned from a single expert witness, the selection of whom can present serious challenges. In cases involving hospital doctors, increasing specialisation and sub-specialisation means that it can be very difficult to find an independent expert witness whose own experience, expertise, and context of working, reasonably matches that of the defendant. This is particularly so where patients have rare conditions and/or they are managed in a tertiary care setting with highly specialised or novel therapies. But it may extend to all areas of practice, as many 'expert witnesses' are otherwise retired or semi-retired. They may not only have no experience of newer treatments, but also have limited insight into current models of working: for example, multidisciplinary teams with complementary and overlapping responsibilities, rather than a single consultant headed 'firm'. Their perspective on prevailing standards may have become 'rose-tinted' in retrospect, and they also have a vested financial interest in the case continuing. The GMC issues guidance on acting as an expert witness.<sup>75</sup> However, there have been cases in which medical case-examiners have accepted reports from doctors whose lack of competence to comment – and breach, therefore, of the GMC's own guidance – should have been readily apparent.<sup>76</sup> It often becomes incumbent on the defence to supply the expertise and analysis that is missing from the prosecution case *before* it is presented to a

tribunal hearing, where lay members outnumber professionals two-to-one and only a balance of probability is required for conviction. Essentially, the defence has to pay to remedy the deficiencies of the prosecution. As it is difficult (as well as expensive) to commission expert witnesses directly without risking prejudicing the process, unrepresented doctors may, yet again, find it hard to establish their innocence in the teeth of presumed guilt.

The majority of complaints received by the GMC originate from patients and/or their families (6,002 in 2012, with a further 988 'enquiries' that were deemed not relevant to FTP). In the 2011 consultation on reform of the FTP procedures,<sup>77</sup> the GMC explicitly acknowledged that complainants can be motivated by a variety of factors, including a wish to see that the doctor is punished in some way. They emphasised that this is not a role of the GMC, and that this has been established through case law. The GMC states that it is "not, nor should it be, designed to provide redress for patients and their families who have been harmed by doctors", and the great majority of complaints made by patients and their families are effectively rejected at an early stage. A minority lead to a full investigation (20% of 6,002 in 2012). Although delays in processing vitiate direct comparison, only 45% of investigations arising from patient referrals in 2011 led to any type of sanction according to the GMC's 2013 report.<sup>78</sup> This suggests that fewer than 10% of patient complaints to the GMC reflect impairment that merits a sanction. The GMC acknowledges that there is often a mismatch between the expectations of patient and family complainants and the reality of the process. Their mooted solution is that the complaints systems across the UK healthcare sector generally be improved to facilitate more complaints and ensure that they are directed appropriately at an early stage.

In contrast, a large majority (84% in 2012) of complaints made by doctors' employers are fully investigated. Again, the time lag invalidates direct comparison, but two-thirds of such cases heard in 2012 led to some sort of sanction, which suggests that about half of management referrals may be justified. Also, there is a rising tide of doctors, outside of management, who refer colleagues to the GMC (1,006 in 2012, of which 48% were investigated).<sup>79</sup> The GMC congratulates itself on what it perceives as a reduced willingness to ignore and condone poor practice: but the fact that half of doctors referred by management were exonerated, and half of referrals from colleagues did not merit investigation, must call into question the motives behind some of these complaints. It is widely known that management bullying is rife in the modern NHS.<sup>80</sup> Part of the increase in referrals to the GMC may be attributable to poor managers abusing the process. Some may be using

the GMC as a (for them) cost free way of dealing with genuine concerns rather than addressing them locally, while others may make referrals out of malice. Most worryingly, some may use referral to the GMC for trivia and spurious issues, and as a tactic to silence doctors who have themselves raised concerns about patient safety.<sup>81</sup> The authors are aware, in confidence, of various cases where the GMC has clearly been used as an instrument of bullying by colleagues and/or management. In one extraordinary instance the GMC continued with an FTP case for three years following malicious allegations that a doctor was fraudulent and bullying. An MPTS hearing was called off at the last minute but the GMC still thought fit to issue advice (its lowest form of sanction, but one that may affect a doctor's employability and remuneration), and this was publicized to colleagues by the original complainant. The High Court found the GMC to have breached procedure on multiple counts, the decision to issue advice was quashed, and the regulator was ordered to pay costs and issue an apology.<sup>82</sup> Whatever the source of a complaint, doctors often feel disempowered, and they may find their vulnerability capitalized on by their management even if there have previously been no concerns.

