PLYMOUTH UNIVERSITY PENINSULA SCHOOLS OF MEDICINE & DENTISTRY

Review of decision-making in the General Medical Council's Fitness to Practise procedures

Final Report

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The views expressed in this report are those of the participants and the authors and do not necessarily reflect those of the General Medical Council.

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List of Abbreviations and Acronyms

AR	Assistant Registrar
BME	Black/Minority Ethnic
CE	Case Examiner
DA	Discourse Analysis
EEA	European Economic Area (re. doctor PMQ)
FtP	Fitness to Practise
GMC	General Medical Council
GMP	*Good Medical Practice*
IHLT	In House Legal Team
IM	Investigation Manager
IMG	International Medical Graduate
IO	Investigation Officer
MoP	Member of Public
MPTS	Medical Practitioners Tribunal Service
NIT	National Investigation Team
PAPC	Person Acting in a Public Capacity
PLA	Principal Legal Adviser
PMQ	Primary Medical Qualification
RIT	Regional Investigation Team
RPT	Realistic Prospect Test
TA	Thematic Analysis
VE	Voluntary Erasure

Executive Summary

Introduction

Ensuring doctors' Fitness to Practise (FtP) is one of the core functions of the General Medical Council, the UK's medical regulator, in its work to protect the public. FtP procedures are used to investigate and if necessary take action against doctors about whose practice or behaviour concerns are raised. However, for a number of years, there has been evidence that some demographic cohorts of doctors – notably non-UK trained doctors, black and minority ethnic doctors, male and older doctors - are overrepresented in FtP procedures and are at increased risk of progressing further through the system and receiving higher impact outcomes.

This report presents findings from an in-depth qualitative review of GMC decision-making within the FtP procedures which aimed to identify instances of bias or discriminatory practice, and more generally to assess the quality of GMC decisions and decision-making processes.

Research questions

- Does decision-making in the GMC's FtP procedures function as intended?
- What factors within the GMC's purview contribute to the overrepresentation of demographic cohorts of doctors in the FtP procedures, if any?
- What institutional and professional discourses shape decision-making in the FtP procedures and how is this manifested?

Methods

The review used a combination of methods to approach GMC decision-making. Fact-finding research interviews with GMC staff (n=7) were carried out to shed light on the working practices of decision-makers. GMC guidance and criteria documents were reviewed providing the framework within which decisions are made. Samples of case files were selected from the three key decision point in the FtP process: triage (n=102); stream two, where cases are referred to employers for further information (n=30); and stream one, or the end of investigation phase (n=55). The research also looked specifically at the GMC's approach to presenting allegations of impairment to doctors at the end of investigations where there is the possibility of further action being taken.

The methodological approach to this study was derived from the nature of the data being reviewed and the focus of the research questions. The main types of data used were FtP case files and the GMC's FtP guidance and criteria documents. The textual nature of the data and the focus of our research questions on in-depth review and understanding decision-making behaviour meant that qualitative methods were appropriate.

Thematic and discourse analyses were used to provide a systematic and reliable approach to analysing these large textual datasets, which included cases files containing hundreds of pages of information. This combined approach enabled the research team to capture breadth and depth of information, and highlighted the roles of both factual information and subjectivity in decision making.

Core findings

No evidence of bias or discriminatory practices was identified, either in the GMC's guidance and criteria documentation for decision-makers, or the sampled case files. Whilst some parts of the guidance and criteria documentation do reference specific doctor characteristics – notably the doctor's stage of career, their health and their cultural background – these references are either in the context of discussing factors which could genuinely impact upon a doctor's fitness to practise or on ensuring that doctors are not disadvantaged within the FtP system.

The decisions reached in the reviewed case files were found to be in line with the guidance and criteria set out for decision-makers. The review identified a few specific instances which raised further questions: these were not about outcomes but about the reasoning behind decisions and the clarity with which they had been expressed and recorded. For example, we found a stream one case which had been recorded as 'concluded' appeared to include advice to the practitioner in the decision rationale, and should perhaps have been recorded as 'concluded with advice'. We also identified some elements of the guidance and criteria which were potentially ambiguous, such as the use of threshold adjectives like 'serious' or 'significant' without absolute definitions which require decision-makers to measure the facts of a case against them. We raised this with the GMC who provided evidence of comprehensive guidance to assist decision makers to apply these thresholds.

The textual analyses highlighted that the language of decision-making (and letters to complainants) in Case Examiner reports is imbued with professional and institutional discourses – this is distinct from the language of complainants. Case Examiner language tends towards more legalistic terminology and objective reasoning, contrasting with complaints, which are typically emotion oriented. However, in-depth analysis also revealed that patient-centred discourse was frequently incorporated into case reports, balancing recognition of the more emotive elements with a dispassionate approach to developing argument and weighing evidence within the decision-making process.

The research interviews raised the prospect that there may be an informal or unrecorded element to the decision-making processes in the FtP procedures in the form of discussions between colleagues which are not fully recorded in case files. Although not unusual or unexpected in a workplace, in a process as high-stakes and contested as FtP procedures, such discussions may raise questions about their impact upon decision outcomes – although none was identified in our review – and about the extent of transparency and accountability of the process.

Conclusion

This review of GMC guidance and criteria documents and the case file data identified no bias or discriminatory practices, and found decisions to be appropriate. Moreover there was evidence of Case Examiners balancing recognition of emotional stakes – of complainants and of practitioners - within a more objective and reasoned approach to developing argument and evidence as a case for final outcomes. The findings also point to a need for greater clarity and transparency. In some instances, though the outcome decision appeared appropriate for the circumstances of the case, the rationale for it was incomplete or unclear. Given that FtP decision-making is a complex undertaking that can involve assessing large amounts of conflicting information, with each case a unique combination of circumstances, it is not possible to standardise or provide definitive guidance on outcomes. Improving the consistency of decision writing and recording, particularly by increasing direct references to the guidance and criteria applicable, would enhance the defensibility of the procedures and the accountability of decisions made within it.

1. Introduction

This report presents the findings of a review of the GMC's Fitness to Practise (FtP) decision-making procedures, based on in-depth analysis of documentary evidence in a sample of the GMC's records of FtP cases.

As the UK's medical regulator, the General Medical Council (GMC) works to protect the public by ensuring that doctors meet the standards set out in *Good Medical Practice*[1] (GMP), and that they are up to date and fit to practise. The GMC's FtP procedures are used by the regulator to investigate referrals and complaints about doctors. The rules governing the current process date back to 2004[2] and are rooted in the powers granted by section 35C(2) of the Medical Act 1983 (as amended).[3]

In 2013, the number of enquiries received by the GMC was 10,012[4], with both complaints from members of the public[5] and referrals from Persons Acting in a Public Capacity[6] (PAPC) (typically employers or other regulators) having increased in recent years. In 2013, nearly 8,600 of those enquiries raised a concern about a doctor's fitness to practise.

In such instances, the GMC is required to decide whether the concerns raised are serious enough to warrant a full FtP investigation – that is whether they may, if found proven beyond the balance of probabilities, eventually lead to action being taken against a doctor's registration. Since 2012, FtP panels have been administered by the quasi-independent Medical Practitioners Tribunal Service (MPTS). However, the GMC retains decision-making responsibilities at earlier points in the FtP procedures, as shown in Figure 1.

After the initial decision, or triage, which establishes if the concern raised is indeed an FtP matter or not, the GMC can close the enquiry, refer the case for a full investigation by its own staff. Alternatively, in cases where the concern is not in itself an FtP matter but may become cause for an FtP investigation if it forms part of a pattern of behaviour, the GMC can refer the matter to a doctor's employer(s) with a request for any further information they may have. These two routes are sometimes known as Stream 1 and Stream 2 investigations.

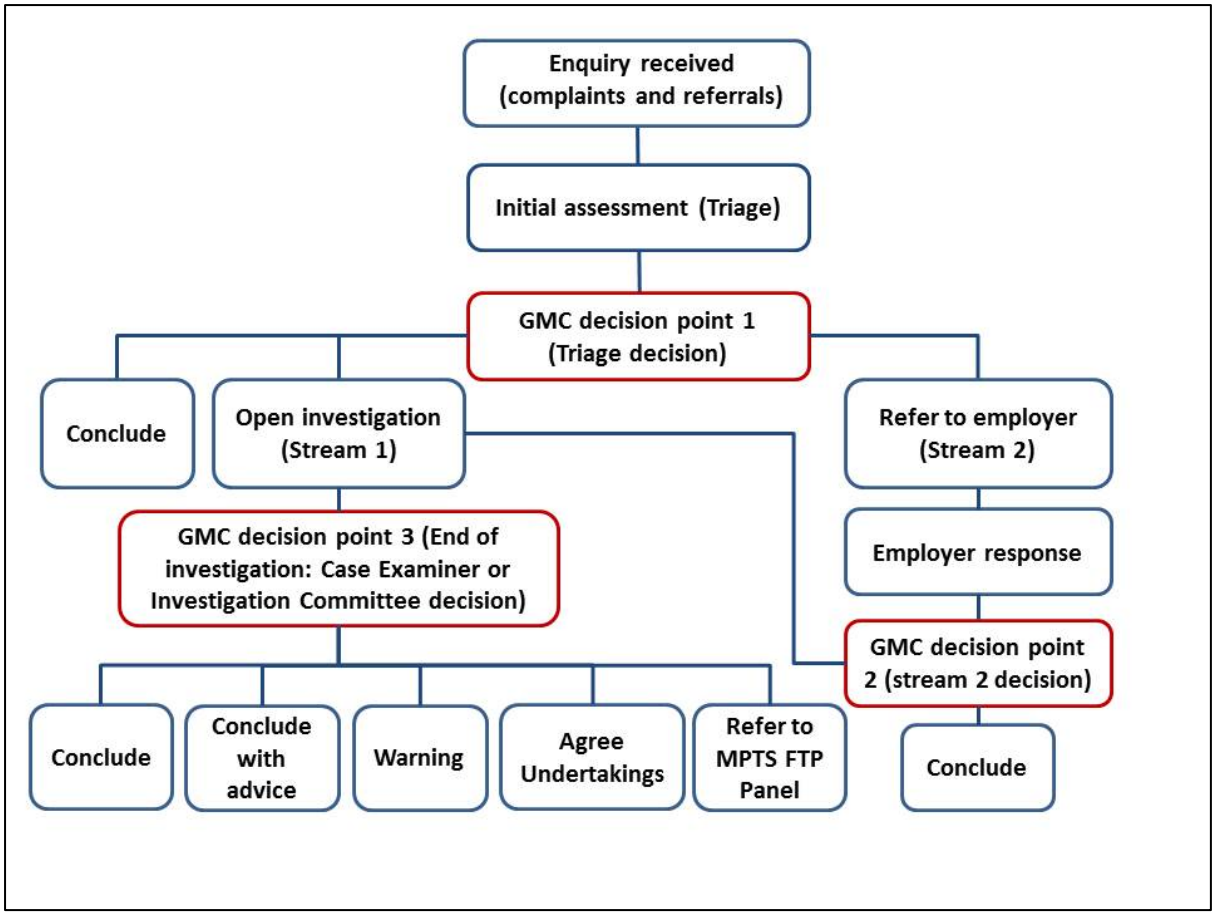

Figure 1: GMC FtP procedures and decision points

When a response is received from the doctor's employers, the GMC must decide whether to conclude the case (if there is no further information causing concern) or to open a full Stream 1 investigation (where information is received). At the end of each Stream 1 investigation, the GMC must decide whether the case can be concluded, can be disposed of with advice, a warning, or by agreeing undertakings with the doctor, or whether there is a possibility of impairment being established and action being taken against a doctor's registration – in which case the doctor will be referred to an MPTS FtP panel hearing.

Ultimately, an FtP investigation can result in a doctor being erased from the List of Registered Medical Practitioners, and therefore barred from medical practice in the UK. An FtP investigation is therefore a high stakes assessment for a doctor, and so it is vital that the system is reliable and valid to ensure that it retains the confidence of both the public and the profession.

In recent years, the GMC's FtP procedures and their associated decision-making have been subject to a number of criticisms. For instance, it has been suggested that the GMC has

become more likely to pursue punitive or rehabilitative action against doctors[7] and that being subject to FtP procedures can be a very stressful experience for doctors, whilst the burden of an increasingly active regulatory regime becomes increasingly expensive for the profession.[8]

On several occasions the GMC has opened its FtP data and procedures to scrutiny[7 9-11], with the most recent analysis of GMC decision-making suggesting that there may be judgemental bias in GMC decision-making as doctors who trained outside the UK are more likely to face high impact decisions at each stage in the FtP process.[10] Earlier analyses also highlighted ethnicity and gender as key characteristics to be considered when evaluating FtP decision-making.[7 11] The nature of the initial enquiry itself – the language used and the level of detail given, for instance – has also been raised as a potential variable which may influence the progression of cases through the system.[9] These previous studies highlighted a number of elements of the FtP process worthy of further investigation; however they also pre-dated significant changes to the FtP procedures.

Our research, commissioned by the GMC, sought to update and extend this previous work. We therefore accessed the FtP system at multiple levels using a variety of qualitative methods to address the key elements of the GMC's activity with the FtP system to produce an in-depth analysis of its design and application.

Aims:

- To produce an in-depth and thorough evaluation of decision-making at key points in the General Medical Council's FtP procedures.
- To support the GMC in ensuring that its FtP decisions are valid and reliable.

Objectives:

- Review decision-making at key stages in the FtP process and establish if GMC guidance is consistently applied
- Assess whether GMC decision-making guidance and criteria may contribute to the overrepresentation of some demographic groups of doctors in the GMC's FtP procedures
- Examine whether the GMC's approach to presenting formal charges to doctors may contribute to the overrepresentation of some demographic groups of doctors in FtP procedures

2. Background

As outlined above, there are three main points at which the GMC makes decisions in the FtP procedures. However, the process involves numerous elements which may impact upon decision-making in some way, including: the various staff roles in the FtP directorate; the systems for collecting, managing and sharing data; and the guidance and criteria documentation which governs decision-making.

Focusing our attention on GMC activity within the FtP procedures, we derived the following research questions from the study's aims and objectives:

Research questions:

- Does decision-making in the GMC's FtP procedures function as intended?
- What factors within the GMC's purview contribute to the overrepresentation of demographic cohorts of doctors in the FtP procedures, if any?
- What are the institutional and professional discourses which shape decision-making in the FtP procedures?

