



The effects of having restrictions on practice or warnings

Research Report for the GMC

November 2015

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

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1. Executive summary

This initial section summarises a research study carried out with doctors, who had been given a warning, undertakings or conditions between 2006-2013 and a range of employers of doctors. The research examines their experiences following the issue of a warning or a restriction on their practice and concentrates particularly on how well these sanctions and warnings meet their objective of enabling reflection and remediation to help improve doctors' practice.

The research study is based on relatively small samples which were self-selecting. It seems likely that doctors were more inclined to take part if they had an experience which they were particularly motivated to share and it therefore cannot be assumed that the findings accurately reflect the wider experiences of doctors who chose not to participate. Nevertheless, much of the feedback is very consistent and, as such, it raises some important issues for the GMC and others to consider.

1.1 Key findings

Warnings

Warnings are one of the lowest levels of response available to the GMC following a fitness to practise (FtP) investigation. They do not indicate that a doctor has impaired fitness to practise; instead they direct a doctor towards better practice in the future.

This research has uncovered a good deal of evidence that suggests severe and long-term impacts are occurring for many doctors receiving warnings from the GMC. Many who received warnings report that their current and ongoing employment is adversely affected. Some have been unable to work again at all.

Only a small minority of the doctors interviewed who had received warnings attributed positive behaviour change to the receipt of their warning. Positive behaviour change that is reported, is often seen as being a response to the original issue or the mistake that led to the FtP investigation; or as a response to the investigation process itself, rather than as a response to the warning per se.

Employers react to warnings in a variety of ways. In some cases warnings are ignored or even ridiculed. At the other extreme the receipt of a warning leads to the end of the employment relationship with the doctor in question.

Both employers' and doctors' suggestions for improvements to the system of warnings centre particularly on suggestions of more sophistication and flexibility. Differentiation is seen as important between different types of cases, different settings and in response to the individual doctor's response to the FtP

investigation. Questions are raised about the appropriateness of warnings always being on a doctor's record and in the public domain for five years.

There were also calls for the terminology of 'warnings' to be changed as this word is felt to suggest something far more serious and dangerous to the public than is actually the case.

The research raises questions about whether the system of warnings (and sanctions) needs to be more flexible so that they can be better tailored to individual doctors and the different situations that they work in. It should be noted that the GMC is already taking forward and developing a new warnings model, which may require legislative change.

Undertakings and conditions

Undertakings and conditions are applied in cases where the FtP investigation indicates that a doctor's fitness to practise is impaired but that it should be possible for a doctor to remediate and return to full fitness to practice. Whilst some of the stories uncovered in this research do describe a process of successful remediation, this is only in a small number of cases. For many of the doctors interviewed, the undertakings and conditions were unworkable and remediation was not possible, meaning that the doctor's failings have led to the faltering or even the end of a doctor's practice and career.

It appears that restrictions on practise are more likely to achieve successful remediation in health cases, than is true for performance or misconduct cases. There are a number of reasons why this is the case; one key reason is that it appears that doctors with health issues are more likely to accept and proactively engage with the restrictions put in place, than is true for performance or misconduct cases. In addition, colleagues and employers tend to be more supportive of doctors with health-related undertakings and conditions than is the case for doctors with performance or misconduct related cases.

Whilst undertakings are meant to be voluntarily agreed to, this is often not how they are perceived. In many cases there appears to be little difference, in reality, between conditions and undertakings since those with undertakings have often only accepted these under the strong direction and advice of their medical defence organisation.

Where a positive picture of remediation has been described, this has not been without negative personal impacts arising from the stress of the FtP process and the additional external and public scrutiny that the doctor has to work under.

The research further indicates that employers do not always believe that remediation is possible for doctors who have accepted undertakings or been

given conditions on their practice. This can make it difficult for doctors with restrictions upon their practice to secure the supervision set out by the GMC. It also leads employers to question who should be funding remediation and what their responsibilities are for ensuring that it happens. There is clearly opportunity to engage health services in a wider debate on remediation.

Those interviewed made a number of suggestions for improving the system of undertakings and conditions. These centred on the need for greater dialogue between all of the parties involved in order to ensure that the restrictions are much more individually tailored; are workable in practice and; (whilst still ensuring safe practice) have as much buy-in as possible from both doctor and employer.

1.2 Methodology

Findings are based on both qualitative and quantitative research conducted during April – July 2015.

A qualitative approach was taken in order to explore the issues at length and on an individual basis with both doctors and employers. This resulted in:

- 14 interviews with doctors who had received warnings from the GMC.
- 26 interviews with doctors who had received undertakings or conditions from the GMC:
- 21 interview with employers

This qualitative research was followed by an online survey with doctors. This resulted in:

- 42 responses from doctors with warnings
- 57 responses from doctors with conditions or undertakings

Given the low numbers and the opt-in nature of the sample, it is not possible to claim any level of statistical reliability for the results. Instead the quantitative results have been used to amplify and provide additional evidence for the qualitative findings.

2. Background, objectives and methodology

2.1 Background

This research is part of an ongoing programme of work undertaken by the General Medical Council (GMC) to ensure that their fitness to practise procedures are fair, consistent and robust. The GMC identified that they have little robust evidence about the impact of ‘warnings’ or restrictions on practice on doctors, and have limited information on what their experiences are of receiving a warning or restriction on their practice.

Given the current pressures on the NHS, it is very important to ensure that as many doctors as possible are retained within the system, whilst at the same time keeping patients safe. Warnings and restrictions play a key role in this overall objective as long as they are working effectively and having a positive impact.

The GMC, therefore, commissioned Community Research to explore the views and opinions of doctors who have received a warning, agreed to undertakings or been subject to conditions and of employers responsible for managing doctors working who have received warnings or restrictions, at a local level.

The GMC’s Fitness to Practise procedures are summarised in Figure 1.

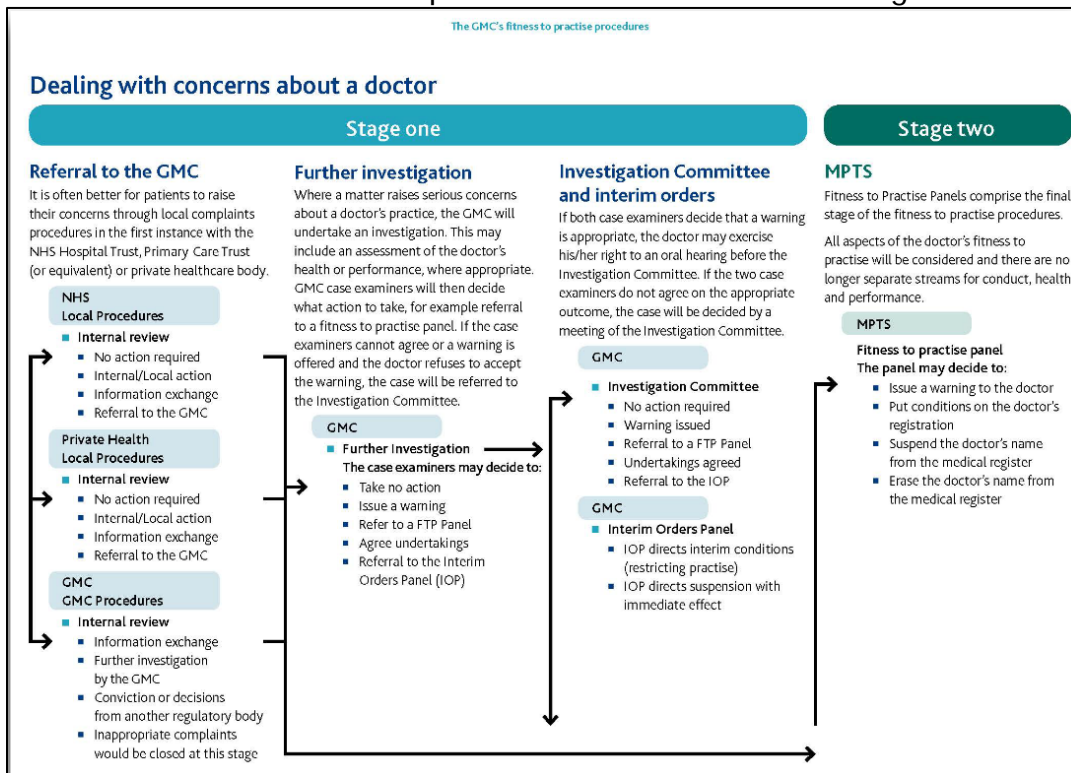


Figure 1: Summary of the GMC's fitness to practise procedures¹

¹ Source: The GMC's fitness to practise procedures factsheet – English Version.