## 9. Double standards?

The GMC contributes to irresponsible referrals by privileging doctors who refer other doctors to the FTP system, or who otherwise support the prosecution: they fail to take action against them, even if subsequent investigation suggests that they may have acted out of malice and have breached GMC guidance themselves. Where the case against an accused doctor collapses, it may be that evidence tendered against the accused was misleading, exaggerated or even fabricated – but it is rare for a complaint to be taken up against an accuser. Both the medical defence organizations and the GMC are, in practice, very reluctant to support such a case, and doctors who emerge from the FTP system are usually loath to undergo the stress of revisiting the case.

There is a perception amongst the ranks of doctors that some of the profession, particularly at the highest levels of management and within the GMC itself, appears to be immune from regulation. This perception has been fostered by media coverage.<sup>83</sup> It is not for the authors of this paper to comment on the rights and wrongs of these cases, but they do contribute to a perception of ‘them and us’ amongst front-line staff, who need to look constantly over their shoulder for complaints while striving to reconcile patient care with stretched resources and an ever-expanding bureaucracy.

## 10. The proposed reforms – a lost opportunity?

The three Law Commissions of the UK published their final report and draft Bill on the regulation of health and (in England only) social care professionals including the GMC in April 2014. Despite being the largest ever proposed reform of healthcare regulation and having the lofty aim of providing a clear and consistent legal framework it would not appear to have dealt with the issues raised in this paper.

The report recommends a single list of statutory grounds of impaired fitness to practise, which are to apply across the various regulators including the GMC. The GMC would be required to refer certain cases – such as those involving certain criminal convictions – directly to Fitness to Practise panel, and there would be a presumption of removal from the register in respect of the most serious criminal convictions, such as murder and rape.

The GMC would be able to take a more proactive role by treating any information that comes to its attention as a potential allegation. In other words, it would not require a complaint to be made to instigate a complaint procedure. The test for all referrals to Fitness to Practise panels across the regulators, including the GMC, would be satisfying a ‘realistic prospect of success’. This, in essence, is the same threshold as currently applied – the balance of probability. The draft Bill requires that all cases must be referred if there is a realistic prospect of a finding of impairment, except where it is not in the public interest to make a referral. The draft Bill expands the range of disposals available at the investigation stage. For example, the regulators will be able to issue advice and warnings and agree undertakings or voluntary removal following an investigation, which may prove helpful.

Aside from some minor procedural matters that are likely to be helpful, such as the right to representation, witness summons, and powers to join cases, the sanctions will remain the same – as will all the underlying tensions identified earlier in this paper.

## Discussion

It is indisputable that systems must protect patients from the effects of poor healthcare, where that possibility can reasonably be predicted. Monitoring doctors' performance and taking action where appropriate is a part of such systems, and recent years have seen a plethora of clinical governance arrangements put in place to safeguard patients against consistently underperforming doctors. This has become an industry in itself. The cost-benefit of the various systems is rarely questioned, as to do so can expose the questioners to the charges of complacency and of failing to put patients' interests first. The GMC is aware that its procedures are not appropriate to deal with the vast majority of instances in which doctors' capabilities come into question, let alone the wider health-care and management contexts that are usually significant contributors to patient dissatisfaction.<sup>84</sup> It should also be well aware that mistakes are common and pervasive. As Sir Peter Rubin, outgoing chair of the GMC, has acknowledged: "we are all human".<sup>85</sup> His predecessor, Sir Graeme Catto, even contributed to a volume of confessions by prominent doctors about mistakes they had made.<sup>86</sup> The GMC has signalled its recognition of the fact that being subject to a GMC investigation is exceptionally stressful by commissioning the BMA to provide a small measure of support through their Doctors for Doctors service, as well as by conducting a review into cases where doctors have committed suicide whilst subject to GMC investigation. But these actions hardly scratch the surface of what the chairman of the BMA's GP committee has called a 'culture of fear'.<sup>87</sup>