Our study design sought to answer these questions, through analyses focused on the decision-making processes, and the decisions themselves.

2.1 Methodological framework

The methodological approach to this study was determined by the nature of the data being reviewed and the focus of the research questions. The main types of data used were FtP case files and the GMC's FtP guidance and criteria documents. Moreover, our research questions focused on the decisions made in FtP cases, and the processes by which those decisions were made (as recorded in the case files), so analysis also sought to illuminate the possible impact of GMC activities on FtP decision-making and the institutional and professional discourses that surround and shape that decision-making.

In the context of FtP case files, decisions literally are 'made', their construction is a key part of the process and this is identifiable in the Case Examiners' (CEs) reports. Decisions

recorded in the case files are written by the decision-maker, and draw upon the content of the file. The case files can, particularly for full investigations (stream one) contain hundreds of pages of text, including the original complaints or referral letter, and all the evidence gathered to support the allegation and in defence of the doctor. The decision-makers consider the information available and then record – and explain – their decision using the GMC's electronic data management system Siebel.

In order to understand the construction of decisions in FtP cases, we 'deconstructed' them using a two stage textual analysis. First we conducted a thematic analysis of content and process, to understand how cases had been put together and identify any patterns or anomalies. This primary analysis was then supplemented with an in-depth discourse analysis, focusing on the language used to support the entire process. In this way we were able to address our aim of identifying the impact of any institutional or organisational discourses on decision making.

2.1.1 Thematic analysis

Thematic analysis (TA) is an interpretative approach to the analysis of qualitative data. The researcher(s) read through the data and 'code' segments of text, assigning labels to define the significance of the segments in relation to the research questions. These codes link the segments of data assigned to them, and can be used explore connections and relationships within and between individual pieces of data. Codes can be applied in a number of ways – to signify associations, topics, or to signal underlying content. Codes can then be developed into categories and broader themes.

2.1.2 Discourse analysis

Discourse analysis (DA) involves subjecting textual information to interrogation at different levels, or layers, of its construction. In the case of this research, DA helped us to understand how any given example of decision-making has been influenced by contextual factors, and how this has determined particular conclusions and recommendations. Implicit in this is the opportunity to seek instances of bias and mis-representation of other texts that may enter into the overall process of decision-making.

2.2 Methods

Fulfilling the multiple objectives of this study required the use of several qualitative research methods, as set out below. In combination, these methods produced an in-depth review of decision-making in the FtP procedures.

2.2.1 Literature review

We conducted a summary narrative literature review to provide context for this study. This was undertaken using systematic searches combined with narrative synthesis of included content.

The review questions were:

- What earlier evaluations of GMC decision-making have been conducted?
- What were their methods and findings?
- Why are effective FtP processes important?
- How are decisions made and benchmarked in comparable procedures?

Academic peer-reviewed literature was explored using systematic searches of selected databases (Medline/Pubmed; Embase; Google Scholar). Grey literature was identified by searching the websites of other healthcare regulators and other comparable bodies. Earlier research reports on GMC FtP processes were included as a third category in the review.

After initial scoping searches, inclusion/exclusion criteria were decided for the review, as shown in table 1. Included literature is listed in annexe A.

	Include	**Exclude**
Date range	2000 onwards	Pre-2000
Type	Original research articles Review articles Grey literature (esp guidance from other systems)	New reports; letters; editorials
Subject	Medicine; allied health professions; non-health professions; regulation	Medical schools; students
Geography	UK; non UK where other criteria clearly met	None UK speculative

Table 1: Literature inclusion and exclusion criteria

Literature selected for inclusion was then imported into Nvivo10 and coded, using a separate coding scheme to that used for the other data in the study.

2.2.2 Interviews

We conducted interviews with seven members of GMC staff, all of whom had decision-making or case management roles within the FtP process. In addition, there was a further informal conversation between the research team and a member of the GMC's In-House Legal Team (IHLT). The interviewees were identified by the GMC as potential participants, with the aim of recruiting a sample of interviewees covering the range of decision points and FtP activities under review. Participants were sent an information sheet explaining the study and asked to return a signed consent form (annexe B). Interviews were conducted by telephone, digitally recorded and transcribed. A semi-structured interview format was used, guided by an indicative question schedule (annexe C). Questions focused on the processes and procedures involved in FtP work, and the participants' experiences of working within the system.

Interviewee signifier	**Role**
R001-CE-L	Case Examiner (Lay)
R002-IM-T	Investigation Manager (Triage)
R003-IM-RIT	Investigation Manager (Stream 1- RIT)
R004-IM-S2	Investigation Manager (Stream 2)
R005-CE-M	Case Examiner (Medical)
R006-M	FtP Manager
R007-LAW	Lawyer (IHLT)

Table 2: Interview participants

As shown in table 2, interview participants have been anonymised and are identified by a signifier, which references their job role. Interview data were thematically coded using Nvivo10 qualitative data analysis software.

2.2.3 Analysis of GMC Guidance and Criteria documents

The GMC provided the research team with copies of the FtP guidance and criteria documents in force during the period from which our sample of case file data is drawn. These documents are listed in annexe D.

A variety of guidance and criteria documents were included for review. *Good Medical Practice* sets out the standards which define medical professionalism and against which

doctors are judged in the FtP procedures. This research focused on the 2006[12] version of GMP which was in force during the majority of the period under review. An updated version was published in 2013[1] and is referred to in some of the case files we reviewed.

2.2.3.1 Thematic and discourse analysis

The guidance and criteria documents were assessed for their content and relevance to our research questions. In all, we were provided with 33 items of guidance and criteria documentation. Of these, ten were excluded from the coding process as they were either a reading list of related documents, a glossary of terms used in FtP, related solely to Interim Orders Panel hearings, or were only focused on operational aspects of the Siebel database.

The remaining 23 documents were coded in Nvivo10. Codes were derived inductively from the documents. The coding scheme resulting from this analysis was then used as a basis for coding the sample of case file data, with new codes being added as appropriate during the analysis of that dataset. Discourse analysis was then applied to identify any institutional discourses evident in the texts.

2.2.4 Analysis of case file data

Analysis of sampled GMC FtP case file data to review the decision-making therein was a major aspect of this study.

2.2.4.1 Sampling case file data

We selected three separate samples of enquiries/cases to analyse in this research, one at each of three decision points identified in Figure 1. The GMC provided a sampling frame including all enquiries/cases which had passed the relevant decision points within the previous twelve months. This sampling frame was provided to the research team in April 2014 and also included demographic details of the doctors associated with each enquiry or case, where held by the GMC, and the final outcome decisions.

Sample sizes, shown in table 3, were based upon published statistics for the numbers of FtP enquiries and cases in 2012 and upon the GMC's estimates of the time taken to conduct internal audits of decisions. The sample sizes were intended to be large enough to identify trends or significant issues whilst allowing an in-depth qualitative analysis of the data to be achievable.

Decision point	Sample size
Triage	102
Stream 2	30
Stream 1	55

Table 3: Case file sample sizes

From the sampling frame, our statistical analyst used SPSS to select a random sample at each decision point stratified by outcome decision and PMQ. Full stratification by all the demographic characteristics of interest was not feasible in samples of this size, so PMQ was chosen due to its significance in the findings of Humphrey et al's 2011 paper[10] and because the GMC data is complete for this characteristic. Having selected the samples on this basis, we then also checked that there was a reasonably proportionate representation across gender, age and ethnicity groupings using the GMC's SoMEP data on the progression of cases through the FtP procedures as a point of comparison.[13]

GMC decision	Doctor characteristics			
Decision point/ outcome	**Ethnicity**	**Primary Medical Qualification (PMQ)**	**Gender**	**Age range**
Triage conclude promote stream 2 promote stream 1	Black/Minority Ethnic (BME) Non BME	European Economic Area (EEA) International Medical Graduate (IMG) United Kingdom	Female Male	<30 30-39 40-49 50-59 60-69 >70
Stream 2 conclude promote to stream 1				
Stream 1 conclude conclude with advice warning agree undertakings refer to MPTS				

Table 4: Sampling strategy

Whilst we selected all the samples based upon the demographic characteristics of individual doctors, when examining the triage data associated with those doctors, we actually reviewed at the complete triage file. This means that in cases where an enquiry was made which involved multiple doctors we looked at all the decisions made in those enquiries.

2.2.4.2 Data collection

FtP case file data is extremely sensitive, containing personal details of doctors, patients and others, as well as details of the concerns being raised with the GMC. Both the GMC and the research team took the confidentiality of this information very seriously during this study.

Once we had selected case numbers for our sample, the GMC produced redacted bundles which reproduced the sampled case files but with patients' and complainants' identifying information removed. Other individuals, such as doctors or other healthcare staff, were identifiable in some instances.

In order to work with the data, three members of the research team made a total of four 'field' visits to the GMC offices to collect case data notes. The researchers took onsite notes on the data, using a template (annexe E). These notes were then transferred to the team in Plymouth using the GMC's secure file transfer system, where they were stored securely on protected university servers. During this data collection phase of the research, all of the researchers worked through and took notes on ten percent of each of the case files samples, in order to discuss issues arising and provide a 'bench-marking' opportunity. The remainder were then divided amongst the researchers.

Our analyses are therefore based on the extensive notes taken from the case file data, rather than directly from the data themselves. Whilst this is not methodologically ideal, this practical approach was conducted to a robust degree, and agreed with the GMC. Due to the sensitive nature of the data, access would have otherwise not been possible.

2.2.4.3 Thematic analysis

Again, we used Nvivo10 qualitative data analysis software to code the data. The software allows researchers to attach 'attributes' to items of data, such as demographic characteristics, which allows the coding applied to the dataset to be viewed and searched in multiple ways. We attached the same attributes to the data that had been used during sampling (see table 4 above). The case file data were coded using the coding scheme derived from the coding of the GMC guidance and criteria documentation, with new codes being added as required. The coding scheme is reproduced in annexe G.

2.2.4.4 Sub-sampling case file data for discourse analysis

Due to the labour intensive and time consuming nature of the method, in-depth discourse analysis of FtP investigation case files required the selection of a smaller subsample from our sample of 55 stream one cases. The subsample was selected to include the full range of outcomes possible at the end of stream one. Following discussion of the full sample, we chose to include in the subsample some 'paired' cases, with similarities in either the source

of complaint or the subject matter of the complaint. This approach was used as locating variability within and between textual accounts is recognised as analytically fruitful[14 15] and selecting similar cases is an effective way to improve the 'capture' of variation.[16]

2.2.4.5 Discourse analysis of case file data

Working with the subsample of ten cases outlined above, our researcher employed a discursive approach, drawing on rhetorical DA which has its roots in academic psychology. In order to conduct the analysis, we applied a systematic analysis on a number of aspects of the decision making processed reported in each file. These included: i) summary leads (the introduction to the piece, which effectively defines it); ii) argument and evidence (and the relationship between these); iii) rhetorical style (with regards to precisely how the case was presented, and directed towards a particular outcome); iv) authoritative voicing (whose version of events were considered and recorded, and how were these weighted in terms of credibility); and v) language and lexical use (including highlighting subjective and neutral styles of writing and representation). We then drew on these to identify any discourses evident in the texts.

2.3 Research Ethics

Ethical approval for this study was sought and obtained from Plymouth University Faculty of Health and Human Sciences and Peninsula Schools of Medicine and Dentistry Research Ethics Committee. Interim approval was given by Chair's action on 30 April 2014 with full approval granted on 24 July 2014. The final approval letter is reproduced in Annexe F.

3. Analysis and findings

The findings presented here focus around the original questions, as the research design was based upon addressing them directly. However, as is the case with all qualitative research, the findings are grounded in the data, and therefore additional contextual, and sometimes new and unexpected, findings emerge from rigorous analysis. Thus we have woven into this section some additional findings, which provide the background, or add substance, to those that address the main research questions.

3.1 Literature review

As detailed above, our literature review included peer-reviewed academic papers and grey literature, with a third category of earlier research reports on the GMC's FtP procedures.

The items included in the review were: 35 peer-reviewed papers identified through our database searches; 6 research reports from various professional sectors; and 6 earlier reports on research about the GMC's own procedures. The items included are listed in annexe A.

The content included in the review was coded, using a separate coding structure to the other data. The codes used are shown in table 6.

Age	Mitigation
Decision-making	Non health
Disciplinary processes	Non UK
Disproportionality	Other health
Employers	Place of qualification
Ethnicity	Recording data
Gender	Sanction severity
Guidance and criteria	Source of complaint or referral
Intersectionality	Specialty or job role
Interventions	System factors
Medicine	UK
Misconduct type	

Table 5: Literature review codes

The review raised several issues as potentially having relevance for the disproportionate representation of demographic cohorts of doctors in the FtP procedures. These factors could be broadly divided into two categories: those about the doctor, their work role or

work place; and those which were about the decision-making processes within the FtP system (or equivalent). In the first category, there have been suggestions in some sectors – such as law – that BME or international graduates may be more likely to work in professional roles or settings which attract more complaints or more serious complaints.[17] Similar trends have also been highlighted with regard to NHS disciplinary proceedings.[18]

It has also been suggested that the source of referral is significant, with Archibong suggesting that managers may refer BME staff members to formal disciplinary proceedings more quickly than they might for white colleagues, due a concern to appear to 'do things by the book' and avoid accusations of racism.[18] Research into referrals to police disciplinary procedures has also highlighted source of referral, and management practices in particular, as being important.[19] Earlier research into trends within GMC FtP data identified that, proportionally, more enquiries about non-UK trained doctors came to the GMC from Persons Acting in Public Capacity.[10] There are also suggestions that cultural differences matter, more than simply skin colour – that differing attitudes towards family or community, or finance, can be significant.[19] It has also been suggested that employers may be more likely to refer male rather than female doctors to support services as 'doctors in difficulty'.[20] However, despite 'source of referral' appearing as a theme in research on disciplinary proceedings and performance issues across a number of sectors in relation to demographic disparities, there is no clarity about the cause of these disparities.