As can be seen from Figure 1, warnings may be issued either following an investigation or as a result of a Fitness to Practise panel hearing; undertakings on the other hand are only agreed following an investigation; whilst conditions are only ever an outcome that arises from a full Fitness to Practise panel.

The GMC is keen to develop an evidence base around the impact of restrictions on practice or warnings and how they relate to future adherence to their standards and the risk of future repeat impairment.

2.2 Research objectives

The overarching aim of the research is to identify the short and medium-long term impact on doctors (and their clinical work) who have restrictions on their practice or who receive a warning from the GMC. Specifically, it has the following objectives:

- To explore the impacts that warnings and restrictions have on doctors' professional work and adherence to professional standards, and the risk of future breaches of standards;
- To explore the impact this might have on patient safety;
- To understand:
 - The impacts on doctors' lives, including their health, relationships, and the reputation of the individuals subject to a warning or restrictions; and;
 - Whether doctors see these outcomes as proportionate.

2.3 Methodology

Initial recruitment and screening

All doctors who had received a warning or restriction between 2006 and 2013, with a number of exclusions², were sent an invitation by the GMC to participate in the research and asked to contact Community Research if they wished to do so.

In total 2,430 doctors were included in the invitation (2,217 were approached by email and 213 by post.) They were then asked to complete a short 'screening' questionnaire which asked some basic factual and demographic questions, in order to allow for the selection of a broadly representative mix of doctors within the qualitative stage. They were offered the alternative of telephoning the researchers if they preferred not to respond online.

² Doctors who are currently involved in ongoing litigation with the GMC and those on the GMC's 'stop communications' list were excluded. For example, the 'stop communications' list includes vulnerable individuals for whom it may be detrimental to receive research requests.

A total of 152 completed the online screening questionnaire and a further two doctors contacted the researchers to provide their details on the telephone. This represents an initial response rate of just over 6%.

Qualitative phase

A qualitative approach was taken in order to explore the issues at length and on an individual basis. An appointment for a telephone interview was made with those doctors who were selected to take part. A mix of doctors by demographics and outcome was selected, the final profile of those interviewed is provided in Appendix A. Participation in the research was on a confidential basis and at no point were the GMC provided with details of individual doctors who took part.

In terms of employers, the GMC contacted Responsible Officers to ask them to either to participate in a telephone interview themselves or to nominate someone else within their organisation. Interviews were conducted with responsible officers (ROs), deputy ROs, recent ROs, and senior colleagues reporting to ROs representing a variety of organisations including secondary care, primary care (NHS), private providers and the Ministry of Defence.

In total, the following interviews were completed:

- 14 interviews with doctors who had received warnings from the GMC.
- 26 interviews with doctors who had received undertakings or conditions from the GMC:
 - Of these, 17 interviews were doctors with undertakings and 9 with doctors with conditions.
 - Of the 26 interviews with doctors with restrictions on their practice, 11 were health related, 9 were performance cases and 2 were cases of misconduct. A further 4 cases amongst those with conditions/undertakings were based on a combination of health issues leading to or coupled with misconduct or performance.
- 21 interviews with employers.

Interviews followed a semi-structured discussion guide in order to allow participants to elaborate on and discuss their views and perceptions freely. The discussion guides used are provided in Appendix B. Interviews were audio-recorded with the participants' permission and fully transcribed to aid analysis.

The qualitative phase took place from the end of April through to mid-June 2015.

Quantitative phase

The ten minute questionnaire was designed and then tested through a cognitive pilot with a number of doctors who had received warnings or restrictions. Six doctors (who had previously taken part in the qualitative phase of research) were emailed the draft survey questionnaire and asked to complete it and then

to provide detailed feedback to a researcher. This took the form of a telephone conversation, running through each question and discussing how it might be improved. There was a particular focus on areas of ambiguity, confusion and also on any gaps in question areas that doctors felt may be important. A copy of the final questionnaire used is provided in Appendix B.

All those doctors who had previously expressed an interest in taking part in the research by completing the screening questionnaire were sent an email with a link to the survey. The sample included those who had already taken part in the qualitative phase. Respondents were also given the option to request a postal version of the survey if they preferred to complete a hard copy.

In total, 151 doctors were sent the invitation link and one doctor requested and was sent a hard copy version of the questionnaire. 99 doctors responded, representing a response rate of 65%. In total, 42 respondents were doctors with warnings and 57 were doctors with conditions or undertakings.

This phase took place during the calendar month of July 2015.

Analysis process

By its nature, qualitative research generates a large volume of data. In this case, all of the interviews were audio-recorded (with the participant's permission) and then transcribed in full. An important part of the research process is, therefore, to try to organise the material in a way that allows themes and patterns in the data to be drawn out.

A grid analysis approach was used, which facilitates analysis across and between interviews. Each participant was allocated a row on a spreadsheet with notes and quotations from that interview being entered in the sheet. The themes, broken down into smaller sub-themes, were arranged across the top of the spreadsheet. When the analysis sheet was completed, it was possible to see the totality of one person's experience by reading across the row, or the totality of the entire sample's views on a particular theme, by reading down the column.

Several researchers undertook analysis independently and simultaneously, and compared results to ensure consistent interpretation. Prior to reporting the entire team of researchers met to develop the themes and structure for reporting.

2.4 Notes on reading the report

There are a number of caveats that should be borne in mind when considering the research findings.

It is worth noting that the doctors who participated in this research 'opted in' to the process and actively responded to communication about the research saying that they were willing to participate. It could be that those who opted into the process are different in some way (in terms of their experiences or views) than the majority of those invited who elected not to participate.

The vast majority of doctors who go through the FtP process have not chosen to do so (although some self-referrals do occur). The nature of the process generally means that a doctor has had a complaint made about their practice or a negative event has led the GMC to investigate the doctor. As such, it is to be expected that doctors will not view the experience positively. Whilst doctors were asked to be objective and to feed back on the impact of the warnings and/or restrictions rather than the details of their own case, it should be recognised that, for many, the process and the case will have been a distressing experience and something that they wished to focus on.

There are also a number of challenges associated with identifying the impact of warnings and/or restrictions on behaviours and practice:

- Doctors may find it hard to retrospectively assess whether behaviour change has occurred or not.
- Doctors only provide their own side of the story. Whilst we did speak to a number of employers, they were not the employers who managed the doctors that we interviewed.
- The full impact is not always known at the time of interview.
- Finally, it was apparent from both employers and doctors that, in many cases, it was difficult to differentiate between the impacts of the sanction, the FtP case and the original incident/error/issue.

Throughout the report, doctors who took part in the qualitative phase are termed 'participants' and those who took part in the quantitative phase are termed 'respondents'. Findings are derived from the qualitative phase unless it is explicitly stated that they are based on the quantitative survey.

Since only 99 responses were received to the quantitative survey and within this report much of the time results are analysed by key sub-groups (i.e. those with warnings or those with restrictions) within that number, raw numbers, rather than percentages have been used throughout. Given the low numbers and the opt-in nature of the sample, it is not possible to claim any level of statistical reliability for the results. Instead the quantitative results have been used to amplify and provide additional evidence for the qualitative findings.

3. Employers' responses

Section highlights:

- Employers' reactions to both warnings and restrictions is dependent on a number of factors that interact with each other in a complex and individualised way. Amongst others, these factors include:
 - The nature of the case.
 - The quality of the doctors' prior relationship with the employer.
 - The attitude of the doctor involved.
 - The health setting the doctor is working in.
 - The specialism of the doctor.
 - The risk to organisational reputation.
- Depending on the factors involved, the employer may choose to do anything from overlooking a warning, fully accommodating any restrictions, through to terminating their relationship with the doctor.
- Undertakings and conditions naturally have more implications for employers than warnings, not least in terms of the resources involved in supporting remediation.