The GMC is said to provide the medical profession with self-regulation and the medical profession pays for its operations, but, in its attempt to adopt the patient's perspective above all, the GMC has become dominated by lay-people in both its investigative and judicial arms. Medicine is an extraordinarily complex discipline, and its regulator appears often unable to interpret cases in the context of the real working lives of most NHS doctors and in the wider context of what gives rise to complaints and motivates complainants. The original research data that relate to the incidence of iatrogenic harm and the likelihood of medical negligence claims derive mainly from US studies of patients' records in the 1980s and 1990s. These provide evidence that harm arising from health-care activities is very common, but that only a minority of it reflects negligence – in the sense of care that is of a significantly lower standard than one might generally expect – and that the more serious the underlying medical condition, the greater the chance of something going wrong.<sup>88</sup> While it is incumbent on everyone to work towards reducing risk, the extreme complexity of medicine and the human condition makes it inevitable that treatment may not be effective and unwanted effects may occur. It is the

nature of the beast. These studies also suggest that there is only a small overlap between those patients who complain and those who have actually experienced medical negligence. This is particularly important to note, given the very high prevalence of complaint now being experienced, and the potential of complaints to damage both a doctor and his/her care of other patients.

One solution to the problem – that complaints may reflect patient perception rather than negligent harm – is to promote the benefits of a culture of good communication, openness and apology. This solution has been central to the thinking of the Department of Health and its agencies.<sup>89</sup> It has been embraced by the GMC. ‘Communication, partnership and teamwork’ now forms a ‘domain’ of Good Medical Practice that doctors have to provide evidence of in their annual appraisals. But judging whether communication has been appropriate will generally owe a lot to hindsight, and perceptions can change rapidly in the face of adverse events. Medical and nursing staff may feel forced into offering apologies for incidents that were in no way their fault, and this can be counterproductive. In their examination of the social costs of litigation, Furedi and Bristow quote a parent who interpreted a midwife’s enquiry about whether she thought anything more should have been done for a sick baby as evidence of a fear of being sued rather than out of any real concern for the family.<sup>90</sup>

Encouraging complaint ignores the wider issue of how much complaint can be sustained without a system of healthcare (and its practitioners) imploding. It also ignores the possibility that a complaints culture may actually be self-perpetuating, as argued by Furedi, rather than providing a solution. The NHS is well known to be struggling with the financial costs of litigation and other forms of complaint that now run into billions. Political appraisal of this issue needs also to take into account how the effects of changes in demands on doctors (and other healthcare professionals) may be laying waste to the pool of expensively trained staff, and either having a negative impact on their performance or removing them completely through retirement, emigration, or even death, and thus aggravating the plight of their patients rather than protecting them. Many doctors who are subjected to the GMC’s procedures experience serious health effects, and this must potentially impact on the care they give to patients: this was noted in McGivern’s study, where the doctor in the child abuse case felt that the stress of the proceedings made her far more likely to make a mistake in other patients’ care. The GMC has commented that a subsequent complaint about a doctor who has previously come to their attention is likely to trigger an investigation, even if the individual complaints do not meet their usual thresholds for concern because repeated low-level complaints



may indicate impairment.<sup>91</sup> We would suggest, on the basis of many personal communications given in confidence, that any doctor who has experienced the stress of a GMC referral is rendered vulnerable in a manner that may affect them and hence their practice forever. The GMC and NHS employers have a duty of care to such doctors that is currently being ignored. Ironically, one of the greatest sources of stress for those referred to the GMC can be the feeling of being sucked into a dystopia, where any confidence a doctor previously had in the regulator is shattered. The very organization that may prosecute doctors for minor lapses of administration and communication, may itself send out incomplete documentation, ignore deadlines, seek to restrict the doctor's access to information, and show absence of professional medical understanding when framing its charges. A response to allegations that attempts to explain and correct the GMC's faulty understanding of technical matters may, in its turn, be met with a further allegation of the defendant lacking insight – and, therefore, can cause an escalation of the case, rather than prompting a re-think by case-examiners under institutional pressure not to back down.