In relation to the second category identified within the literature review, that of themes relating to decision-making within disciplinary processes, there is evidence that IMG and BME doctors[10] – and other professionals[19 21] – were more likely to progress further and receive more severe sanctions. However, there is no evidence within our reviewed literature that bias or discrimination by decision-makers are responsible for the disproportionality or that the procedures themselves are structurally biased. There is also no evidence that these things are not the case. The complex interaction between the characteristics of the referred professional, the subject of the referral or complaint, the source of that referral or complaint, and the system which handles it mean that there are many variables to be addressed. However, there are some suggestions of matters which should be considered about decision-makers and the processes they work within, such as whether they are aware

of equality and diversity issues, and their responsibilities under equality and diversity legislation where this applies.[17-19] With regards to decision-making within disciplinary systems, several papers question whether the demographic characteristics of decision-makers are important, and whether these have kept pace with changes in the demographics of the professions they regulate.[17 18]

A final key theme which emerges from the literature surrounding disproportionality, is the importance for organisations of recording full and consistent data in order to allow trends relating to referrals and outcomes to be identified and interrogated. With its electronic data management system, Siebel, the GMC appears to now have an effective system in place and records extensive information. However, the repeated references in the literature to record keeping suggest that keeping data collection practices under review and considering potential analyses when deciding what data to collect may be helpful.

3.2 Interviews

Our interviews with GMC staff were designed to access each stage of the FtP procedures at which the GMC has decision-making responsibilities, and to include a range of FtP functions. Our questions largely focused on the GMC employees' experiences of FtP work, especially making and recording decisions, and their use of the guidance and criteria documentation.

GMC FtP enquiries and cases are investigated at all stages by Investigation Officers (IOs), guided by Investigation Managers (IMs). IMs, many of whom are also Assistant Registrars (ARs), have some decision-making powers as they must decide – usually guided by the IOs' work – whether to promote or conclude cases at triage and whether stream two cases should be concluded or promoted to stream one for full investigation. Decisions at the end of investigation stage are made by Case Examiners (CEs). The GMC employs both lay and medically qualified CEs, and the decision-making at the end of an FtP case is shared by one lay and one medical CE. These staff work together with the GMC's IHLT and other FtP managers to progress cases through the FtP procedures and make decisions on their outcomes. Our interview participants included IMs, CEs, an FtP manager and a member of the IHLT. A copy of the guide interview questions can be found in annexe C.

3.2.1 Staff training and experience

Overall, our interview participants were generally comfortable with, and felt well supported in, the decision-making aspects of their roles.

Most of the participants had worked within the FtP procedures for several years and some had held several different roles during their time with the GMC, progressing to take on more responsibility (for example from Investigation Officer to Investigation Manager). The training they had received varied, but generally seemed to consist of a mix of formal training sessions introducing the procedures and the guidance, and mentoring by more experienced colleagues. Decision-makers described spending some time making practice decisions and having their decisions reviewed by experienced staff members before beginning to take on their own case load. Two participants noted that the amount of formal training had increased since they themselves took up their roles in the organisation several years previously, and that new starters were now enrolled in more structured induction programmes.

3.2.2 Support for decision-making

Interviewees typically felt that they worked in a supportive atmosphere and that, although much of their decision-making work was done individually, they could if necessary discuss matters with colleagues to seek a second opinion. The FtP procedures incorporate formal processes for requesting and receiving what is termed 'case advice' during the triage or investigation phases. IOs can request advice from CEs or the IHLT for example, using the Siebel electronic database which records both the terms of the request and the response given as part of the case file. This function is often used in clinical cases during triage, where an IO might seek guidance on clinical treatment or prescribing from a medically qualified CE.

In our samples of case file data, case advice was recorded in our notes as being requested in 17 of 102 triage cases, 1 of 30 stream two cases, and 25 of 55 stream one cases. At triage, the majority of these requests related to clinical care or treatment cases, and saw the IO seeking advice from a Medical CE about whether FtP concerns were or were not raised in a complaint. In some of the closure letters sent to complainants in these cases, reference is made to the fact that the GMC has consulted 'a medically qualified colleague' prior to making the decision to conclude the case. CEs, including lay CEs, were also consulted at triage in some other cases, typically to help decide if a complaint falls within the scope of

the GMC FtP remit. At stream one, CEs were consulted for advice on a range of issues, often including whether an expert report or health assessment should be sought, and the case advice field in Siebel also records CE comments on whether the evidence gathered is sufficient and whether anything more needs to be done in the investigation. Towards the end of cases, approaching the rule seven stage, the point at which the doctor is notified of the outcome of the investigation and any allegation of impairment against them, CE advice includes matters such as whether the case is likely to meet the Realistic Prospect Test or whether a warning might be an appropriate outcome.

In addition to the case advice process, more general advice about case management and progress during the investigation phase can be sought during regularly held case review meetings. At these meetings, Investigation Managers present cases, describing their content, what has been done to that point in the investigation and what remains to be done. The extent to which these discussions are recorded in Siebel was not totally clear, but a participant suggested that where a case review meeting resulted in an action to be taken in a case – such as collecting more evidence, for example - then this would likely be recorded.

Beyond these formal processes, three interview participants, when asked whether they worked independently on decisions or with colleagues, mentioned that they would sometimes discuss either their thoughts on the decision or matter arising from a case with colleagues in more informal ways.

> ‘I think the best thing about here is the local support, there are always other managers around, and I know we can all get together and just have a quick chat about something and the head of section’s almost always on the floor.’ R004 (Investigation Manager)

> ‘…anything kind of slightly debatable, I personally, I mean I’m not necessarily instructed to do this but we all know that there is this option for us and will go and debate it with another manager, another AR, just to see what they would do. I mean the guidance that I was first given, the kind of instruction I was told to work under here, was in respect of, you know you can always debate a decision, if I think one thing you know, you may think something totally different, the point is about being able to rationally explain the fact that I did think through the different options of this and this is the decision I made, and as long as I’m doing that and I can demonstrate that in my decision then effectively you’ll never make an error.’ R004 (Investigation Manager, Stream 2)

> '…but equally informal chats across the desk frequently take place, you know we might say, or a colleague might say […] I've got this, this is an IOP you know […] what do you think, or it might, a discussion about particularly interesting case might even involve two or three people expressing an opinion, I mean the decision is still yours, it has to be laid out clearly as such, but I don't think that's the, I think that's probably a minority of cases, of the more tricky ones…' R001 (Lay CE)

Clearly discussions likely take place in this manner between colleagues in every workplace. In the GMC context, there is no suggestion here that such discussions might alter or distort decisions, rather that they may simply represent a layer of the decision-making process which is not well recognised, which may not be clearly recorded and which may as a result lack transparency. As two of the quotations above make clear, it is very important that decisions are well thought out and clearly laid out in the decision rationale. If this is done properly, it can be demonstrated that the outcome is in line with the GMC's guidance and criteria and it is therefore defensible. However, an informal or unrecorded layer in such a high stakes process may raise questions about how that process functions in practice. Essentially, this issue is one of accountability. There is no suggestion that outcomes are being affected, but that aspects of the process by which they are reached may not be fully documented.

3.2.3 Case Examiner selection

The two CEs in our sample, one a lay CE and one a medical CE, both commented on the process by which cases are assigned and passed between CEs at the end of investigation stage (stream one). All cases at this stage are seen by two CEs, with one formulating and writing out the decision rationale first and the second reviewing and adding to or clarifying the decision as appropriate. The process for allocating cases to CEs is a mix of pragmatism and workload management, but may also include some consideration of whether particular CEs have already given advice in a case and so have existing knowledge of the content. One CE described the process:

> '…very frequently you won't know who the second CE is, sometimes it might be already clear from the IO might have specified who the two CEs are because they may be two CEs who've had some previous involvement with the case in terms say of providing advice, or making an IOP decision, but very often, probably with the majority, you write your decision, you may not, it may not be clear, it may just go into what we call the cab rank, in other words it just goes into the pot and it's given to the next CE, if it's a

relatively uncontroversial decision it will be done by the second CE, you know you won't know anything about it. But occasionally the second CE may pick up the phone to discuss one or two things with you, yeah.' R001 (Lay CE)

The other CE we spoke with also explained that prior knowledge of case content might influence case allocation:

'Now particularly if we think at an early stage a case is going to close with a warning, we quite often have a chat with one of the lay colleagues, you know say yeah that seems reasonable so therefore, say I have talked about this with [X] and [X] agrees with me that a warning would appropriate, please make sure [X] sees the case next.' R005 (Medical CE)

Again, these quotations suggest that there may be some informal practices used in allocating cases to decision-makers. Where a decision rationale is clearly in line with the guidance and criteria provided, such practices may well have no bearing on the outcome. It is also important to recognise that the number of decision-makers available at the end of investigation stage is limited, as there are only eighteen CEs, and that the workload throughout the FtP process has increased in recent years. Resource management is therefore a significant consideration for the organisation and allocating cases to CEs who have prior knowledge of the content is likely to be a time effective approach. However, if the concept of having two CE make the decision on the outcome of each case is to improve the validity of those decisions, this may be undermined if CEs are sometimes selected to work on a case because they are already known to share the same view of it. Overall then, is important that the decision-making process is clear and that as much as possible of it is recorded.

3.2.4 Use of guidance and criteria documents

When asked, participants generally found the guidance and criteria documents provided by the GMC to be clear and useful.

'Yes it is clear, it is to me anyway, helpful and clear; I think for me it's quite a straightforward thought process, it's like well is it this, if it's this, this, this and this then it's likely we're going to have to investigate so you know, it is about the application of that…' R002 (Investigation Manager, Triage).

'I will have a quick read through of it. And also for weighting of things, I'll have a read of it as well just to see weighting we give to certain aspects, so it is useful, it can

provide you with the prompts that I need.' R003 (Investigation Manager, Stream 1, RIT)

Several of the interviewees referred to there being few absolutes within the guidance and criteria documents and that this is due to the individual nature of each FtP investigation.

'…a black and white document doesn't exist, and having never really discussed this before with anyone but I assume the problem being is that it's practically impossible to write.' R004 (Investigation Manager, Stream 2)

'…it can't be too didactic because the case material that we're dealing with doesn't fit into easily categorised things sometimes, but generally it's fairly helpful.' R005 (Medical CE)

'…they are as comprehensive as possible in terms of trying to sort of give criteria, but […] it's not possible I don't think to be a hundred percent prescriptive in that guidance because every case is different…' R006 (Manager)

Some staff members raised the fact that they used the materials provided on the GMC's intranet rather than hard copies as the guidance and criteria documents were often updated in response to matters arising in cases or court rulings and so online access would ensure use of the current version. This shows good practice, and illustrates that the FtP procedures are responsive to emerging issues.

Participants reported that the frequency with which they referred to the guidance could depend upon a number of factors, including their level of experience, the nature of the case under consideration, and whether a particular piece of guidance was a 'core' text or related to matters arising less often. One CE told us that they sometimes cut and paste sections from the guidance documents into their decisions where appropriate to cite the specific text, and our analysis of case file data showed that this is a common practice, showing good practice in terms of specificity and transparency.

3.2.5 Feedback and audit

To close the interviews, we asked participants about what happens after they have made decisions under the FtP procedures, and specifically whether they receive feedback on those decisions. Interviewees described audit processes being in place at each stage in the process, with samples of decisions being reviewed, and feedback being received from those audit processes, either at group or individual levels. In addition, one participant working as an

Investigation Manager, described presenting case studies for discussion with his team of IOs if something new, unusual or challenging had arisen in order to share the approach taken towards it.

3.2.6 Particulars: setting out allegations of impairment

When commissioning this research, the GMC asked that the review of decision-making should include their approach to presenting formal charges to doctors. As part of our response to that request, we asked our interview participants about their knowledge of this process and any role they play in it. Of our seven interviewees, four had some involvement in the process of drawing up the 'particulars of the allegation of impairment' as they are properly known. The 'particulars' detail the reasons why the GMC is alleging impairment of that doctor's FtP under the section 35C(2) of the Medical Act 1983 (as amended)[3] and are sent out to doctors under rule seven of the FtP Rules[2] in cases where the GMC is likely to seek to impose a sanction on the doctor or refer them to an MPTS panel.

The four participants with involvement in the process were the two CEs, a senior FtP manager, and a lawyer/Principal Legal Adviser (PLA) from the IHLT. Of these, the CEs' involvement in the process was limited – they might sometimes be asked to comment on the particulars but often may not see them prior to receiving a case for decision under rule eight. One of the CEs stated that there were rare occasions where something may not have been included which they felt should have been, in which case they would raise this but otherwise their role was very limited.

Our interviews with the senior FtP manager and the PLA clarified recent changes in the process for producing particulars, with the responsibility for this now lying with the IHLT, who work in consultation with the CEs and the IOs involved in the case to ensure that the correct information is included. FtP managers retain a quality assurance role in the process, reviewing particulars to ensure that they are set out in accordance with the correct format and include the correct information. In particular, the FtP Manager and the PLA both stressed the role of case law in determining the required content and format of the particulars, noting that this was especially important in cases of dishonesty or sexual impropriety. Overall, these participants emphasized the need for the particulars to be clear and concise, setting out the necessary 'facts' found by the GMC to show impairment and the

reason(s) for that impairment (under the five 'heads of impairment' set out by the Medical Act[1]).

During the interviews, GMC staff used the words 'charges', 'particulars' and 'allegations' to refer to the information sent to doctors at the rule seven stage alleging impairment. This lack of clarity over terminology amongst some of the staff appeared to reflect a degree of complexity in the process itself, being as it is closely governed by requirements set out in case law. In his interview, the PLA suggested that in considering the particulars, it would be helpful to bear in mind that further 'allegations' were sent to doctors referred to panel at the rule fifteen stage and that the rule seven particulars were formulated in a way which anticipates the requirements of that process. That is to say, that there is potentially a further stage to the process, which our research does not include, but which may influence the process of formulating rule seven particulars, so that they are set out in a similar way as panel documents would be.

Conclusion: 2.3.7

The interviews with various GMC FtP staff provided the research team with insights into the practical operation of the FtP procedures, allowing us to explore the mechanisms and tasks at each of the decision points, and the relationship between the various stages in the process and the different responsibilities of the staff playing roles within it. They clarified institutional terminology and engaged the researchers with the human elements of the 'system': the decision-makers without whom it would not function. The interviews also revealed some of the complexities of FtP work, and the exchanges of information and discussions about cases which can take place informally, thus raising the issue of transparency.