The stigma and embarrassment of receiving *any* form of sanction from the GMC was talked about by one secondary care employer in relation to the more informal aspects of employer and organisational responses. They explained:

"I think every case is different and it depends very much on the nature of the sanction. It's going to sound a bit odd, this, but there's usually a whole degree of embarrassment about somebody that's got a condition or a warning so...I think there's a whole general embarrassment about it, yes, so it's quite difficult to talk about, but it's one of those things that everybody knows but nobody is talking about sort of thing." (Employer)

3.1 Employers responses to warnings

A wide range of employer responses to warnings was described, as illustrated in Figure 2 below:

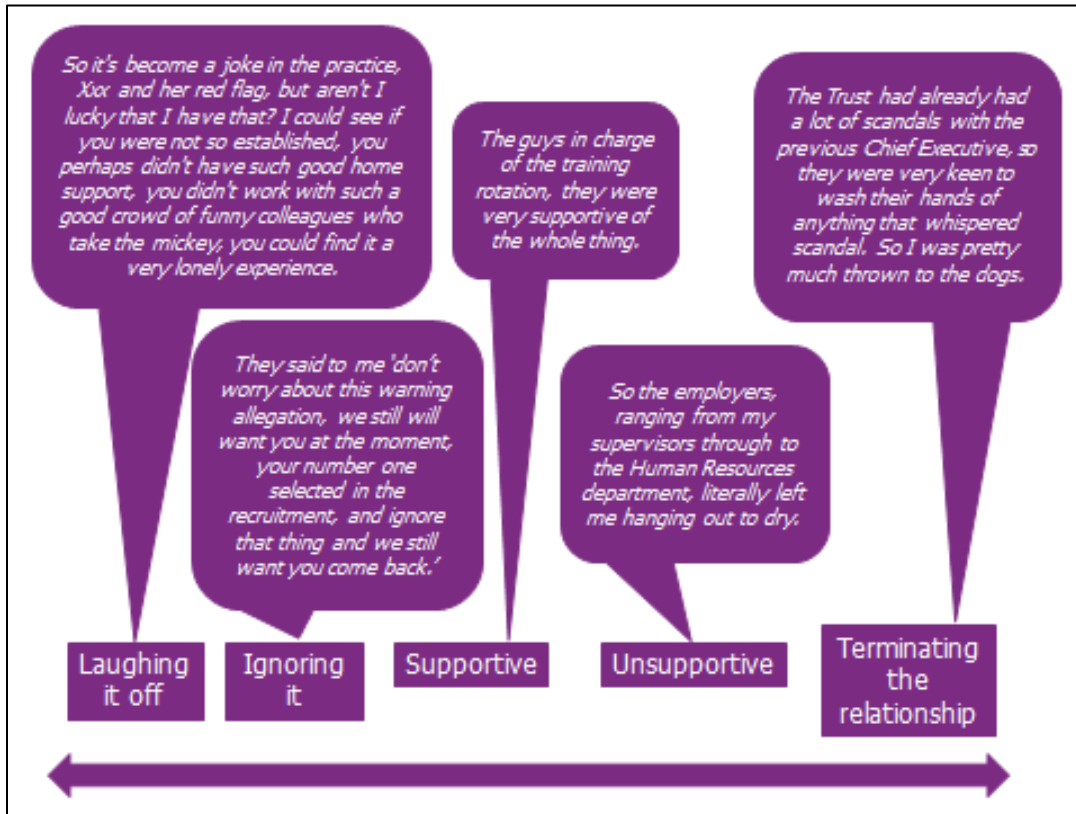


Figure 2 – The Range of Employer Response to Warnings

For those doctors who remained in the same post, the employer response varied considerably, with some indicating that they provided greater levels of supervision or monitoring. Some employers talked about making arrangements for chaperones and support, likely to have been part of their own or a parallel NCAS assessment. One RO, based in a secondary care setting, explained regarding warnings specifically:

".....it's a message to me that this individual needs particular support. I have to make sure that they are not going to put themselves in the firing line for disregarding the warning. I have to look at what the warning is and make sure that can be applied. So I speak to that individual and I speak to the line manager so we can make sure; so if it is a warning and they have to be chaperoned or whatever then we'd go through how to put that in place."

Interviewer: *In my understanding, if they've been given a warning, you don't have to do anything with their practice?*

I would still speak to them. I would invite their line manager and the clinical line manager there, because there's a potential for them to have this highlighted by

people who find it out, and not to put them in danger of breaking whatever warning they've got. So I would discreetly make it known with the clinical line manager and see if we needed to do anything."

(Employer)

Conversely, for an NHS England RO, warnings were something which were logged for the purposes of revalidation and appraisal, but for which there were no additional resources to follow up beyond this.

Of course the employers' reaction is also partly related to employers' involvement in the case referral. Employers have often referred the doctor in the first place. In fact, 9 of 42 doctors with warnings who responded to the quantitative survey had been referred by their employer and a further 6 by a work colleague or other fellow professional.

Employer responses to the provision of warnings by the GMC appear to be determined by a number of different factors, including:

- **The nature of the case and whether or not the issue is something that colleagues and employers feel sympathy with.** Employer reactions were impacted by the nature of the issue that had led to a warning. Where colleagues and employers felt that the warning had been given in response to a minor issue; an issue that did not relate to clinical performance and/or an issue that others felt they themselves could easily have fallen foul of, the reaction tended to be more sympathetic and supportive. For example, one warning was received for late payment of GMC fees (and continuing to practise whilst not on the register) and another for a one-off drink-driving conviction - in both of these cases the doctor reported that employers at the time, and new employers since, have been very relaxed about the existence of the warning, more or less disregarding it as irrelevant to the doctor's abilities.

Less sympathetic cases (e.g. warnings because of inappropriate touching of/text messaging to colleagues) and/or cases that are more closely related to clinical skills and outcomes (cases that have resulted in the death of or late diagnosis of a patient) were less likely to engender such sympathetic and supportive reactions.

- **The position of the doctor within the organisation and the quality and nature of the relationships within that organisation.** Where doctors who had received warnings were senior partners in GP practices or were well established and in senior positions, the reaction of the employing organisation appears to be more supportive. The existing relationships between the doctor and their colleagues within the organisation are vitally important. Where a doctor is trusted and respected prior to the warning this

stands them in good stead to receive support from their employer (depending on the nature of the case.) Having said this, at least one of the doctors who received a warning received it because the case (as they perceived it) had been concocted by the other partners in their shared GP practice as a way of ousting them from the practice; clearly in this case the employing organisation was not supportive.

A strong message from employers across settings was that an employer's response often depended on an individual doctor's orientation toward the complaint or issue. If they were able to reflect and were proactive about seeking help and support they were likely to be treated more favourably than those who denied that there was a problem, avoided communication with their employer, or who were seen as 'difficult'.

The importance of the relationship with the employing organisation has strong implications for those who receive a warning and are working as a locum. Relationships for locums with existing employers are naturally more tenuous and less well-established. One locum recipient of a warning explained that the existence of a warning on their record resulted in 'near bankruptcy' and ultimately had led this doctor to have to change career paths in order to continue working at all.

- **The reputational risk for the organisation and the level of external (including press) interest in the case.** The perceived reputational risk to the organisation of a warning appears to impact significantly on the employer's reaction. This seemed to be particularly the case within large secondary care organisations. Cases receiving press attention and which result in a good deal of external scrutiny for the organisation, appear to make it more likely that the doctor will be left unsupported or will even be managed out of the employing organisation.
- **The availability of the particular skills of the doctor in question.** It also appears that if a doctor who receives a warning has skills and abilities that are in particularly short supply, the employer's reaction is less likely to be severe since they have a stronger drive to preserve the employment relationship with that doctor.