Patients as a whole may be disadvantaged by systems that are ostensibly intended to protect them, but which can be used to further the agendas of individual patients. Not only may doctors who experience a complaint suffer physical and/or mental health breakdown, but they are also liable to change their practice in ways that might reduce their personal risk, but which are prejudicial to good patient care. They are highlighted by Furedi and Bristow in terms of the financial cost of unnecessary investigation<sup>92</sup>, but can also be positively harmful. These effects on medical practice go far wider than just the accused doctors. They extend to medical friends, family members, and colleagues who support them and know that 'there but for the grace of God, go I', and even extend to professional and expert witnesses who see the process in action. The threatening activities of the GMC have now become a common topic of conversation between doctors, with many being able to cite friends and colleagues who are regarded as good doctors by their peers, yet who have had their lives made a misery for extended periods. This is particularly the case for doctors over 50, for those who undertake procedures, and for psychiatrists. The GMC has speculated that the disproportionate number of complaints for older male doctors may either reflect changes that come with age, or be a cohort effect that will disappear with time – that is, the doctors who qualified in the 1970s and early 1980s do not have the 'right' attitudes for the 21st century.<sup>93</sup> Both points merit attention, not least in view of pension policy changes that will lead to most doctors working into their late 60s. For the purposes of this paper, however, the cohort effect is of greater concern. It is very plausible that doctors

maintain the culture in which they were educated, and in which they worked for the greater part of their careers. Whilst there are some aspects of past medical culture that few would defend, it is interesting that recent scandals in the NHS, including the infamous mid-Staffordshire debacle, have led to calls for a return to previous values. It is also interesting that some of the most popular doctor characters in recent television fiction exhibit these values. The American creations, House and Becker, and Britain's Doc Martin, are irascible: they are often not empathic and do not waste time on social niceties, but their vocation, technical knowledge, and skill are second to none. We speculate that many older male doctors may be pale reflections of these overdrawn TV characters and are at particular risk of complaint because they, above all others in the NHS, are the 'doers'. They have an inbred culture of working long hours; they are the most experienced doctors in practical and technical terms; and they are the most likely to have to take on difficult cases. They have been used all their lives to just getting on with the job as best they may.<sup>94</sup> These doctors now feel alienated by what some see as a politically-driven imposition of a new culture, and many will leave the profession as soon as they can and whilst their scarce skills are still needed. Perhaps the best way for the general public to understand this is to regard doctors' experience in this regard as an extension to the more general one of feeling increasingly criminalized in relation to minor traffic offences or the expression of politically incorrect views.

The next generation of doctors will have benefited from a GMC-approved education that has eliminated the rites of passage that were traditionally used to de-sensitise doctors in training. Undergraduate medical school curricula now include the study of ethics, as well as lectures from lawyers on how to avoid being sued. This may possibly protect the doctors of the future from complaint and allegation on the scale being experienced by their elders. However, it is by no means certain that this will actually improve the lot of their patients. The lack of connection between good medicine and an ability to cover one's back has been highlighted by Cigman as well as by McGivern. Writing about medical undergraduate education, Cigman comments on "what goes missing when ethical thinking is tied to legal thinking and professional guidance". She argues that, in a bid to avoid legal action, modern doctors risk burdening patients with superfluous information in circumstances where there are not realistic alternative options.<sup>95</sup>

The practice of medicine is increasingly focused on an imperative to meet and manage patient expectations, and the GMC acknowledges that the culture of dissatisfaction has been driven by increasing expectations, rather than by any fall in medical standards.<sup>96</sup> It has identified that women are more likely to complain