[1] Our research focuses on a sample of cases in which decisions were made prior to April 2014. At this time, the five heads of impairment were: conviction or caution; determination by another regulatory body; health; misconduct; and deficient professional performance. In April 2014, a sixth category of impairment, that of not having the necessary knowledge of English was added to the Medical Act.

3.3 Analysis of GMC guidance and criteria

Our analyses of GMC guidance and criteria documents for FtP decision-makers focused particularly upon interrogating those documents for any aspects which may contribute to the overrepresentation of some demographic groups of doctors in the FtP procedures, impact upon the progress of doctors through the system, or the eventual outcome of their cases due to their particular demographic characteristics. In addition, we also reviewed the documents generally for notable content, particularly relating to decision-making itself.

This section of the report sets out our findings about the GMC's guidance and criteria documents.

3.3.1 Demographic characteristics

The guidance and criteria documents were reviewed for any references to doctor demographic characteristics, namely: ethnicity; place of primary medical qualification; gender; or age. In reviewing the documents, two other aspects relating to the registrant – FtP history and health - were identified as arising in the guidance and criteria, and these are also discussed below.

3.3.1.1 Ethnicity and gender

There are no explicit or obvious references to doctor ethnicity or gender within the guidance and criteria documents reviewed. No implicit references to these characteristics were identified either.

3.3.1.2 Place of Primary Medical Qualification

GMC Guidance for decision-makers on assessing insight when considering whether undertakings are appropriate contains several passages which address issues of cultural difference. These may be of particular relevance for those doctors who achieved their Primary Medical Qualification outside the UK. The guidance encourages decision-makers to recognise that attitudes towards apologising may differ between cultures, as there may be different understandings of the meaning or potential consequences of expressing fault. The guidance recognises that there may be communication issues relevant to such matters, particularly when a doctor is working and engaging in a second language. The guidance also

acknowledges that non-verbal behaviours, such as eye contact, facial expressions and physical gestures may also differ between cultures.

The intention of this guidance seems to be to encourage decision-makers to consider the possibility of cross-cultural differences, if there is no apology or acceptance of responsibility or blame present where they might expect it to be.

Decision-makers are therefore advised to focus on two considerations when deciding whether undertakings may be an appropriate outcome by looking for evidence of insight: indications that the doctor is likely to be co-operative in accepting undertakings; and indications that the doctor will then comply with those undertakings. In flagging these points, the GMC has sought to move away from apology as the single key indicator of insight, although the organisation has recently conducted a consultation on indicative sanctions guidance which included consideration of insight and apologies, so guidance on these matters may develop further.[22]

It is also important to consider whether the context-specific nature of *Good Medical Practice*[1] (GMP), as the foundational text setting out standards for medical practice in the UK, places non-UK trained doctors at a disadvantage in relation to FtP matters. Evidently, GMP encapsulates a UK perspective on medical practice. There are some areas where this may differ from medical practice in other countries, and/or other cultures, for example the relationship between doctor and patient and the focus on patient centred care.

The standards set out in GMP translate into the GMC FtP guidance and criteria documents, as points of reference for decision-makers when considering potential outcomes, as in this extract from *Case Examiner guidance: Guidance on undertakings*:

> 'Under Rule 10(5) the CEs cannot consider undertakings when there is a realistic prospect of the doctor being erased if referred to a panel hearing. Indicators that there is a realistic prospect of the doctor being erased if the case were referred to a panel include:
> a. The allegations involve dishonesty (especially where persistent or covered up), violence or indecency and abuse of position of trust.

b. A particularly serious departure from or reckless disregard for the principles set out in Good Medical Practice.
c. Violation of a patient's rights or exploiting a vulnerable adult or child for example in relation to expressing personal beliefs.
d. Putting the doctor's own interests before those of patient, for example in relation to conflicts of interest.'

It is clear that some of these indicators may relate to the doctor's understanding of the doctor-patient relationship (points c and d), and on their knowledge and application of GMP. Research by Slowther et al[23] [24] shows that non-UK trained doctors can be surprised by the differences between approaches to medical practice in the UK and their countries of qualification, in particular the degree of patient autonomy and the focus on shared decision-making. It is therefore vital for non-UK trained doctors that they are aware of the expectations for the behaviour of medical practitioners in the UK. In our analysis of sampled case files we cross-referenced doctor PMQ with references to GMP in stream one decision rationales. Although the numbers were small, we identified that in 13 cases concerning UK trained doctors which including references to GMP there were no trends within those references. In 14 cases involved IMG doctors, there were five instances of GMP paragraphs about honesty when writing reports or completing records, and four cases which referenced content about keeping up to date relevant laws and codes or local policies. The cases covered mixed topics including treatment cases, declaring FtP issues to employers, resuscitation orders, abortion documentation, and certification as an approved clinician under the Mental Health Act. Tracking references to GMP across larger sample would be necessary to establish if these are widespread trends, which if replicated across a larger sample might indicate particular areas of practice may pose challenges for non-UK trained doctors due to unfamiliarity with local policies and processes for example.

The GMC recognised that non-UK trained doctors may need more support in becoming familiar with UK medical practice and standards in its *State of Medical Education and Practice in the UK 2011*[25] report and has since piloted and evaluated a 'Welcome to UK practice' programme for doctors new to the UK.[2]

[2] Further details on this programme are available online: http://www.gmc-uk.org/doctors/WelcomeUK.asp

3.3.1.3 Age

Age is not directly referenced in the guidance and criteria documents, however there are references to seniority or stage of career which could be interpreted as proxies for age in some circumstances.

The CE decision guidance: making decisions at the end of investigation stage, cites 'the seniority of the doctor' as one of the factors which CE should consider when deciding whether allegations about treatment/clinical practice meet the 'investigation stage test' or RPT. It is more likely that a more senior doctor will be older, simply because medical career progression generally depends upon the acquisition of experience and skills over time.

Examples of how such considerations are applied are seen in the work of medical experts commissioned by the GMC and the use of their report findings in CE decision rationales. Experts judge clinical practice by how far it meets, falls below, or falls seriously below, the standards expected from a doctor practising at the level of the doctor under investigation. So in investigating an F1 trainee, they apply a different set of expectations than if it is a consultant under investigation. More senior doctors can therefore be judged by stricter standards – notably in terms of their clinical skills and knowledge – than their junior colleagues, whose lesser experience may in some cases count in their favour.

It is therefore possible that this section of the guidance may indirectly/unintentionally contribute to greater numbers of older doctors progressing further through the system or receiving heavier sanctions. Quantitative analysis of the age of doctors, the type of allegation/impairment and the outcome may shed further light on this.

The other piece of guidance documentation which refers quite extensively to the doctor's stage of career is the *Guidance on dealing with voluntary erasure*. In this document, stage of career is presented as a key indicator for the likelihood of a doctor – if they were to be granted voluntary erasure (VE) - to seek restoration to the register at a later point. Doctors at a later stage of their career and able to provide evidence of their intent to permanently retire from practice should be considered unlikely to seek restoration and therefore good candidates for VE. Doctors at the early or mid-point of their careers are considered more likely to seek a return to practice, although there is recognition that this is not always going

to be the case and CEs are advised to carefully consider any tangible evidence of their intentions, such as retraining for another career.

3.3.1.4 FtP History

A doctor's FtP history may be relevant to the outcome of a new FtP investigation in some instances. The guidance for CEs entitled *Making decisions at the end of investigation phase* states that evidence of the doctor's previous FtP history may be relevant to the issue of remediability as it speaks to the likelihood of repetition. For example, if a doctor has previously been investigated for the same or similar reasons it may indicate that repetition is likely. No previous FtP history may indicate that a failing is likely to be a one-off.

The *Guidance on Warnings* also references previous good history as a factor which may be considered as an example of personal mitigation in cases where the CEs are satisfied that the doctor's FtP is not impaired or where the RPT is not met.

3.3.1.5 Health

Doctors' health is the 'characteristic' most extensively referred to in the GMC's guidance and criteria documentation, and is an issue subject to considerable research[26-32] and attention[8] in relation to the FtP process. The CE Decision Guidance: *Making decisions at the end of investigation stage* explains that a doctor's health may call their fitness to practise into question if it appears that they have a serious health problem (including alcohol or drug misuse) and do not appear to be following medical advice about how to modify their behaviour/practice to minimise risk to patients. It also notes that, in the Cohen ruling[33], Justice Silber took the view that psychiatric or psychological problems which made remediation difficult or impossible would point toward impairment.

The *Guidance on dealing with VE applications* refers to health considerations several times. Decision makers are advised to reflect carefully on the nature of the doctor's health issues and their implications for the likelihood of the doctor seeking restoration to the medical register in future. For example, chronic ill-health with a low likelihood of recovery indicates that VE should be granted, whereas as acute ill-health with a stronger likelihood of recovery counts against VE being granted as the doctor may be likely to seek restoration to the register. This is relevant where there are other allegations beyond those relating to health.

This document also instructs decision-makers to pay careful regard to whether a doctor's health issues may have impacted upon their ability to instruct legal representation. Furthermore, it also notes that in cases dealing exclusively with health allegations, applications for VE should be granted even where the doctor has indicated that they may seek restoration in future. Decision-makers are told to advise such doctors that they can only be restored fully to the register, and that restoration will not be offered with conditions restricting practice so they must be fully fit to practise in order to be restored. This reads almost as though decision-makers should warn doctors against VE if they may be better suited to conditions or undertakings for a limited period whilst their health issues are resolved. Both this and the references to legal representation seem to show the GMC are concerned with ensuring that fairness towards the doctors is balanced with the goals of maintaining patient safety and confidence in the profession.

When assessing risk in health cases, decision-makers are also advised to consider the source of the information that they receive carefully. Whilst it is acknowledged that self-referral by a doctor to the GMC may indicate that the doctor will be open and co-operative, the guidance counsels that they may still withhold information or provide information that is incomplete. Decision-makers are therefore advised to seek corroborative evidence from other sources.

3.3.2 Thresholds

Within the guidance and criteria documents, there are several examples of descriptive terms being used as 'threshold' points for decisions. Here, we are referring to terminology within the guidance, typically adjectives such as serious or significant, to which decision-makers apply their own definition. In particular, CEs at the end of an investigation must decide whether a case meets the description or not. This decision can then impact upon the range of outcomes which the guidance sets out as suitable. These require decision-makers to assess whether an alleged failing is a 'serious' or a 'significant' departure from GMP. For example, the core guidance for CEs, *Making decisions at the end of investigation stage,* includes the following:

> 'There will also be cases that demonstrate significant departures from *Good Medical Practice* or a significant cause for concern on assessment. These cases may not be so serious as to warrant action on a doctor's registration but may require a formal response from the GMC in the interests of maintaining good professional standards and public confidence in doctors.'

However, within the guidance and criteria documents there are no absolute criteria by which these threshold adjectives are defined, as they are not defined in the legislation from which they are derived.[2 3] This issue of definition is acknowledged within the guidance, as in the *Guidance on Warnings,* which states that 'there is no definition of 'significant' in the Medical Act or in the Fitness to Practise Rules.' We found reference to this issue of threshold adjectives in one of the CE decision rationales in our sample of stream one cases, where the CE wrote that 'there is no definition of the term 'significant' in the warnings guidance.' As our interviewees recognised (see section 3.2.4), providing full criteria or absolute definitions for such terms would be problematic due to the multi-faceted and individual nature of each FtP case. However, within several of the guidance and criteria documentation there are substantial efforts to provide examples and points of references to help decision-makers identify behaviours as serious or significant departures from GMP.

For example, the core guidance for CEs *Making decisions on cases at the end of investigation stage* provides information about what types of behaviours may be considered such serious departures from the expected standards that there would be a presumption of impairment of FtP, particularly in reference to criminality and dishonesty. With regard to clinical and treatment cases, this guidance offers factors to consider in assessing whether a failing should be considered serious including whether the doctor has deliberately or recklessly disregarded their clinical responsibilities or whether their actions have harmed patients or created a risk of patient harm. Paragraphs 48-61 of the document discuss a number of factors which CEs may perhaps need to consider when assessing the seriousness of an alleged failing. Paragraph 62 of the document recognises that the guidance provided is 'only illustrative' and that it, along with other GMC guidance, is not exhaustive.

Decision-makers therefore have to weigh the various factors of the case, and make an assessment of the seriousness of the alleged failings. CEs do this within the framework offered by the guidance and criteria documents, but they are still required to make an

individual decision in each instance. Some cases may very clearly map to the examples and parameters set out in the guidance, whilst others may not.

The lack of absolute definition assigned to terminology such as 'significant' and 'serious' is important because these terms require decision-makers to assign weight to alleged failings using them. Deciding that an allegation constitutes 'a significant departure' or a 'serious failure' places impacts upon the range of appropriate sanctions. Providing definitions for such 'threshold' terms would be challenging, due to the unique nature of each FtP enquiry or case and the contextual, mitigating or aggravating factors associated with each one. This difficulty was acknowledged by our interview participants (see above, section 3.2.4) and is the reason why the guidance and criteria documentation largely features general guidelines.

However, the lack of absolute definition also means that in deciding whether an alleged failing should be considered as significant or serious, an additional step in decision-making is present in the FtP process. This is to say that, in deciding whether an allegation meets the threshold for being described as 'serious' or 'significant', the decision-maker must apply their own understanding of those terms, and precisely where the threshold for meeting them lies, within the specific context of that case. Whilst this must be done in reference to the guidance provided, that guidance itself does not provide absolute definitions and so they remain open to a degree of interpretation.

3.3.4 Conclusion

The GMC's guidance and criteria documents are clearly written and as thorough as they can be without providing explicit details of exactly which types of allegation or case might lead to particular outcomes. This limitation arises from the need to ensure that the FtP procedures are not too rigid and are able to cover and include the individual mitigating and aggravating circumstances of each enquiry. The guidance and criteria documents do contain some references to doctor characteristics, in particular stage of career, health and cultural background, but these generally focus on either matters which may genuinely impact negatively on a doctor's fitness to practise, or upon seeking to ensure that doctor's with health problems or from different cultural backgrounds are not disadvantaged during FtP investigations. Discourse and thematic analyses did not identify bias or discriminatory language within the GMC's guidance and criteria documents.