These various factors that impact on the reaction of the employer interact with one another in a complex and individualised way. For example, a well-established and very senior doctor with 30 years' history in an organisation was not supported by their employer because (despite their seniority and the quality of the relationships they had established) of the extremely serious nature of the case that ultimately led to his warning. The employer's lack of support in this case was also in part due to the external and press interest that the case

attracted, because it related to the death of a patient and had, even prior to the GMC investigation been subject to a high profile inquest. Whilst the GMC outcome was a warning, the ultimate outcome for this doctor was termination of the employment contract through enforced early retirement.

Reflecting the varied employer responses identified in the qualitative interviews, the quantitative research revealed that 12 out of 30³ doctors who continued to practise after receiving a warning felt their employer 'not very supportive' (2) or 'not supportive at all' (10) following the determination in their case; whilst 11 of these doctors described their employer as 'quite supportive' (4) or 'very supportive' (7).

3.2 Employers' responses to undertakings and conditions

As with warnings, doctors reported a wide range of responses from employers towards their undertakings/conditions – from fully supportive through to terminating the relationship. These are set out in Figure 3. Again, the employers' reaction is likely to be partly related to employers' involvement in the case referral. In fact, 26 of 57 doctors with restrictions, who responded to the survey, had been referred by their employer and a further 12 had been referred by a work colleague or other fellow professional.

The employers' reactions to the restrictions were influenced by a number of factors, many very similar to those set out in section 3.1. However, clearly, for all employers a doctor with undertakings and conditions usually has significantly more implications in terms of the provision of support than for a doctor with a warning.

³ Due to a routing error at the launch of the questionnaire a small number of respondents missed this question, the base size given is the full number answering the question.

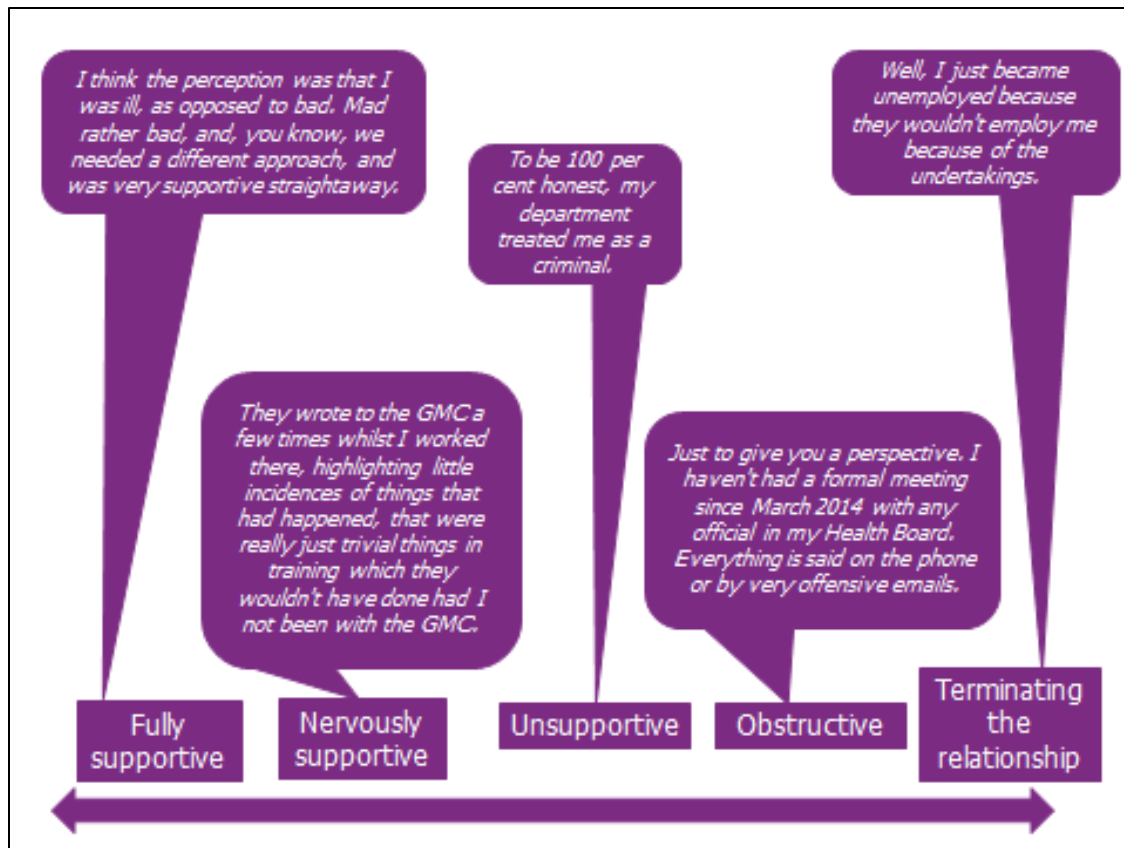


Figure 3 – The Range of Employer Response to Undertakings / Conditions

Approximately half of the doctors interviewed in the qualitative research who had conditions or undertakings did not return to work with their original employer as relationships had broken down, either due to the original incident or during the subsequent FtP case.

Therefore doctors' views of employer reactions to existing restrictions necessarily cover the reactions of both existing and new employers.

In common with warnings, a number of different elements were important influencing factors as to the likely reaction of employers. Many of the influencing factors are similar to those outlined for warnings but with some nuances and differences also apparent:

- **The nature of the case / issue.** There was generally more sympathy and support shown towards doctors with health related undertakings/conditions. In general doctors with health related undertakings/conditions were more likely to report that their employers had been sympathetic and supportive of their situation. However, this is by no means universal and in some cases relationships with employers had terminated before undertakings/conditions were even imposed.

"I think the perception was that I was ill, as opposed to bad. Mad rather bad, and, you know, we needed a different approach, and was very supportive straightaway." (Doctor, Health, Undertakings)

Doctors with performance related undertakings and conditions were most likely to report a difficult relationship with employers, with some of them unable to secure the supervision they needed to be able to continue practising.

Across settings employers themselves also reflected that there tended to be more positive, supportive responses to health related cases, than to performance or misconduct related cases where wider reputational risks might be more difficult to manage, and where supervision requirements might be more challenging to arrange. There was a sense among the employers that doctors who were sick, had addiction problems, or mental health problems, were more likely to successfully remediate than those with complaints related to misconduct and interpersonal communication. It was also easier to put in place supervision arrangements, for doctors to seek clinical and psychological help for health related issues (with the GMC providing a medical supervisor), than performance or misconduct related ones.

- **Position of doctor and existing relationships.** Doctors who reported being totally 'open' about their conditions/undertakings and how they came about were more likely to report a positive employer reaction – from both current and future employers.

"Actually I feel all the jobs I've done have been very supportive. Although I would say there is still a stigma about mental health in the NHS, most of the time they have been understanding. I openly say that my problems were due to mental health issues and they've been very supportive of that." (Doctor, Health, Undertakings)

Conversely, doctors who described having complex relationships with the employer and work colleagues were also more likely to describe difficulties associated with working under conditions/undertakings.

The central importance of this prior relationship with the employer was particularly relevant in cases where the doctor perceived that the employer had purposefully instigated the GMC FtP process in order to oust them from the organisation. A number of doctors believed that the process had been used against them in this way – see Text Box on page 16.

- Related to this, **from the employers' perspective, the doctor's own attitude** was perceived to be a very important factor in determining the employer's reaction and the response of colleagues, in the words of one employer:

"If they want to remediate then you tend to have colleagues quite willing to help with that". (Employer)

This was also borne out by the quantitative survey results. Doctors who agreed that their case was justified; the outcome reasonable and/or the consequences proportionate; were more likely to agree that their employer was supportive at the time of the determination than other respondents. For example, half (12 out of 24 doctors) who felt that the outcome of their case was 'a reasonable response to the issues involved', described their employer as quite or very supportive. This compares to just under a third (12 out of 44) of doctors who felt that the outcome was unreasonable saying that their employer was very or quite supportive.

Text Box – Employer abuse of the FtP process?

In some cases it was suggested that employers did not support a doctor with sanctions because they had deliberately used the FtP process against that doctor. Several doctors believed that they had been reported to the GMC by malicious colleagues/employers who were manipulating the FtP process for their own agendas. These included:

- To oust a GP partner out of a practice, where other contractual routes would have been too costly.
- As revenge on doctors for raising concerns about clinical practices in their place of work.
- As part of ongoing bullying or victimisation in the workplace.