than men, and has noted that there has been a disproportionate rise in young people complaining, but it shies away from any consideration of whether complaints are reasonable or whether their impact may damage rather than enhance patient care.<sup>97</sup> The GMC has engaged Victim Support to assist complainants, and the final chapter of its 2013 status report devotes more than a page to 'supporting complainants'.<sup>98</sup> In contrast, there is just a brief statement that "some doctors may need more support". This seems to refer to support to prevent incidents that give rise to complaints. The extreme distress of those who find themselves enmeshed in an FTP investigation for prolonged periods does not merit a mention, although some small measures have been introduced with the aim of rendering the hearings themselves less adversarial.<sup>99</sup> In a 2011 press release, Niall Dickson, GMC chief executive, said that: "a referral to the GMC can be the start of an anxious time for everyone involved". With no hint of irony, he added: "employer liaison advisers can bring real benefit to medical directors and we will soon have someone in each area of the UK to support them."<sup>100</sup> There are signs that, on the point of stepping down as GMC chair, Sir Peter Rubin, has perhaps realized that his organization may be having a detrimental impact on how medicine is practised, and therefore on patients as well as doctors. In 2013, the *BMJ's* correspondent reported that Rubin told the Health Select Committee: "Medicine is a risky business. The worst thing we could do as a regulator would be to discourage doctors from taking reasonable risks understood by and shared with the patient". He added: "Over my professional career there has been a huge increase in the likelihood of a doctor having legal proceedings taken against them or being referred to the GMC."<sup>101</sup>

The authors of this paper are supporters of good medical regulation and have no wish to be apologists for unsafe medical practice. Some complaints must be followed through and the experience will inevitably be distressing to the doctors concerned. But the current system has encouraged excessive complaint at zero cost for complainants and for motives that are not always pure. It has demonstrably failed to follow due processes in many cases. We believe it is not only damaging doctors on an unjustifiably wide scale but is likely to be having knock-on effects on their patients, as well as imposing further costs on our NHS. Harry Cayton, chief executive of the Professional Standards Authority for Health and Social Care, which now oversees the GMC and other health regulators, has been reported as saying: "We don't need more guidance and guidelines ...the role of regulators is to provide a framework in which professionalism can flourish".<sup>102</sup> To do this adequately, the GMC must develop the self-awareness and insight that it demands of doctors. FTP complaints that have not been progressed to full investigation were

audited for the Professional Standards Authority in 2013 and no evidence was found of the GMC letting doctors off the hook.<sup>103</sup> There has been no corresponding published audit of the handling of FTP cases promoted to investigation and beyond. For such cases, the GMC should follow its own prescription of audit with apology where appropriate. Its officers must reflect on whether they are really protecting patients and their trust in the medical profession, or whether, as McGivern's inside informants suggested, they are often just protecting the GMC.

## Conclusion: A new charter for the GMC?

In light of the above, we believe that, yet again, it is time to re-appraise the purpose and scope of the GMC. We question whether the current arrangements for fitness to practise issues can reasonably be described as 'self-regulation', a concept that has traditionally been considered a 'given' in UK medical practice. In any new debate about the GMC's functions, the issue of whether or not doctors still have (or indeed should have) self-regulation needs to be addressed explicitly for the benefit of patients and doctors alike. Further starting points in a new 21st century approach to handling the issue of doctors' fitness to practise medicine include:

- The GMC should publicly acknowledge their duty of care to doctors alongside that due to patients.
- The GMC must not only acknowledge that its role is not to punish, but also review its decision-making to ensure that its determination to protect the profession's public image does not lead to sanctions that are effectively a punishment.
- The GMC must audit its own practice by undertaking regular feedback surveys of doctors who have been subject to their FTP investigations. This must be done anonymously via a trusted intermediary organisation.
- The GMC must develop its own culture of apology where they have clearly got things wrong. For example where their processes and/or determinations have been strongly criticized by High Court Judges.
- NHS employers must acknowledge the effect on their staff of adverse events and complaints (including those that they have instigated themselves) and have regard to their duty of care to staff. They must be required to put in place measures to ensure proper support for doctors (and other professionals) subject to complaints, and they should be performance-managed on this.
- There must be a method of redress and a method for recouping costs against the GMC where GMC and MPTS processes and decisions have resulted in successful court challenges.
- The GMC must undertake to pursue vexatious or dishonest complainants through civil or other procedures.

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41 Note also, substantial numbers who were not suspended but had restrictive conditions applied so may have been unable to work in practice

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