3.5 Review of decision-making in sampled FtP case files

A major element of the study involved reviewing three samples of FtP files, drawn from the triage decision point, the end of stream two decision points and the end of investigation or stream one decision point. Overall, the research identified no major concerns about the decisions reached in the samples and the guidance and criteria issued by the GMC were largely applied consistently by decision-makers. The few exceptions to this overall finding – the cases where the researchers raised some points requiring clarification – are discussed below. The descriptions of the cases are necessarily generalised due to data protection concerns, and the discussion here focuses on the issues raised for decision-making.

3.5.1 Themes within the sample

Although our analysis involved assessing each of the cases within each of the samples individually against the guidance and criteria documentation, it was notable that there were some prominent trends across the samples.

There were a number of themes within the complaints and referrals entering the FtP procedures. Those coming from members of the public had often arisen in response to the death of loved one, and of these there were several that focused on allegations of missed or late diagnoses of cancer. This theme was also noted by Humphrey et al during a similar review of FtP cases, published in 2007.[9]

It was also common for members of the public to have already pursued their complaint elsewhere – such as through local resolution processes, or in some cases the Parliamentary and Health Services Ombudsman[5] – prior to approaching the GMC. Of the complaints from members of the public, 22 of 59 in the triage sample, 13 of 28 in the stream 2 sample, and 15 of 23 in the stream one sample, had complained elsewhere.

Thirty of the cases we reviewed originated as complaints or referrals from doctors. The source of enquiry for these cases is usually categorised by the GMC as 'other', although that category also includes solicitors, members of parliament and some organisational bodies. Of the cases from doctors, seven were self-referrals relating to health issues or cautions and convictions. The content of the remaining 18 were far more mixed, and many centred on interpersonal disputes, including issues such as general practice partnerships and

management, the writing of references, and issues between trainee doctors and their employers or deaneries. In some cases, it appeared that the GMC was being asked to act as mediator or arbiter in these disputes. In others, it was clear that doctors had potentially identified issues of poor practice and rightly reported their concerns. Doctors are in a strong position to assess the fitness to practise of their peers as they should have a better understanding of the standards set out in GMP than non-medics. Two of the 18 doctors reporting other doctors identified themselves as whistle-blowers and had used the GMC's confidential hotline, which launched in December 2012 to support doctors reporting patient safety concerns.

Our samples also contained references to revalidation, also introduced in December 2012, and to associated processes and functions such as appraisal, Responsible Officers (ROs), and the GMC's Employer Liaison Service. ROs were typically involved in Stream 2 cases with information being sought from them about doctors' performance, and doctors are required to name their RO and their designated body in the Employer Disclosure Form sent to them at the beginning of stream one and stream two investigations.

3.5.2 Characteristics of doctors within the sample

The representation of doctor demographic characteristics within the case files we reviewed was as expected as these determinants were used as part of the sampling strategy. However, beyond this, we noted that some specialties were heavily represented in the samples, notably general practice, surgery, psychiatry, and obstetrics and gynaecology – mirroring trends seen in other countries, such as Australia.[34]

Although our samples sizes, selected for in-depth qualitative review, are not large enough numbers for statistically sound co- or multivariate analyses, we did look at how the various demographic cohorts in our samples progressed through the FtP procedures. Table 7 shows outcomes in our triage sample by doctor PMQ, for UK and IMG doctors only as the number of EEA qualified doctors was very small, only seven in total. 17 cases in the triage sample had no identified doctors. Table 8 shows triage outcomes by doctor ethnicity, although 29 cases of the 102 had no doctor ethnicity recorded – including both cases where no doctor was ever identified and those where a doctor was specified but the GMC did not have ethnicity data recorded for them.

	Total in sample	Conclude	Promote to Stream 2	Promote to Stream 1
UK	52	29 (55.7%)	6 (11.5%)	17 (32%)
IMG	26	11 (42%)	3 (11.5%)	12 (46%)

Table 6: Triage outcomes by doctor PMQ

	Total in sample	Conclude	Promote to Stream 2	Promote to Stream 1
BME	32	11 (34%)	4 (12.5%)	17 (41%)
Non BME	41	26 (63%)	5 (12%)	10 (24%)

Table 7: Triage outcomes by doctor ethnicity

As these examples illustrate, although the numbers in our samples are necessarily small, the trends identified by Humphrey in her statistical analysis of GMC FtP data[10] are reflected within the outcomes for our sampled cases, with IMG and BME doctors more likely to progress through the procedures. Our samples also reflected the known trends for age and gender, with male and older doctors more likely to progress through the procedures.

3.5.3 Triage

Of the 102 cases sampled for review at this decision point, all of the decisions fell within the range of available outcomes for their contents as determined by the guidance and criteria documentation. There were several cases where no doctor could be identified or where the events in question fell outside of the GMC's five year rule with no public interest reason for them to be pursued beyond that, and many which were about service provision or healthcare policies (for example regarding waiting times or referrals). There were also many cases which raised issues which did not meet the threshold for FtP investigations, including complaints centring on disagreements about prescriptions or diagnoses. These complaints were typically from members of the public.

Cases promoted to stream two, for referral to employers for any further information, also came from members of the public and frequently referred to attitudinal or behavioural issues, such as rudeness, which may be of concern if part of a wider pattern of behaviour. These issues were present in all but one of the ten enquiries in our triage sample which were referred to stream two. The other was a disagreement about consent for sharing information.

Enquiries promoted to stream one, for full investigation, included: allegations of criminal offences, including domestic violence and sexual assault, and criminal convictions; concerns about doctors' health impacting upon their fitness to practise; and allegations about clinical competence or treatment, particularly where there had been serious consequences of the alleged failings, such as death of a patient. This latter subset of cases were in line with GMC *Guidance on categorising Stream 1 and Stream 2* cases, which states that 'an adverse outcome (in particular the death of a patient or serious harm)' is one factor which should be considered in assessing clinical care or treatment cases at triage. The enquiries promoted to stream one came from a mix of sources, including members of the public, employers and the police.

There was one case in the triage sample which we sought clarification from the GMC about. The case file actually included two triage decisions, as two different complaints were made about the same doctor within a short timeframe. Both alleged criminal conduct, of fraud or theft using patient details. The first case was closed due to the complainant being anonymous; the second was promoted to stream one after the complainant agreed to reveal their identity to the GMC. In this case, we were interested in whether the GMC could ever act if a complainant remained anonymous. The first complaint included some reasonably detailed allegations, including reference to the practice manager being aware of the allegations. However, it is also clear that anonymous complainants could easily be malicious and that not having a complainant willing to give a witness statement would weaken an FtP case. In the case of the first complaint in this case, the GMC did seek to contact the police to check if they were aware of any issues and closed the case when the police had no information. This case made clear that there are a wide range of factors which can influence whether the GMC feels able to act to investigate allegations, which the decision-makers need to weigh and balance.

3.5.4 Stream 2

The review of the stream two sample was the most straightforward of the three stages, which is a reflection of its role and the guidance which applies to decisions at this point. Essentially, by promoting an FtP enquiry into stream two, the GMC has already made a decision at triage that the content of the enquiry does not in itself constitute grounds for a full investigation and is not an FtP matter, but that it may do so if it were to form part of a

pattern of behaviour. Therefore, stream two decision-makers focus on whether any new information is received from employers and whether it provides cause to promote the case to stream one. Only one of the cases in our sample for this stage of the FtP procedures produced new information which prompted further investigation. In this case, adverse information contained within the doctor's employer disclosure form regarding prescribing issues resulted in a referral investigation being opened, meaning that the new information was sent to triage staff and a new case opened to consider it. All other cases in the sample were concluded appropriately having produced no new information.

There was one stream two case which raised some questions and which the research team discussed further with the GMC. However, it was the initial triage decision in the case which was the focus of those questions. In brief, the case involved a complainant alleging that a doctor had ignored a request for a chaperone and had performed a (non-invasive, fully clothed) physical examination without obtaining consent. The triage decision stated that the case 'raised no issues to suggest it would be necessary to open a Stream 1 investigation'. Mapping this issue to the relevant guidance on categorising cases as Stream 1 or Stream 2 identified the statement that '[s]erious or persistent breaches of GMC guidance on consent and/or confidentiality' should be classified as S1.' The standards for obtaining consent from patients are set out in GMP, in paragraph 36 of the 2006 edition.[12]

The case in question, as a single incident, clearly did not represent persistent breaches, but did raise the question of how 'serious breaches' would be measured or judged in this context. The GMC explained that the decision to close the case was due to the fact it was clear that the complainant knew the appointment would involve a physical exam (which had not involved an intimate examination) so that although they were unhappy with the process this did not raise consent issues. This query relates back to the use of threshold terms in the guidance and criteria documents discussed above (section 3.3.2).

In this particular case, within the full context of the enquiry, the decision not to classify the 'index' or original complaint as stream one was entirely appropriate. The promotion to stream two served to check whether there was any knowledge of a pattern of behaviour involving consent issues which could constitute 'persistent breaches' and merit promotion to stream one. The case did illustrate though that there are elements of ambiguity in the

guidance surrounding threshold decisions – smaller decisions which contribute to the overall outcome of a case.

3.5.5 Stream 1

The cases in our sample from the end of investigation point were very mixed in subject matter, doctor characteristics and outcomes. The case files contained anything up to c.600 pages of information – few were less than 50 pages, and those were typically straightforward referrals to panel in the case of convictions or very swift closures in the case of some driving convictions or cautions. Longer case files were more common, and typically featured content received from the complainant(s), witness statements, expert reports (in clinical and health cases), and responses from the doctor or their medical defence organisation.

Overall, the outcomes of the files were decided in accordance with the criteria set out for decision-makers and were in line with the guidance documentation. One case, of the fifty-five examined at this decision point, raised some questions for the researchers. The case featured a doctor convicted of fraud having written false prescriptions which were in fact for their own use. The outcome of the case was that undertakings were agreed with the doctor. In this case, the research team were unclear, how the CEs had reached this decision, as the guidance document *Making decisions at the end of investigation stage* states that:

> 'Under Rule 5(2) there is a presumption that the Registrar shall refer any other convictions or cautions directly to an FtP Panel, unless he thinks that it should be referred to a medical and lay Case Examiner (CE) for consideration.
> There are certain categories of cases where the presumption should apply and they are:
> […] any conviction involving an element of dishonesty.'

As the conviction was for fraud it is clear that there was dishonesty involved. However, the guidance documents also instruct CEs to consider mitigating and aggravating factors in cases. In this instance, the court judgement included in the case file stated that the offence had not resulted in financial gain for the doctor nor in loss to the NHS, and the judge was sympathetic to the doctor because of health difficulties. These health issues became central to the GMC investigation of the case, and it appears to have been approached as predominantly a health case with the conviction as a secondary consideration. However,

from the CEs' decision rationale, it was not clear whether the presumption of referral to panel had been directly addressed – it was referred to in the case file in case advice when a CE wrote 'in similar previous cases where there has been a conviction in addition to the health issues, we have tended to send these matters to panel.' Agreeing undertakings with the doctor to limit their practice was not an unreasonable outcome given the full content of the case, including that the doctor full admitted and accepted their wrong-doing. However, the reasons why this outcome was reached and why a referral to panel was rejected are not clearly and fully set out in the decision rationale. Had the CEs referenced and responded to the appropriate guidance documents explicitly, using them to frame their reasoning, greater clarity could have been achieved.

3.5.5.1 Case Examiner decisions: conclude or conclude with advice

One issue identified within the sample of CE decisions at the end of investigation stage (stream one) suggested that the 'conclude' and 'conclude with advice' outcomes were not being used consistently. In cases which had outcomes of 'conclude with advice', doctors were typically directed to reflect upon or review a relevant paragraph from GMP. The extracts below show how the advice is given:

> 'The matter should be closed advising Dr X to review paragraph 53 of Good Medical Practice and the explanatory guidance *Maintaining a professional boundary between you and your patient* (2013).
> FtP Action: Advice
> You must not use your professional position to pursue a sexual or improper emotional relationship with a patient or someone close to them.' (S1-039)

> 'We have decided that these cases may be closed. Dr Y is advised to take careful note of the provisions of Good Medical Practice 2013 paragraphs 65 and 71. […]
> FtP Action: Advice
> Dr X is advised to take careful note of the provisions of Good Medical Practice 2013 paragraphs 21, 65 and 71.'(S1-008)

However, we identified similar directions to doctors to review paragraphs in GMP in two cases in which the outcome was recorded as being 'conclude'. We also found one case which was concluded but where the decision rationale featured a direction to the doctor to reflect upon the issues raised by the case. These extracts are shown below:

> ‘The Case Examiners therefore conclude that this aspect of the investigation can be closed without further action. Dr A is reminded of his obligations under paragraphs 68 and 71 of Good Medical Practice (2013) to ensure the accuracy of data he records on forms and paperwork.’ (S1-038)
>
> ‘Some of the comments Dr B made on the instant messaging system were clearly inappropriate and unprofessional, although we do not believe they are serious enough to warrant action on his registration. Dr B will likely have reflected on the importance of being polite and considerate to patients, and treating them fairly and with respect, as outlined in paragraphs 46-48 of Good Medical Practice (2013). […] This case can be closed with no further action.’ (S1-030)
>
> ‘We therefore close this case with no further action. In doing so we trust that Dr C will reflect on all of the aspects of this case.’ (S1-035)

This is significant not only because it suggests a possible lack of shared understanding amongst the CEs about the ‘conclude with advice’ outcome, but because it may lead to cases in which a doctor has received advice about an aspect of their practice being recorded in their FtP history as having been simply ‘concluded’. This could become relevant if they were to be referred to the FtP procedures again for similar or related matters.

In some of these cases, the CEs’ comments directed towards the doctor – for example, that they ‘trust that Dr C will reflect’ – may be broad and general remarks which should not necessarily be formally recorded as advice. However, it appears inconsistent that a direction to reflect upon specific paragraphs of GMP may not have been recorded as ‘conclude with advice’, and raises questions the clarity of the distinction between ‘conclude’ and ‘conclude with advice’ outcomes in some instances.