These doctors explained that regardless of the eventual outcome of an FtP case, a doctors' reputation is sufficiently damaged by the process to have a negative impact on their career and ability to practise. Therefore, those making false allegations through the FtP process could not lose.

"They were trying to remove some of my rights and penalise me financially and I objected. This matter, naturally because having ganged up against me, they expelled me from the partnership only to discover that our contract was a mutually exclusive one. We all had to work together. In order to exclude me further they then proceeded to write all sorts of things to the General Medical Council about me because if I then lost my right to practise - my license - then I could not have any right to the contract with the PCT. That was the basis of everything." (Doctor, Performance, Undertakings)

Several further doctors with health related sanctions expressed concern that their employer had reported them to the GMC without any attempt to resolve their health issues locally. They felt that by escalating the issue to the GMC that employers avoided having to spend time, effort and resources in addressing the needs of individual doctors.

"No, I have a lot of feelings about that Trust, they weren't particularly supportive and there were a lot of steps that they should have taken before reporting me to the GMC that I don't feel that they took. There's a Doctor in Distress programme, they didn't seem to go down that route at any point, certainly not to my knowledge, and jumped to refer me to the GMC in my opinion." (Doctor, Health, Undertakings)

"I think they knew that I wasn't coping with that job, I'd written a number of letters to them saying that I was trying to do two people's jobs and it was very stressful, and they knew I was under a lot of stress and they didn't do anything." (Doctor, Health, Undertakings)

"He refused to send me to counselling and everything else and eventually took me out, said I was questioning his judgement so he then went to the trust and told them I wasn't cooperating with the alcohol policy, which he wouldn't give me.....I'd had no communication at all from management, apart from some letters saying why hadn't I handed this form in or that form in. Then I got a phone call....saying they had reported me." (Doctor, Health, Undertakings)

- **Health care setting.** Doctors working as GPs often felt that it was more difficult for them to continue working with undertakings/conditions than might be the case in a hospital setting. They explained that even if a practice was willing to work with a GP they often didn't have the expertise to provide the required supervision. The more intimate nature of a primary health care setting also appeared to make working with conditions/undertakings a more uncomfortable experience for the individuals involved.

Doctors believed that locum agencies found it particularly difficult to accommodate doctors with undertakings/conditions, and that work offers dried up as a result.

In contrast, doctors working within hospital settings, particularly more junior doctors, reported how their employer had procedures in place to be able to deal with GMC undertakings/conditions and the supervision required.

"My medical director, basically, delegated sort of workplace supervision, who was happy to take on that role. So that side of things worked quite well, because I think it works - I mean, you think you're an individual when these things happen, it's only happened to you, but actually it's happened to loads of people, and within my trust I'm sure there are loads of others, and so the trust has got it a bit sort of off-pat, if you like, ...so the mechanics of the supervision sort of went okay from the conditions point of view." (Doctor, Health, Undertakings)

However, in two instances, large hospital trusts had placed restrictions on their surgeons, over and above those set out by the GMC. Doctors believed that there was a greater willingness to supervise the work of junior hospital doctors but that a number of factors came into play when it came to supervising the work of consultants – namely, the time and resources available to the hospital, the willingness of doctors to take on the responsibility of supervising senior colleagues, the reputational risk to the organisation.

The three NHS England-based regional employers we interviewed explained the particular difficulties in effective employer response, and provision of supervision to support remediation caused by the fact that many primary care GPs are self-employed. Organisational and structural differences between primary and secondary care made the provision of continued employment, if appropriate, and arrangements for supervision, if and when necessary, more challenging in primary care. One employer also felt that problems were more likely to present late in the case of GPs, than in secondary care where more collegiate working practices, and clear line management meant that any problems in a doctor's health, or clinical practice, might be more likely to come to light earlier rather than later.

One employer reflected that NHS England can also place conditions on GPs and that these can differ (and sometimes contradict) those placed by the GMC. Indeed, across settings the challenge of potentially multiple processes of an employer, NCAS and Royal Colleges potentially investigating a case prior to it being referred to the GMC for a summative assessment were flagged. One employer felt that this meant the system can be extremely confusing for doctors, who often have a poor understanding of the details, and implications of these parallel processes.

Arrangements and funding for any remediation support for GPs appeared to vary across regions. For example, some NHS England employers explained that doctors had to fund their own support, while another explained:

"There is a temporary policy that NHS England have about funding and at the minute it's up for negotiation but we would probably fund, if we think they're remediable, a 50/50 remediation package." (Employer)

Different area teams appeared to have different approaches, and resources assigned to supporting remediation. One employer explained the situation in her area:

"...we have Performer's List regulations that we function to, and, as an area team, we were recognised as having a slightly different approach. The GMC's ELA describes us as being nuanced rather than formulaic, is what he sort of said. We've always taken an educational remediation approach from the beginning because, no disrespect to the GMC, their processes take forever and, while they're doing what they're doing, the majority of doctors that they deal with are still doing their day jobs." (Employer)

- **Specific issues in the private sector and in the Ministry of Defence MoD)**⁴ led employers in those sectors to react somewhat differently. One doctor who ran a private clinic described how he had lost a number of patients since having his undertakings, as his employer would not fund referrals to doctors with undertakings. He felt that this had a detrimental effect on his relationship with his private employer, and whilst the private hospital continued to employ him he was unsure how long this would last.

Several private healthcare employers/ agencies reflected that their response to undertakings and conditions requiring some form of supervision was likely

⁴ This interviewee has given explicit permission that their organisation may be identified in the report; despite the fact that this may reveal the participant's identity for some readers.

to be different to that in the NHS and, in many cases, was likely to result in the doctor being unable to work in the private sector. This was either because of the impossibility of meeting supervisory restrictions or because of negative attitudes towards doctors with restrictions.

"So when the GMC has as one of the restrictions the fact they should have a Clinical Supervisor, we basically have to suspend their privileges and stop them from working. If they're fulltime private that's quite a big deal, the GMC may feel they're just putting restrictions on somebody but, as they're restrictions that we can't comply with, basically the person is suspended from work and suspended from earning a living." (Employer)

However, one employer operating in the private sector indicated that they did go out of their way to help doctors remediate but, crucially, only if it is in their interests to do so:

"Well, it's interesting, you see, the doctors I'm talking about are working in an Out of Hours Service where recruitment is difficult so it's in our interests to, if we think a doctor is rescuable, to help rescue him." (Employer)

At the same time, in comparison to larger trusts and NHS England, the fact that the private provider was operating across a relatively smaller system seemed to allow for more dialogue between the RO and doctor in question, and indeed between the provider and the GMC. The provider explained that they met regularly with their GMC Employer Liaison Adviser (ELA) to discuss cases with an eye on prevention of escalation to the GMC.

The RO who was based at the MoD reflected on the balance required in responding to a complaint and potential GMC investigation. It appeared that most cases would have an internal investigation underway prior to being referred to the GMC in a way that wasn't always the case in the NHS or private practice. Similarly to the private provider, the fact that the MoD was more of a self-contained system, with fewer points of contact between itself and the GMC, and other organisations, potentially means better communication about cases.

"Well, there's two angles to it. One is that, because sometimes you see the restrictions and you understand what's happened and you think actually we need to protect patients in this case and you do need to be fairly... you find yourself being very much the employer thinking we need to make sure our organisation is protected, we do the right things. But, equally, you've got to look after the individual doctor as well because they haven't been found guilty yet necessarily, sometimes there's restrictions pending investigation." (Employer)

It appeared that the MoD was also better placed than either the NHS or private providers to coordinate relocation and supervision for doctors with restrictions requiring support.

- **Employer experience of FtP cases and understanding of the nature of warnings and restrictions.** It appeared that responses also depended on the employer's previous experience of GMC cases – both in terms of the organisation, the doctor's line manager and the RO themselves. The following elements were of relevance:
 - Knowledge of GMC processes - whether held by an RO or the employer's HR department.
 - Knowledge of the process and requirements of parallel investigations and assessments that may be carried out by NCAS, NHS England or a Royal College.
 - The level of communication and existing relationships between the RO and the GMC and GMC ELA were talked about as helping to provide some clarity about an employer's response and next steps.