3.5.6 Conclusion

All the case files we reviewed resulted in outcomes which fell within the range of acceptable outcomes proposed within the GMC’s guidance and criteria documentation. A few cases raised questions about the treatment of specific issues within the FtP procedures, such as defining a ‘serious’ breach of patient consent and the treatment of anonymous complainants. However, typically these questions centred not on challenging the outcome itself but on understanding the reasoning behind it and the rationale for selecting that outcome over others. Clearly expressed rationales, with specific references to relevant guidance, make decisions easier to understand and engender transparency within the decision-making processes.

3.6 The GMC's approach to presenting formal charges

As part of this study, the GMC asked that we consider their approach to presenting formal charges to doctors at the end of investigation stage, in cases where there was the prospect of a sanction being imposed. We did this in two ways: by discussing the process with our interviewees; and by closely examining the examples of such cases that arose within our sample of case file data.

3.6.1 The structure and content of the 'particulars'

As discussed in section 3.2.6 above, this was an aspect of the FtP procedures which was less familiar to those interview participants who were not directly involved in it, unlike – for example – the triage process. Our interviews did show that the content of 'the particulars' is tightly regulated by case law and that their production is, therefore, guided by the GMC's legal team.

In our sample of 55 case files from the end of investigation (stream one) stage, 13 case files included particulars. These are sent to the doctor as an annexe to a 'rule seven letter', which includes information signposting the doctor to the Doctor Support Service, which is provided for the GMC by the BMA Doctors for Doctors service and offers emotional support to doctors going through the FtP procedures. The letter also stresses the importance for the doctor of having medical defence representation or other independent legal advice. Figure 2 gives a mock example of the types of information given in the particulars.

Annexe A
That being registered under the Medical Act 1983 (as amended):
From 6 May 2012 to 12 September 2012 you were employed by ABC NHS Trust.

Patient L
2. When treating Patient L on 9 August 2012:
You failed to take an adequate history
You failed to record a diagnosis
You did not seek a medical opinion…
[…]
And that because of the facts above your fitness to practise is impaired by reason of your misconduct.

Figure 2: mock 'particulars'

The particulars themselves are concise, and focus on setting out the alleged facts of the case as determined by the GMC's investigation and end with the allegation of impairment and the reason that the alleged failing constitutes impairment under the Medical Act.

3.6.2 Categorising impairment

The particulars must allege impairment under one or more of the heads of impairment listed in the Medical Act 1983 (as amended) 35C (2). Table 9 categorises the allegations of impairment contained in the 13 examples of particulars in the sample reviewed for this study.

Impairment type	Number of cases
Misconduct	13
Deficient professional performance	1
Conviction/caution	0
Adverse physical or mental health	1
Determination by a UK health or social care regulator or non UK equivalent	0

Table 8: Allegations of impairment within the sample

Eleven cases including particulars alleging impairment by misconduct only. Of these, six were clinical/treatment cases and five were non-clinical, featuring matters such as: self-prescribing; practising without the correct authorisation under the Mental Health Act; and practising without indemnity cover.

One case including allegations of impairment due to misconduct and deficient professional performance, and one case alleged impairment due to misconduct and health issues.

The differentiation between the clinical cases categorised as impairment due to misconduct and those categorised as deficient professional performance was not always straightforward. For instance, one of the clinical cases reviewed which was categorised as misconduct featured reference to three patients, the same number as featured in the case categorised as misconduct and deficient professional performance. The degree of similarity between the patients' treatment (for example, was the same procedure a problem for the doctor in each case) and the question of whether the doctor had knowingly practised beyond their scope of competence seemed to be the significant factors, with the latter weighing towards an

allegation of impairment due to misconduct. The PLA interviewed for the study outlined the distinction between misconduct and deficient professional performance:

> '…I see misconduct can be narrow but has to go deep, ok has to be serious, can be one incident that has to be a serious departure, whereas performance has to be wider, has to be by reference to a fair sample of the doctor's practice, shouldn't therefore, can't therefore, just be one incident alone, but doesn't necessarily have to go so deep, the test is unacceptably low, and that's not the same as a sufficiently serious departure on this occasion to amount to serious professional misconduct. So that's all a bit, and that's from case law, that's not set out in statute anywhere. So first thing is you need to either be a lawyer or somebody who's had the misfortune to be talking to lawyers about this, to understand what that really means in practice, and therefore, it's not as clear and transparent as ideally it might be, which is part of the reason why you have to have lawyers drafting these particulars.' R007 (Principal Legal Adviser, IHLT)

The division between these two categories of impairment in clinical cases is therefore marked by complexity, with allegations of impairment due to deficient professional performance often drawing on performance assessments of doctor's practice. This issue is one which led the Law Commission to propose revising the grounds of impairment to bring more clinical cases, including single incidents, under the heading of deficient professional performance in order to bring greater clarity.[35]

In addition, the IHLT representative we spoke to also discussed the possible perception of impairment by misconduct and impairment by deficient professional performance as being qualitatively different. He accepted that there may be a view in some quarters that misconduct is perceived as 'worse' than deficient professional performance, perhaps because deficient professional performance is seen as more remediable or perhaps because some influence from the pre-2006 system - where separate committees dealt with performance, health and conduct cases offering different potential outcomes – lingers in the professional psyche. Our interviewee of course made the point that this is not the case, and that it is 'the substance of the allegation', whatever category of impairment it falls into. This research does not address whether practitioners might view categories of impairment differently[26], but it may be that this is an avenue worthy of further investigation.

3.6.3 Conclusion

Our sample size does not allow us to determine whether the formulation of particulars or the GMC's approach to issuing them to doctors might impact upon the overrepresentation of demographic groups of doctors within the FtP procedures or their progress through the system or the sanctions ultimately received. Our review of the particulars included in our sample did not reveal anything in their language or construction that indicated potential bias in these cases. It is not known whether the GMC record statistical data about how many cases feature particulars, or the categories of impairment that are alleged within them. This data might allow further statistical analysis to examine trends relating to demographic characteristics and particulars issued under rule seven. Looking at how doctors respond to receiving particulars, which they have 28 days to do prior to the CEs making a decision on their case at the rule eight stage, particularly whether there are different responses to allegations of misconduct or deficient professional performance, and whether these are linked to any demographic factors may also be enlightening.

3.7 Discourse analysis of a subsample of case file data

Ten cases, from the end of investigation (stream one) sample of case files, were selected (see section 2.2.4.1) for in-depth discourse analysis. This close textual analysis focused on the content and construction of the CE decision rationales at the end of the case files, and considered how the CEs built their arguments and evidenced their decisions, in reference to the material contained in the full case files. This in-depth discourse analysis of ten cases was preceded by a broad top-level discursive analysis of the full sample of 55 stream one cases.

This discourse analysis did not identify any discursive or rhetorical structures showing explicit bias in favour (or otherwise) of particular demographic groups. Beyond this, the ways in which reports were structured around the FtP decision-making process were not entirely neutral, which is to say that choices have been made about how the decisions are written and what is included or excluded, and how the facts of the case are described. The decisions were constructed, as all texts are, and analysis of their construction highlighted a number of key features. Professional and institutional discourses were apparent in the language of the case reports, and certain rhetorical devices guided the lines of argument that led to particular decisions. We therefore outline here the ways in which CE's construct cases using different techniques that may shape the overall nature of a case or decision.

3.7.1 The structuring of decision rationales

Although the structure of CE narratives varies, most followed a general 'inverted pyramid' style, beginning with broad introductory statements about the case and progressing through increasingly detailed sections to a statement of the outcome as the end 'point'. This typically consisted of:

- A summary lead (a broad précis of the event almost always beginning with how the GMC came to become involved).
- Next, a more detailed 'background' paragraph. Usually constructed in chronological order and written in the 'empiricist' style of a 'factual' report.
- A decision section. This is often prefaced with stock phrases or sentences to 'explain' the role of the CEs, the realistic prospect test, and how together these things determine the way in which CEs evaluate and decide upon the information or evidence before them.

- Sometimes there was a post-decision comment. This was apparent in the cases where the complainant is tenacious. They were most evident in the decision letters sent to complainants. These comments are structured and phrased in a way which could be described as rhetorical 'last words'. That is, they effectively close off any future dialogue:

  "The case examiners offer their condolences to Mrs X."

An alternative narrative format for decision rationales was evident in some cases. This consists of:

- Summary lead
- Decision
- Rationale for decision

Within this structure, the CEs construct, or reconstruct, the 'story' of a case, presenting their interpretation of the allegations, evidence, responses, and other documents gathered during the investigation process. One of the CEs we interviewed stated that although there is no template for the decisions, there is a preferred format.

3.7.2 In-depth analysis of CE decision rationales

Interestingly, in nine of the ten cases we examined, the outcome of the CEs' deliberations was completely absent from the summary lead. This had the effect of prioritising the key factors that brought forward the case in the first place, rather than the measured judgements of the CE represented in the outcome. However, we found no evidence of any prejudice as a result of this.

The narrative of the background sections were written as 'factual' accounts, whereby subjective interpretations were minimised. Events and 'facts' appeared in chronological order and led the reader to the next section of the narrative, where allegations were listed and considered. Exclusive use of a third person 'passive' voice added to the dispassionate style of reportage, for example:

'a clinical negligence claim <u>was taken out</u> against Dr B ...'

The narrative themselves within each case provided a synthesis of events collated from various sources available to the CEs. This was evident in the supporting documentary evidence for the case, demonstrating which 'facts' the CEs include and which 'facts' they leave out. Some 'facts' were reported in a plain, matter-of-fact way:

> 'Dr B was working as a freelance locum GP in various locations'

However, others were more subjective. Analysing the sample, it was notable that when contentious or disputed 'facts' were included, CEs used a rhetorical device known as 'footing'[36] to distance themselves or qualify the comments, for example:

> 'It is ***alleged*** Dr B did not have medical insurance at the time of an incident of clinical negligence' (our emphasis).

At its simplest, 'footing' is where speakers and writers let their audience know who said what[37], as in 'Dr B explained …' Sometimes, as with the 'it is alleged' example, the source of the allegation or the speaker of the original words was not made specific. Wider discursive research shows that footing such as this is a regular feature of talk and written texts – especially in organisational settings where legal considerations around libel and slander are always a consideration.[38]

Although most of the reports were written in fairly neutral language when presenting more obvious facts of the case, closer examinations revealed that CEs were able to, and did, inject scepticism or confidence into their narratives about particular claims, or lines of argument. This was most obviously done by prefacing statements with words or phrases that were value-laden (which, by implication, could encourage the reader to read the narrative in a particular way).[39] When included in a narrative that has the appearance of being factual reportage, the cumulative effects of such prefacing can be very persuasive in terms of leading the line of argument in a particular way that might not otherwise have been directed by the 'facts' of the evidence alone, for example:

> 'During this time he states ***he thought*** he had indemnity cover with the MPS, ***however it appears*** this was cancelled by the MPS' (our emphasis).

In this instance, the highlighted words and phrases work to sow the seeds of doubt rather than adding clarity. This can, on occasion - but not on all occasions - lead to bias. Research

using discursive techniques is well placed to pick up on footing that prioritises the interests of certain individuals, social groups or institutionalised cultures over others. This has been clearly demonstrated where footing has been used to highlight certain voices as being more authoritative than others in providing accounts of particular events (see Van Dijk for discursive analysis of representations of race and ethnicity[40]), and prefacing has had the effect of denigrating or questioning the views or interests of other groups. When such rhetorical techniques exert influence on a narrative, discursive analyses would typically reveal them in action, and this can be used to highlight any implications they might have for supporting prejudice and discrimination. However, despite rigorous interrogation of the instances of footing and prefacing in our sample, we found no examples of this occurring in any of the CEs reports.

Our discursive analysis focused on what facts and evidence have been included in decision rationale narratives. How those facts and evidence were then used to build arguments that lead logically to an appropriate outcome was the next step in our systematic analysis of the sample.

In writing the decision rationales, CEs frequently referred to themselves and described their role, usually using a third person voice, as the extracts below show for example:.

> 'The Case Examiners are asked to determine whether there is a realistic prospect of establishing that Dr X's fitness to practise is impaired to a degree justifying action on his registration…'
>
> 'The Case Examiners have considered all the available evidence…'

This served to make the CEs' institutional role visible, as well as creating distance and a tone of objectivity or impartiality. In this way, CEs position themselves, and by extension their reasoning, as detached. Our interviews and the prevalence of case advice in our samples of case file data have shown that CEs are often involved in investigations prior to the decision stage. Using the third person voice may therefore serve to detach not the CEs as individuals or as a body, but the particular 'decision-making' stage of their work from the investigative stage. Together with footing and prefacing, this use of the third person voice contributed to the tone of the narratives and the lines of argument, which in turn primed the reports for the CEs' final decisions.

Discourse analysis always involves rhetorical analysis of argument and evidence, in order to identify the explicit and implicit arguments being made. When someone overtly selects one piece of evidence, or argues for one position, they implicitly exclude others.[41] In some of the sample, lines of argumentation and evidence were clearly stated and the logic of rationale was obvious. In a few instances however, some of the arguments were less explicit and less logical in construction. In one case, for example, numerous sceptical references to a doctor's behaviour made it difficult not to form the impression that his honesty is being tacitly questioned by the CE:

> 'It seems Dr B ***was accepting financial reimbursement*** for his MPS fees ***yet didn't notice that a substantial payment to the MPS was not being made each month***, the CEs find this surprising.' (our emphasis)

To break down this example, we can see first how the numerical amount, which should have been going to MPS, and the reimbursement from his employers, are now re-described as a 'substantial payment'. Therefore a subjective concept is now forming the premise upon which the argument is to be based. The CEs' argument follows that in accepting financial reimbursement the doctor would, or should, notice that the MPS payment was not going out of his account. As a form of reasoning there is no obvious logical flow to the assertion because, on the evidence available to the CEs, the second clause does not follow from the first. It might if Dr B's funds were meagre, but the documentary evidence shows that they were not. Discursive research demonstrates that the use of non-sequiturs such as this is often uncontested, and can lead the narrative in a particular direction – in this case to an unstated but apparent implication that the doctor's integrity is questionable.

Of all the elements in the CE decision rationale process, it is in the presentation, assessment and weighting of evidence that bias, discrimination, and prejudice is most likely to operate – either intentionally or unintentionally. This is evident particularly in discursive studies of racist text. As van Dijk and others have pointed out, what has been called 'new racism' takes a different discursive form, perhaps in the form of allusions, metaphors and euphemisms - to the 'old racism', which was much more explicit and crude.[40-42] 'New racism', as with other forms of discriminatory language usage, is more sophisticated and insidious than racism of the past. It is therefore more difficult to detect, but not impossible. Raising doubt, as demonstrated above, is one such device, but although we found a couple of isolated

examples of this, no discriminatory discourses were identified that related to particular social groups or institutionalised cultures.

If, in analysing the CE's decision rationales, we had found what might be deemed unnecessary or repeated references to the doctor's culture, for example, these might be considered the first hint that figures of speech were indicative of some other more negative rhetorical work. In the case extracted above, the use of value-laden prefacing by the CEs was more prevalent than the remainder of the sample. However, whilst Dr B was an IMG doctor, there was no evidence that this was the reason for the greater prevalence of such 'doubt raisers' in this decision rationale, and the CEs made no reference to his IMG status in any way, shape or form.

3.7.3 Examining institutional and professional discourses

Discourse analysis enables the researcher to identify any discourses (common ideas and agendas informing entire systems of meaning that can be applied to any particular object of discussion) evident in a text. This is important because discourses can shape actions and behaviours stemming from those ideas. The discourses identified in the DA or CE's reports were two-fold: i) "legalese" (a sense of legal format, but within an official language rather than actual legal terminology) and ii) "stock phrasing" (which imprints the professional identity and institutional role of the CE).

CE narratives were overtly formal in tone. They were written in legalese style and contained many 'stock' phrases or words. These featured prominently across the subsample and helped construct the institutional character of the narratives and of the CEs. By constant reference to what they are required to do as CEs, the texts made their institutional role visible. Sometimes this included explicitly what the GMC's role is or isn't:

> *"… negligence in itself is not a matter for the GMC to determine. Rather, when considering a doctor's fitness to practise something more is required than a degree of negligence enough to give rise to civil liability."* (S1-019)

Even in this short extract the words such as '*negligence*' and '*civil liability*' have a recognisably legal register. The syntax, style, and grammar, as in '*in itself is not a matter for*' or '*enough to give rise to'* are typical of what grammarians call 'officialese'.[43 44] This style of

writing permeated the sample and marked them as GMC documents, setting them apart from other regulator documents. This was reinforced through repetition: through constant reference to the 'GMC', to 'fitness to practise', to the 'realistic prospect test', to 'Good Medical Practice' (including the use of quotes), to 'impairment', to the role of CEs, and to the purpose of any sanctions etc.

From our analysis, the main professional discourse presented the reports was the CEs 'stake' (their professional 'interest'); the fact that they are employed by the GMC (the regulator) to consider allegations made against medical doctors. Thus, it is acknowledged that CEs are not independent from the regulatory process, but part of it. At the same time, however, the formality, the style, and the tone of the language; together with the use of third person narrative and a tendency to privilege the passive voice over the active, provided the discourse of the decision documents a detached and neutral frame.

This language of neutrality is interesting when compared with the language of complaints. Complaints were highly distinctive. While complainants often couched the nature of their complaint in quasi-professional, neutral language (in setting out the case), their narratives became more emotional as the description of events developed within their accounts. It is at this point that personal feelings, subjectivity, and assumption commonly entered complainants' narratives.

The contrast between such narratives and those contained in the CEs' reports was striking. CE reports, and subsequent GMC letters to complainants following decision making, were neutral in tone and respectful and courteous in nature – balancing the legalistic language of decision-making with recognition of the more human elements of the whole procedure. Thus professional discourses (when highlighted against patient/public discourses), demonstrated a person-centred tone within the more objective approach to stating the facts. In short, throughout the sample, impartial reasoned argument was consistently evident in CEs' accounts and, while the human elements of FtP were evident, these were presented objectively and even a rigorous interrogation of these discourses revealed no evidence of bias.

3.7.4 Conclusion

We found no empirical evidence to suggest that any discrimination or prejudice was present in the sample of ten CEs' decision rationales we subjected to this in-depth discourse analysis. There was evidence of professional and institutional discourse entering the texts, and there were instances, as reported above, where the strength of argument and quality of reasoning could be challenged. The strength (or weakness) of an argument is in how well it is supported by evidence and the quality of the reasoning.[45] Strong evidence, poorly reasoned, may well result in an unconvincing argument. Weak evidence with good reasoning can often produce a strong argument.[46] Patient centred language was also evident as part of professional discourse.

On the basis of this subsample, there may, therefore, be room for improvement in terms of the transparency of decision-making in CE reports: in the consistency of decision construction and the presentation of strong argumentation underlying decision-making. For instance, clear references to relevant guidance and the factors which led to a particular outcome being selected instead of others, strengthen the decision rationale. The DA has also highlighted the prioritisation of dispassionate treatment of what are otherwise highly emotive and sometimes controversial matters. Specifically, we have not been able to identify any instances of discrimination in any of the multiple layers that serve to make up the decision-making process, as expressed in the decision rationales.

4. Discussion

As the description of our analysis and findings shows, decision-making in the GMC's FtP procedures can involve a number of people in a variety of roles, making decisions at several stages. The cases investigated range from straightforward examples to very complex situations. The GMC procedures, and the guidance and criteria for decision-makers working within them, therefore have to be both as comprehensive as possible whilst retaining the flexibility to encompass the unique nature of the enquiries received by the organisation. As cases progress through the procedures, decision-makers must weigh the evidence available, frequently including both mitigating and aggravating factors, and measure the facts of the situation against the guidance and criteria. There are, particularly at the end of investigation stage, often several potential outcomes and in selecting from these, decision-makers possess a degree of agency. As long as the outcome can be shown to be reasonable and in line with the guidance, there may not be a single 'correct' result. In this complicated context, this discussion therefore considers the overall findings from the various strands of our research.

4.1 Does decision-making in the GMC's FtP procedures function as intended?

Overall, we found decision-making in the case files we reviewed did function as intended. The outcomes of the cases were in line with the GMC's guidance and criteria documentation.

We did identify some aspects of decision-making which raised questions. Firstly, we found that in some stream one cases, CEs had offered advice to registrants – typically to review a paragraph of *Good Medical Practice* – in cases that were categorised as having been concluded. This apparent advice occurred in similar formats to that offered in cases that were recorded as having been 'concluded with advice', but would not have been recorded as such in the doctor's FtP history, which can contribute to assessing insight in cases of recurrent failings.

We also found three specific instances where aspects of the decision-making were unclear to the research team and further clarification was requested from the GMC. In two of these

cases, the complete reasoning for reaching the selected outcome was not fully recorded. In one, we identified that the relevant guidance required the decision-maker to measure whether an alleged breach of patient consent was 'serious' or not, but this guidance was not referenced and the decision taken not explained in the context of that guidance. In another case, at the end of an investigation, the guidance indicated that a conviction for fraud should fall into the category of cases where there is a presumption of referral to panel, but the focus of the decision-making was on the registrant's health problems and undertakings were agreed. In that instance, the reasoning behind the decision was not fully and explicitly laid out.

In addition to the content of the sampled case files, our interviews also produced rich information about the decision-making processes and working practices of GMC FtP staff. The staff we interviewed found the guidance and criteria documentation that they worked with useful and effective in supporting decision-making. Through talking to those who work in FtP decision-making, it emerged that informal and unrecorded conversations about the nature of cases and their potential outcomes take place between colleagues. This is not surprising and collegial discussion would be expected in any workplace. It is also not known to what extent, if any, such discussions may shape decision-making. However, in a context as contested and controversial as FtP procedures, accountability and transparency are important values. These values, or at least how demonstrable their application is, may be challenged if decisions are not fully reasoned in writing.

4.2 What factors within the GMC's purview contribute to the overrepresentation of demographic cohorts of doctors in the FtP procedures, if any?

In the course of our research, looking at sampled case file data, the GMC guidance and criteria documents, and speaking to GMC FtP staff, we did not identify any factors within GMC's activity which might constitute bias or discriminatory practices against demographic cohorts of doctors. However, our sampled data did show the same demographic trends as those identified by Humphrey's statistical analysis[10], which have been a long-term issue for FtP procedures.[9 11]

There are potentially things which may justifiably contribute to the overrepresentation of some demographic groups of doctors in the FtP procedures, such as if non-UK trained doctors are practising without a full working understanding of the standards set out in GMP.[23] In addition, the GMC's guidance makes reference to doctor's stage of career being a factor to take in account when assessing FtP matters, and this may have some impact on the higher likelihood of older doctors progressing further through the system. However, these are only suggestions. Our analysis has identified no causal factors for these trends, or for those which see male doctors and BME doctors more likely to enter the FtP procedures and to progress further. The literature on the topic, both in healthcare and other sectors, suggests a number of potential avenues of enquiry on this related to the topic of disproportional representation of some demographic groups within equivalent disciplinary processes. These include the possibility that employers may be more likely to refer doctors possessing certain demographic characteristics into formal procedures or that these doctors may be more likely to work in roles or settings that are subject to higher levels of complaint.[17-19]

As well as reviewing case files and guidance documentation, we also considered whether the GMC's approach to presenting formal charges to doctors at the rule seven stage of the FtP procedures, by issuing 'particulars', might contribute to overrepresentation of demographic groups or to the severity of sanction received at the end of investigation stage. The particulars themselves are typically concise and very direct in style, and again we found no evidence of bias or discriminatory language in those contained within our case file sample. There is perhaps an issue surrounding the definitions of the categories of impairment by misconduct and impairment by deficient professional performance but there is no known link between this issue and demographic characteristics. Without knowing how doctors faced with allegations of impairment respond to them or interpret the different categories of impairment, or whether some categories of impairment are more common in cases involving doctors with certain characteristics, no further conclusion can be reached regarding particulars.

4.3 What are the institutional and professional discourses which shape decision-making in the FtP procedures?

The GMC guidance and criteria documents are shaped by the standards set out in GMP and are therefore imbued, as the whole of the FtP procedures understandably are, with values derived from UK-specific notions of medical professionalism. Beyond this, many of the documents and processes involved in FtP decision-making are highly legalistic in tone due to the fact that the FtP rules[2] are rooted in specific legislation and echo its terminology, and due to the influence of case law on particular elements of the procedures and guidance.

We have already noted above the existence of undocumented, informal discussions between GMC staff about cases and their management. These discussions constitute another, more inaccessible, type of institutional discourse around FtP, which may be both constructive if debating and justifying decisions to colleagues serves to test and strengthen the reasoning behind those decisions, but which may give rise to challenge as an unrecorded element in a contested process, if decisions are not fully reasoned in writing.

In our analyses, the strongest voices within the FtP procedures were those of the CEs, whose role as recorded in the case files and as discussed by our interview participants, was more extensive than revealed by a simple description of the FtP system which would typically feature only their decision-making function at the end of investigation stage. The structure and the discursive style of those decisions typically present CEs as detached – as being removed from other activity within the FtP procedures. However, CEs are often involved at all stages of the FtP procedures, offering case advice, contributing to investigation planning, and feeding into the process of producing particulars. Whether these other functions have any bearing upon their decision-making at the end of investigation stage is not known but it is clear that they are not reflected or revealed in the decision rationales. CEs make their decisions within the framework provided by GMC guidance and their training, but they are still required to make judgements and weigh the available evidence to reach their decisions. Ensuring that all decision reasoning is fully and consistently set out in writing will effectively demonstrate the appropriateness of the outcome in a case, whatever the role played earlier in the FtP process by the CE or their CE colleagues.

5. Conclusion

This review of decision-making in the GMC's FtP procedures has covered a number of aspects contributing to that process, at three key decision points. This analysis has not identified discriminatory practices or bias in either the decisions in sampled case files or in the GMC's guidance and criteria documentation. Moreover, the textual analysis revealed that CEs' professional language was distinct from that of complainants, and that it generally incorporated some patient-centred discourse within a neutral and objective approach to developing argument and evidence.

We have raised some specific issues, around the use of threshold adjectives without absolute definitions in the guidance and criteria documentation, which require decision-makers to measure a case against them. We have also indicated particular points which may need to be addressed, such as clarifying the purpose and usage of the 'conclude with advice' outcome.

Beyond these specific findings, several of the issues we have raised have centred upon a shared theme. Whilst the decision outcomes we reviewed were in line with GMC guidance there were a number of occasions where the reasoning behind the selected outcome was not fully explained, in reference to the relevant points in the guidance and criteria. In addition, we identified informal and sometimes unrecorded aspects to decision-making which may occur in discussions between staff. In such instances, the defensibility of decisions may be compromised as the clarity and transparency of the processes through which they were reached may be susceptible to challenge. Providing full explanation of the reasoning behind decision outcomes – justifying decisions with clear references to the relevant standards and guidance, for instance – would mitigate this risk effectively by ensuring accountability. In this regard, as clear and comprehensive reasoning as is possible would contribute to demonstrating that the GMC's decision-making is careful, fair and valid.

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7. Annexes

Annexe A: Literature review content

Academic papers

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Annexe B: Interviews - Information for participants and consent form

PLYMOUTH UNIVERSITY PENINSULA SCHOOLS OF MEDICINE & DENTISTRY

Review of decision-making in the General Medical Council's fitness to practise procedures

Information for participants - Interview

[v1 08/04/2014]

This information sheet details research being undertaken by the Collaboration for Medical Education Research and Assessment (CAMERA) research group within Plymouth University Peninsula Schools of Medicine and Dentistry. The research is led by Dr Sam Regan de Bere.

Thank you for showing an interest in this research. Please read this information sheet carefully before deciding whether or not to participate. If you decided to participate we thank you. If you decide not to take part there will be no disadvantage to you of any kind and we thank you for considering our request.

What is the aim of the research?

The aim of the research is to produce an in-depth and thorough independent evaluation of decision-making at key points in the General Medical Council's (GMC) fitness to practise procedures. Fitness to practise (FtP) procedures can, in the event that serious impairment of a doctor's fitness to practise is identified, ultimately result in a doctor being removed from the medical register and barred from practising medicine in the UK. It is therefore vital that decision-making within the procedures should be valid and reliable. The objectives of this research are to analyse a sample of decisions made during the last twelve months and to:

- Review decision-making at key stages in the FtP process and establish if GMC guidance is consistently applied.