Some employers admitted a certain amount of confusion over where the duty of care lies for individual doctors working with restrictions. Indeed, the responses of secondary care providers being approached to support the remediation of doctors who had received restrictions based on work in other settings appeared to be variable. For example, one RO based in a secondary care setting saw taking on responsibility for a doctor with restrictions as their *'being part of something like the NHS, you have an expectation that you will contribute to the greater cause.'* However, another commented:

"I've been approached three or four times to say: 'can we give this guy an attachment?' But to be honest, the sanctions are so onerous that actually we don't feel we owe a duty of care to this person. So other than general philanthropy, why should we be picking up the bill for supporting this person back into clinical practice when that money is being taken away directly from other people, and possible direct patient care?" (Employer)

In this context, some secondary care employers had concerns that in the case of some Trusts doctors might be slipping through the net; something that was evidenced in our interviews with doctors:

"Either you do it really well and look after these people at great resource cost to the organisation or you go, 'enough'. Then they end up slipping through the net because they're unemployed and nobody wants to employ them so it's very difficult." (Employer)

- **Resourcing issues** are also highly relevant in relation to employers taking on doctors with conditions or undertakings. Some employers were frank

about the assessment that they would make in terms of whether that doctor would be 'worth' the effort and resources needed to support them. Some mentioned the fact that specialisms with shortages were more likely to take on doctors with restrictions than those that were well-staffed, reflecting in turn on the implications of this for the doctor's remediation. For example a secondary care based employer reported:

"I can think of recently going to someone in ED, in the emergency department, where it's virtually impossible to recruit male grades at the moment and where we have agreed to undertake somebody who has quite severe undertakings if he couldn't see any female patients. But given the shortage specialty it is, that we have decided to employ him on a fixed term contract with close supervision." (Employer)

However, the picture is complicated and staff shortages do not always seem to influence employers' responses. For example, an NHS England based employer explained that it can often be difficult for GPs to find alternative working arrangements if they have restrictions on their practice, despite the shortage of GPs:

"Undertakings and conditions, they can make it difficult, because if the doctor's partners decide to get rid of him/her because they're not happy working with somebody who's in this situation, they then have to find somewhere for them to work. Now, even though there's a shortage of GPs out there it's difficult to find work if you've got undertakings." (Employer)

Linked with this, some employers felt that too much resource and time was spent trying to ensure that some doctors are able to continue to practise. In some cases, employers felt that it would be better all-round just to erase or suspend the doctor in question.

"Yes, almost a cry for help really, saying 'we've done all we can here, we have serious concerns about this doctor, we really don't think they should be practising'. Then the GMC spend many many months going through all their procedures and then they send them back out with conditions and you just think 'oh right, well, two years down the line and we're not really that much further forward'... it's easier for them to put somebody on conditions than make a difficult decision to say 'actually your performance is sufficiently below expected standards so we're going to suspend you'." (Employer)

4. Supervision arrangements

Section summary:

- Supervision requirements are not always easily understood by doctors and a significant minority of doctors feel that they are not adequately supported by their employers to set up supervision arrangements.
 - With the obvious exception of medical supervision which is organised by the GMC.
- Employers acknowledge that setting up clinical supervision can be problematic, particularly in terms of identifying suitable and willing supervisors and making the necessary resources available.
 - These issues are compounded if the employer does not agree that the doctor in question is remediable.
- Clinical and educational supervision appear to be easier to organise for those working in secondary care and at a more junior level and more complex for consultants and GPs.
- Overall, doctors are quite sceptical about the overall impact of supervision, with many agreeing that it is humiliating and 'a tick box exercise' rather than agreeing that it improves practice and makes them a safer doctor.
 - That said, medical supervision is welcomed by a significant proportion of doctors in health related cases.
- Employers also questioned how many doctors were able to successfully remediate under clinical and/or educational supervision and questions are asked about who should be paying for doctors to remediate.

Employers and doctors with undertakings or conditions were asked about their experiences of the supervision arrangements associated with restrictions.

4.1 Understanding of supervision requirements

Results from the quantitative survey highlight that just over half of all doctors who had continued to work with restrictions (24 of 45) had found it 'quite difficult' (14) or 'very difficult' (10) to understand what the GMC expected of them in terms of making the necessary supervision arrangements.

Furthermore, doctors interviewed in the qualitative research were not always able to provide an accurate view of the local supervision arrangements in place to support them during their remediation. This was due to a wide range of factors including:

- Time lapse since the restrictions on practice were put in place.
- Multiple arrangements across different workplaces.
- Lack of engagement and sometimes hostility towards the supervision process.

- Perceived lack of distinction and understanding of the different supervisory roles, this is particularly the case for Workplace Reporters.
- Confusion between the supervision offered as a routine part of their job and supervision required as part of the conditions/undertakings, this is particularly the case for junior doctors in training.
- A desire to 'blank out' that part of their lives – particularly if it also relates to a period of poor mental health.
- Difficulties setting up the necessary supervision arrangements.

4.2 Workplace Reporters (for all doctors with restrictions)

Half of (21 out of 42) doctors who were aware that they had required a workplace reporter⁵, said that it was 'very easy' or 'quite easy' to put a workplace reporter in place. When asked to rate the quality of workplace reporting arrangements two thirds (25 out of the 39) of doctors who actually worked under restrictions said that this aspect was 'very good' (12) or 'quite good' (13.)

Doctors within the qualitative research explained that the role of workplace reporter was often subsumed within another supervisory role. Most of the doctors described the Workplace Reporter role as part of the clinical supervision they received or as part of their existing line manager's responsibilities. Whilst, the role of Workplace Reporter was often blurred, the function of workplace reporting was usually clear to doctors. Employers also mentioned few issues with the identification and working of the Workplace Reporter role.

Several doctors explained that they had been unaware of the need to establish Workplace Reporters in every health setting that they worked and had unintentionally broken their undertakings/conditions on this basis.

4.3 Medical supervision (for doctors with health restrictions)

In the survey 23 out of 28 doctors reported that medical supervision was 'very easy' or 'quite easy' to put in place. However 2 doctors indicated that it 'was not possible at all'. When asked to rate the quality of medical supervision, 21 out of 26 who had experience of it rated it as 'very good' (13) or 'quite good' (8) and just 5 said that it was 'quite poor', no-one rated it as 'very poor'.

Qualitative research participants also regarded medical supervision as broadly positive. This was true for both doctors and employers. The fact that Medical Supervisors were appointed by the GMC meant that doctors did not have as many initial difficulties in setting this element of supervision up as was the case with clinical and educational supervision.

⁵ Despite the fact that a workplace reporter is a requirement for all doctors working under restrictions, of the 45 doctors in the survey who worked under restrictions 3 indicated that they did not know if they required a workplace reporter(1) or that they had not needed one (2.)

Many of the doctors interviewed with experience of a Medical Supervisor held very positive views, and regarded it as a supportive role. At their best, Medical Supervisors were seen as mentors and were instrumental in getting the doctor back on their chosen career path.

“He had a background in Psychiatry so he understood health problems, and I got the impression anyway that he was tailored for my case. There was no judgement, no recriminations about my actions, he just listened, was accessible at all times and was willing to help me out in any way he could.” (Doctor, Health, Undertakings)

In cases where medical supervision was less well received by doctors, it was often because it was seen as a ‘tick box’ exercise, with doctors simply required to turn up and undergo tests. Doctors who were more negative towards medical supervision were more likely to believe that medical supervision was not required or to feel that they had found better support for their health conditions elsewhere, for example via NHS Practitioner Health Programme for Doctors, Occupational Health or Alcoholics Anonymous.