- Assess whether GMC decision-making guidance and criteria may contribute to this overrepresentation of some demographic groups of doctors in the GMC's FtP procedures.
- Examine whether the GMC's approach to presenting formal charges to doctors may contribute to the overrepresentation of some demographic groups of doctors in FtP procedures.

We hope that the findings of the research will support the GMC in ensuring that its FtP assessments of professional competence are valid and reliable.

What types of participant are needed?

We are interested in speaking to people who are GMC's Fitness to Practise staff, either in decision-making roles or in management roles. We would like to speak to people who handle initial enquiries, make triage decisions, are Case Examiners, or FtP managers.

What will participants be asked to do?

Should you agree to take part in the research, you will be asked to complete and return the consent form which accompanies this information sheet. One of the research team will then contact you to arrange a convenient time for them to interview you by telephone.

Time commitment:

Approximately 40 minutes.

Can participants change their mind and withdraw from the project?

You may withdraw from participation in the project at any time up to the **end of October 2014** and without disadvantage to yourself of any kind. You are not required to give a reason for your decision to withdraw. If you decide to withdraw please contact us by phone, email or post using the contact details below.

What information will be collected and what use will be made of it?

This research involves an open-ended questioning technique where the precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. However, we have prepared some guide questions

covering key aspects of the FtP system which the researcher will use as prompts. In the event that a line of questioning does evolve in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from participation in the research at any time before the end of October 2014 without disadvantage to yourself of any kind.

Participants will be anonymised. Individual interviews will be recorded and transcribed. Digital audio tapes will be sent to the transcriber securely. The transcriber is bound by a confidentiality agreement. Your interview transcript will be combined with those of the other participants and the resulting dataset will be analysed as a whole. Participants will be provided, on request, with a copy of the transcript of their interview in order to check for accuracy and to request omissions but not to alter the content.

The university's research ethics policy states that data should be securely held for a minimum of ten years after the completion of the research project. Electronic data will be stored on password protected computers or laptops and individual files and/or discs must be encrypted. Hard copies of data must be stored in locked filing cabinets and disposed of securely when no longer required.

The data will be used as primary research material for a research report *Review of decision-making in the General Medical Council's fitness to practise procedures* to be submitted to the General Medical Council. The findings of the research will be disseminated to GMC staff. Findings from this research may also be published in peer-reviewed journal articles and presented at academic conferences. In each case, quotations used will be attributed to the professional orientation of the interviewee (eg. triage enquiry handler; lay case examiner; Fitness to Practise manager, etc).

Why me?

You have been invited to participate as we are interested in speaking to people who have knowledge or experience of working in the GMC Fitness to Practise decision-making process.

If you have any questions about this research, either now or in the future, please feel free to contact either:

Dr Sam Regan de Bere Deputy Director of CAMERA Lecturer in Medical Humanities Tel: 01752 586777 Email: Samantha.ReganDeBere@plymouth.ac.uk	OR	Dr Marie Bryce Research Assistant CAMERA Tel: 01752 586799 Email : marie.bryce@plymouth.ac.uk
Postal address: Plymouth University Peninsula Schools of Medicine & Dentistry, Portland Square, Plymouth University, Drake Circus, Plymouth, PL4 8AA		

If you would like to receive further information about the outcomes of the research and to be informed of any future publications resulting from this work, please indicate this on the consent form or let us know later.

Complaints

If you have any complaints about the way in which this study has been carried out, please contact the Principal Investigator Dr Sam Regan de Bere in the first instance. This may be followed by a complaint to the administrator of the Faculty of Health and Human Sciences Research Ethics Committee.

…….	…….	…….
(printed name of participant)	(signature of participant)	(date)

This research has been reviewed and approved by the University of Plymouth Faculty of Health and Human Sciences Research Ethics Committee.

Review of decision-making in the General Medical Council's fitness to practise procedures

Consent form for participants

[v1 08/04/2014]

I have read the Information Sheet for Participants Version 1 Date 17/01/2014 concerning this research and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

[Please mark as appropriate]

	YES	NO
1. My participation in the project is entirely voluntary	☐	☐
2. I will be anonymised	☐	☐
3. I am free to withdraw from the project at any time before the end of October 2014 without any disadvantage and without having to give a reason for my decision to withdraw	☐	☐
4. Data will be retained in secure storage	☐	☐
5. The precise nature of the questions which will be asked in the interview have not been determined in advance but the researcher has prepared some prompt questions	☐	☐
6. The results of the research may be published and I understand that any quotations used will be attributed to my professional orientation	☐	☐
7. I understand that a trainee researcher may be present during the interview for training purposes and I am happy [mark as appropriate] for them to be present.	☐	☐

I would like to be updated about the outcomes of the research and any publications resulting from it. ☐ ☐

……. ……. ……..

(printed name of participant) (signature of participant) (date)

This research has been reviewed and approved by the University of Plymouth Faculty of Health and Human Sciences Research Ethics Committee.

Annexe C: Interviews – interview schedule

PLYMOUTH UNIVERSITY PENINSULA SCHOOLS OF MEDICINE & DENTISTRY

Review of decision-making in the General Medical Council's fitness to practise procedures

Indicative interview schedule

[v1 and 04/04/2014]

**Researcher to double check consent has been obtained and that the participant has seen the information sheet and is happy to continue.*

Part 1 – personal experience

Q1: What is your role at the General Medical Council?

Q2: How long have you worked at the General Medical Council?

Q3: What training did you/do you receive about decision-making?

Part 2 – FtP activity

Q4: When you receive a new [enquiry/referral/case] what is the first thing you do?

Q5: What is the process involved in making a decision at [triage/end of stream 2/end of investigation]?

Q6: How long do you spend working on each [enquiry/referral/case]?

Q7: How do you record your decisions?

Q8: Do you work alone or do you consult colleagues?

Q9: What do you do if you are unsure about the appropriate decision in an [enquiry/referral/case]?

Part 3 – GMC guidance and criteria

Q10: Do you routinely consult GMC guidance and criteria?

Q11: How well do you feel you know and understand the guidance?

Q12: Do you feel that the guidance available to you is helpful and clear?

Q13: Can you think of any ways in which the guidance could be improved?

Part 4 – Presentation of charges (Case Examiners/FtP managers only)

Q14: How do you go about deciding what charges should be made against a doctor and how these should be categorised?

Q15: Do you feel that the categorisation of charges is a useful approach?

Part 5 – After the decision is made

Q16: Is there a moderation or review process for decisions?

Q17: Have you ever changed your mind about a decision, and is there a process to follow in such cases?

Q18: In cases where you have made a progress decision, do you find out the end result?

**Researcher thanks the participant for their time and contribution to the research.*

** Ask if the participant has any questions about the research.*

** Ask if the participant would like to see a transcript of the interview.*

**Inform the participant of the next steps in the research and remind them that they may make contact at any time and they may withdraw at any time before the end of October 2014.*

Annexe D: Guidance and criteria documents reviewed

The GMC provided the research team with versions of its guidance and criteria that were in force during our case file samples' progress through the FtP procedures.

Current versions of many of the documents are available online: http://www.gmc-uk.org/concerns/the_investigation_process/decision_makers.asp

- *Five Year Rule Aide Memoire*
- *Five year rule - Final approach*
- *Guidance for dealing with queries on unregistered doctors*
- *Guidance on categorising Stream 1 and Stream 2 cases*
- *Triage decision making process map*
- *Public Interest Guidence*
- *Guidance and procedure for dealing with adverse information received during an investigation*
- *Guidance on Convictions Cautions and Determinations*
- *Rule 12 - Review*
- *S30 5 Decisions - Siebel Guidance*
- *Guidance on authorising administrative erasure for doctors with fitness to practise concerns*
- *Voluntary Erasure Applications - Operational Guidance*
- *Stream 2 Investigation Manual*
- *CE Decision Guidance - Making decisions on cases at the end of the investigation stage*
- *CE Decision Guidance - Annex A - The Meaning of Fitness to Practise*
- *CE Decision Guidance - Annex B - Realistic Prospect Test*
- *CE Decision Guidance - Annex C - Interim Orders Panel Guidance on Referral*
- *CE Decision Guidance - Annex D - Convictions Guidance*
- *CE Decision Guidance - Annex E - Undertakings*
- *CE Decision Guidance - Annex F - Examples of failures to meet standards that may lead to GMC action*
- *Guidance on warnings*
- *Guidance on warnings - Annex A*
- *Guidance for decision makers on dealing with voluntary erasure applications*
- *Guidance for decision makers on assessing insight when considering whether undertakings are appropriate*
- *Guidance on assessing evidence of insight in consensual disposal cases Supplementary paper*
- *Guidance for decision makers on assessing risk in health cases*
- *Glossary of terms used in Fitness to practise actions*
- *Undertakings bank*
- *Guidance for case examiners on whether to issue undertakings or warnings following an Investigation Committee hearing*
- *Guidance for case examiners on cancelling an Investigation Committee hearing under rule 28*
- *Extracts from triage manual*
- *Good Medical Practice* (2006 and 2013 editions)

Annexe E: Research notes template

Researcher:

Decision point:	☐ Triage ☐ End of Stream 2 ☐ End of Investigation (Stream 1)	
Identifier:		
Decision:		
Decision-makers involved:		
Source of enquiry:	☐ PAPC ☐ MoP	☐ Other ☐ GMC
1) Source of enquiry (Details):		
2) Content of enquiry:		
3) Evidence included in bundle:		
4) Decision rationale:		
5) Other potential outcomes considered but discounted:		
6) Other potential outcomes not considered:		
7) Other notes:		

Annexe F: Ethical approval letter

RESEARCH WITH PLYMOUTH UNIVERSITY

24th July 2014

CONFIDENTIAL

Sam Regan de Bere
Peninsula Schools of Medicine and Dentistry
Portland Square
Drake Circus
Plymouth
PL4 8AA

Dear Sam

Application for Approval by Faculty Research Ethics Committee

Reference Number: 13/14-244
Application Title: **Review of decision-making in the General Medical Council's fitness to practise procedures**

I am pleased to inform you that the Committee has granted approval to you to conduct this research.

Please note that this approval is for three years, after which you will be required to seek extension of existing approval.

Please note that should any MAJOR changes to your research design occur which effect the ethics of procedures involved you must inform the Committee. Please contact Sarah Jones (email sarah.c.jones@plymouth.ac.uk).

Yours sincerely

Professor Michael Sheppard, PhD, FAcSS
Chair, Research Ethics Committee -
Faculty of Health & Human Sciences and
Peninsula Schools of Medicine & Dentistry

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Professor Michael Sheppard
CQSW BSc MA PhD AcSS
Chair, Faculty Research Ethics Committee

Annexe G: Coding scheme

This coding scheme was developed from the Guidance and Criteria documentation initially and then developed further during the review of case file data. Indented codes are 'children' of the 'parent' code they nest under. Some but not all of the parent codes aggregate the coding from their 'child' nodes.

Name	Sources	References
Adverse information	20	50
Allegations	207	956
Abuse of trust	4	8
Clinical or treatment	124	277
Communication or interpersonal skills	50	104
Convictions, cautions and determinations	18	42
Dishonesty	53	119
Gravity of allegation	2	5
Health	25	61
Other	33	64
Prescribing issues	13	36
Serious or persistent breaches of GMC guidance on consent etc	22	52
Sexual misconduct or inapproriate relationship	22	49
Unprofessionalism	32	56
Unregistered or unlicensed Drs	8	12
Violence	9	15
Case flags	4	5
Complainants or source of enquiry	204	466
Consent	22	57
GMC	10	18
MOP or Patients	121	207
Other	35	65
PAPC	34	65
Complaint - method	2	2
Email	41	42
Hard copy form or letter	31	38
Helpline or phone	9	10
Online form	40	44
Complexity or ambiguity	3	9
Consequences of alleged behaviour	51	93
Criminal investigations or court proceedings or other regulators	84	320
External or local inquiry	66	203
Decision point	1	1
Registrar refer direct to panel	4	16
Stream 1	73	460
Agree undertakings	14	41
Close	42	130
Close with advice	10	28
Other	1	1
Refer to MPTS FTPP	13	78
Voluntary Erasure	4	7

Warning	13	39
Stream 2	35	106
Close	32	71
Open GMC investigation	3	18
Triage	113	239
Close	63	94
Open GMC investigation	43	87
Refer to Employer	14	28
Doctor	20	95
Age	7	10
Ethnicity	9	10
FTP history	57	102
Gender	10	14
Health	15	67
Insight	30	75
Legal representation	34	111
mitigation	12	20
PMQ	19	31
remediation	26	99
Response to complaint	55	170
Specialty or role	107	213
Emerging themes	0	0
Already complained elsewhere	63	152
Altruism	7	10
ATOS or DWP or Med Reps	11	15
Cancer diagnoses	12	22
Death and the grieving process	15	35
Dr vs dr disputes	24	56
End of life care or care of the elderly	12	24
Language or articulacy	32	46
Maternity or antenatal care	5	6
Mental health care	13	17
NHS vs private	1	1
Patient expectations of medicine	15	26
Patient, cpl, and others refs to guidance etc	16	32
References to other HCPs	9	16
Employers	101	354
Examples	7	26
Fairness	1	1
GMC activity	21	47
Discord between GMC staff	15	21
ELA or ELS	9	18
Expert Report	34	153
Critical of note-taking	4	9
GMC facilitation of complaints	18	23
References to guidance and criteria or case law	88	426
Good Medical Practice	46	113
Realistic prospect test	57	137
Request CE advice	48	99
Rule 12 Review	6	14
Seeks outside assistance	5	38
Signposting	31	32

GMC staff	88	701
Case Examiners	81	322
Deputy Registrar	1	1
Internal Legal advice	17	58
Investigation Committee	7	31
Investigation managers	15	50
Investigation Officer	29	136
Registrar or assistant registrar	24	88
High profile cases or publicity	7	18
Impairment	50	299
Conviction	7	13
Determination by another regulatory body	4	9
Health	15	55
Misconduct	32	89
Performance	12	45
Particulars or charges	18	66
Public interest or safety or public confidence	45	120
Revalidation or appraisal etc	29	48
Standards or ethics or professionalism	3	10