A number of practical issues with medical supervision were raised, as follows:

- Medical Supervisors were not always conveniently located to the doctor, and doctors were required to take more time off than deemed necessary to attend appointments.
- One employer identified a particular issue with a perceived lack of appropriately trained medical supervisors and also of adequate succession planning.
- Medical Supervisors were not always appointed soon enough, which caused problems for some doctors trying to secure new employment.
- Medical Supervisors having to approve employment was not always practical for doctors undertaking a high number of locum posts.
- Medical Supervisors were not always a specialist in the condition of the doctor that they were supervising.
- The same Medical Supervisor was not always available throughout the time that the conditions/undertakings were in place – leading to the need for multiple supervisors.
- Doctors were not always clear about what needed to be reported to the Medical Supervisor.
- Several employers raised the issue that there was not always clarity over the medical supervisor's role and that some misconceptions exist amongst doctors that the supervisor was their doctor or should be acting in more of a mentoring role than was actually the case.
- One employer also raised the potential for tension when there is a difference of opinion between the medical supervisor and the GMC:

"Another issue that can arise is just a difference of opinion between the medical supervisor and the GMC, so I've quite often been in situations where I've made recommendations to the GMC that they haven't effected. Then I'm in this very funny position of meeting repeatedly with the doctor who I don't agree with what the GMC is doing with that doctor but I'm the GMC's agent. That puts one into quite a difficult position." (Employer)

4.4 Educational supervision (for retraining/development restrictions)

Although numbers within the survey are small, it appears that setting up educational supervision is difficult to achieve. In the survey, less than half of doctors (6 out of 16) said that educational supervision was 'very easy' (1) or 'quite easy' (5) to set up. Conversely, 7 out of 16 said it was 'quite difficult' (5) or 'very difficult' (2) to do so.

Some doctors had difficulties with setting up educational supervision arrangements but once these were in place, two-thirds of doctors (13 out of 16) rated the quality of educational supervision arrangements as 'very good' (6) or 'quite good' (5).

Some of the difficulties in arranging educational supervision were uncovered further. Senior or experienced doctors, in particular, can face a number of difficulties meeting the training requirements necessitated by educational supervision. This issue can become quite complex, as explained by one survey respondent:

"First of all, my solicitor from the [medical defence organisation] explained to me what the jargon actually meant. They were extremely helpful. Training posts, such as I needed, do not exist within the NHS! Owing to three helpful people, who were not obliged to help, they made up a post for me. I have often wondered whether the GMC is actually aware that there are no training or re-training posts for practitioners following illness. Unhelpful: - the postgraduate dean (you cannot work in a training post without a training number, you cannot get a training number because you are on the specialist register); - the GMC; - the regional teaching hospital (we cannot look after someone with such complex needs); - trust management where I eventually worked. An HR member was on the appointment panel and I stated explicitly the conditions the GMC had place on the posts I was allowed to work in. The same person later backtracked and told me that because I had an LAS post {locum appointment for service} I was not entitled to training or study leave. Luckily, the department provided both, all the same." (Survey respondent)

Within the qualitative interviews, the experience of doctors ranged from one doctor who successfully found her own educational supervisor and remediated, to another doctor who explained that he was unable to fund an educational supervisor as they charged £500 a session. A further doctor had initially secured an educational supervisor but the relationship did not last.

One employer highlighted the perceived differences in the provision of support by Deaneries:

"That clearly wasn't consistent up and down the country because different Deaneries did different things. So I didn't realise until I went out and about that we were quite spoilt because Dr X who's at the Deanery, basically we used to send people to him and say they need a package and he would just sort out a package. And it would always be to put them in a training practice to start with, and it would always be with an experienced trainer and it would always be with what we call an educational prescription, so an assessment to highlight the educational needs." (Employer)

Variation in primary care between different regions also means there are different degrees of support available to access supervision in different locations. One NHS England RO reflected:

"In {Region} it is clear and there's a single professional support unit ..., there's a single email, phone number and email address and they'll get allocated to somebody... my observation would be its an incredibly helpful and supportive process on the whole. I think the other bit is that, in {Region} we had a very well established process for ages so it still works relatively smoothly. I think different parts of the country have different experiences but generally in here it is a well-established team and process." (Employer)

4.5 Clinical supervision (for doctors with performance restrictions)

Similarly to educational supervision, fewer than half (10 out of 24) doctors reported that it was 'very easy' (4) or 'quite easy' (6) to set up clinical supervision; whilst 13 out of 24 reported this as being 'quite difficult' (8) or 'very difficult.' (5)

However, when asked to rate the quality of clinical supervision the majority (17 out of 23) of doctors who worked under clinical supervision, rated it as 'very good' or 'quite good'.

Few of the doctors interviewed within the qualitative stage of the research thought that their clinical practice had ever really been an issue. The doctors who reported making a 'one off' clinical error explained that they had learnt from the original case rather than from working under conditions/undertakings. For the most part, Clinical Supervision was regarded as a way of protecting employers and easing doctors back into the workplace rather than a means of remediation. Most of the doctors interviewed reported being under regular rather than close supervision.

Doctors who were accepting of their undertakings/conditions were also more accepting of the need for clinical supervision. Whereas, at the negative end of

the spectrum there was a sense amongst some of the doctors interviewed that they were being made to 'jump through hoops' to fulfil requirements that they didn't necessarily agree with.

The ability to successfully set up the appropriate clinical supervision appears to be linked to: individual behaviour; how well respected and liked the doctor is; doctor's level of seniority; type of health care setting (see Section 3.)

Clinical supervision appears easier to organise within a secondary care setting than is the case in primary care. Doctors working within hospitals were either in more junior roles that already had clinical supervisory roles in place as part of their training, or they had greater scope to take on a more junior role and access the supervision required.

"So, working under conditions was not excessively restrictive for me, working in the guise of the junior hospital doctor." (Doctor, Combined, Conditions)

Conversely, GPs were more likely to report difficulties in meeting supervision requirements, with one having to move location to find a position within a training practice and another having to move into a secondary care setting in order to have their work supervised. Such difficulties were attributed to a number of factors, including:

- The fact that colleagues within primary care settings did not have the skills required to take on clinical supervision (they did not work within a training practice);
- The initial incident that triggered the FtP case had led to the breakdown of relationships/trust with partners in the practice;
- Doctors being employed as locums within the primary care setting and therefore there was not in a contractual relationship to help them remediate.

"In my experience, doctors with conditions who are practising in a practice where they are well peer supported often fare better than doctors with conditions who are locums or who are in less supportive practices. I think sometimes that's probably not always taken into account, that sometimes the ability to carry on practising under certain conditions is easier or harder in a particular clinical setting." (Employer)

Employers also highlighted differences in supervision provision between primary and secondary care settings because of structural and organisational arrangements. In secondary care support to make arrangements for supervision was more readily available through existing organisational systems and processes. For example, an employer working in a secondary care setting explained their approach to supporting a doctor to find an appropriate supervisor:

"I would speak with the individual under the conditions to see if there's a natural candidate, but if I didn't think that was appropriate or it was going to provide what the conditions required, then I would seek somebody else based on my knowledge of individuals, or I would go to the clinical director and say, 'This is what we need for this person; who do you think is the best person to do it?' Unfortunately, it's always busy people who attract those kind of jobs that they don't need, but you've got to do it right." (Employer)

In the case of primary care settings, the challenges for ROs at NHS England covering large areas with often thousands of doctors, and the challenges for doctors themselves being responsible for making supervision arrangements that are suitable, were very apparent. An RO based at NHS England, explained the challenges GPs face:

"Supervision is our biggest problem... finding a Supervisor that is suitable and that is prepared to do it, and that the doctor is happy with, and that the GMC is happy with and that they are always happy with, to try and identify that individual with all those caveats is our biggest problem. And, funnily enough, I've got that problem at the moment with a doctor, and it's not because the doctor's not trying, the doctor is desperately trying to identify a supervisor and I'm trying to help with that but it's not my job to find it, it's my job to help. We're struggling to find a supervisor and, of course, he's at risk of falling foul to the GMC condition and, therefore, ending up in further difficulties because he can't find a supervisor." (Employer)

In other cases there appeared to be less centralised support and an RO would be taking on the role of facilitating a potential supervisor for a GP, and faced challenges in doing so.

More broadly, one regional RO at NHS England felt there was less support – practical and emotional – available today via NHS England, and CCGs, than there was previously via Primary Care Trusts.

Supervision is also often easier to organise for junior doctors/doctors in training. Clinical Supervision is usually well established for junior doctors and therefore working under regular clinical supervision was not reported as being problematic. In some cases clinical supervision arrangements did not change - existing supervisors simply reported to the GMC.

"Yes, I fulfilled a role more junior to the role I had left when I had stopped working and the reasons for that were I had a period of time away from work, so obviously wanted to ensure that I had a safe environment in which to come back to work. So, familiar ground and in jobs that I had previously done, was a safe option. Also working in a more junior level meant that being supervised in that way was a more natural process." (Doctor, Combined, Conditions)

One employer also made the point that it is easier to keep supervision confidential for doctors who are still training because they would be expected to be supervised in some form at that level.

"So there are just some real practical difficulties about preserving the offender's, if you like, dignity and confidentiality but at the same time making suitable practical arrangements. So sometimes it can be done without it being obvious. It's usually if they're trainees because people might not spot that they're never sitting in a clinic on their own or whatever. But it's really difficult for consultants; it's usually blindingly obvious to people and the gossip mill is going full speed. It just is practically very difficult, I think - unless somebody is very upfront about it - to deal with it." (Employer)

In two instances hospital trusts had taken a more stringent approach to the clinical supervision required by the GMC and had prohibited surgeons from carrying out a wider range of clinical work.

"Yes, and the conditions were whatever they were but the interpretation were more strict than what they were meant to be by my workplace.....They stopped my routine work, they stopped my on call, they wanted my every aspect of my work being supervised by another consultant, so I felt like a criminal." (Doctor, Performance, Conditions)

One employer mentioned the confusion about conditions imposed by the two organisations:

"I do think one of the biggest problems that we often face is doctors understanding GMC process, GMC conditions, GMC undertakings, what they actually mean, what the words actually mean, particularly because with GPs, as you know, they have to be registered with NHS England on the performance list and we might have conditions and one of the biggest things doctors don't understand is that they're two different things." (Employer)

4.6 The impact of all supervision

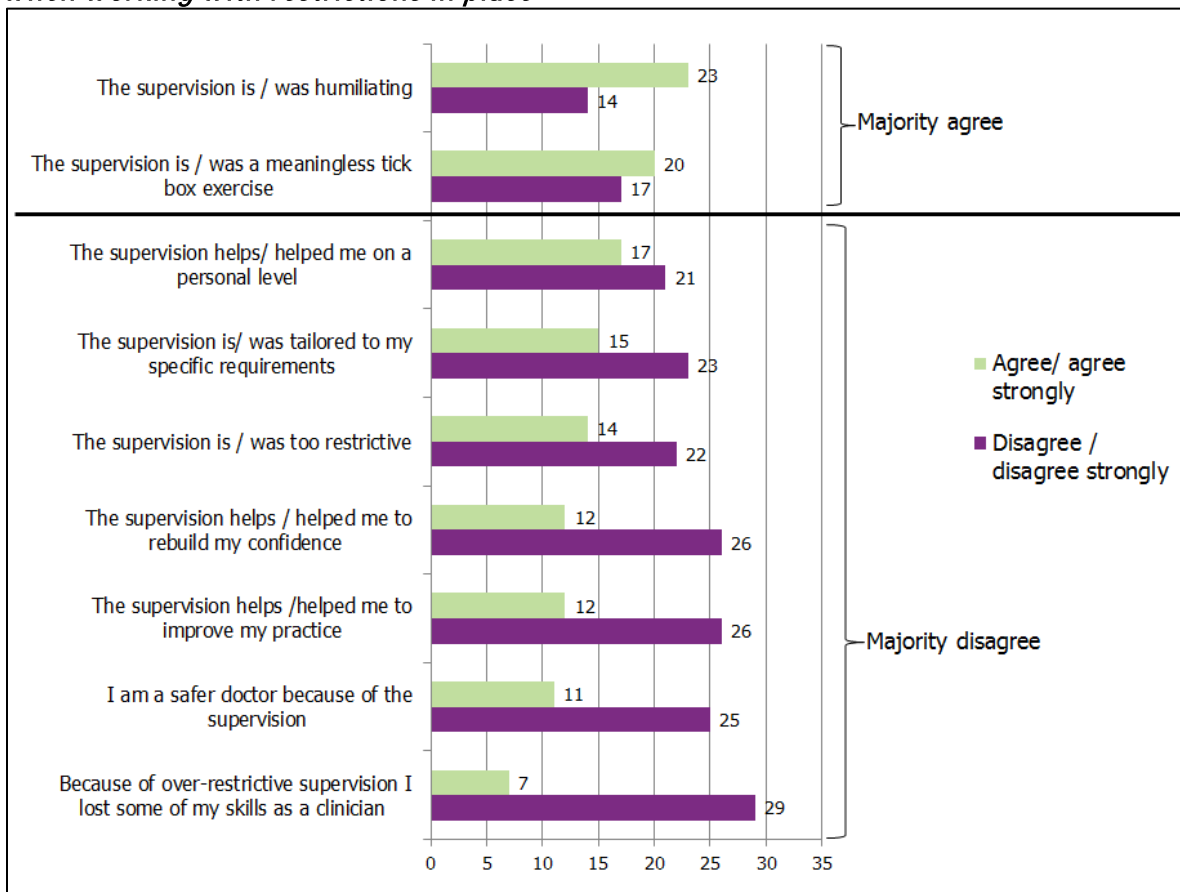
In the quantitative survey, doctors who had worked with restrictions and under supervision were asked to what extent they agreed or disagreed with a set of statements about the impact of supervision.

Whilst few doctors rated the quality of supervision as poor, many are nevertheless quite negative about the effectiveness of supervision. As Figure 4 shows, views amongst the 39 doctors who answered this part of the questionnaire were quite split, but the only two statements with which a majority of doctors agreed were 'the supervision is / was humiliating' (23 agreed or agreed strongly) and 'the supervisions is / was a meaningless tick-box exercise' (20 agreed or agreed strongly).

Whilst a proportion of doctors did agree with some of the more positive statements, for example 'the supervision helped me on a personal level' (17 agreed or agreed strongly); in general the more positive statements about supervision were not endorsed by a majority of doctors.

The highest levels of disagreement were seen with regard to the statements 'because of over-restrictive supervision I lost some of my skills as a clinician' (29 disagree or disagree strongly) and 'I am a safer doctor because of the supervision' (25 disagree or disagree strongly.)

Figure 4 – Level of agreement with a list of statements about supervision received when working with restrictions in place



Base: All who continued to work with restrictions and under supervision (39), 'don't knows' are not shown (39).

4.7 Challenges for employers relating to supervision arrangements

Many doctors in the quantitative survey reported that their employers were not helpful in the process of setting up the necessary supervision arrangements. Just over half of doctors (25 of 42) said their employers were very (13) or quite (12) helpful in supporting them to put the necessary supervision arrangements in place; a significant minority (14 of 42) described their employers as very (12) or quite (2) unhelpful.

Employers within the qualitative research freely admitted that supervision creates many challenges for them. Difficulties with making supervision arrangements (of all kinds) identified by ROs and employers, across and within different settings included:

- Significant resource implications were identified by employers.

"It will be different depending on what level you are, obviously at a consultant or non-trainee level the impact of having restrictions on your practice is much greater because essentially you need to get another individual to do your work and to do their work as well. So that does take quite a lot of a) organisation and b) an awful lot of money, it's hugely expensive to get locum cover in for somebody whose practices are restricted or they're excluded, e.g. we have a staff grade who's excluded at the moment and the annual cost of her cover is £200,000, it's just extortionate." (Employer)

- Practicality and cost of making arrangements for chaperones, and staff who can prescribe / see women and children, dependent on doctor's particular practice restrictions. For example:

"Yes, it's anything like that; it's anything that practically interferes on the day-to-day running of the organisation, so chaperones are potentially expensive. Prescribing is always really difficult because obviously it's a fundamental part of what a doctor is supposed to be doing." (Employer)

- In primary care, some cases of GPs requesting/making arrangements to have partners, colleagues or employees act as supervisors. For example:

"From my point of view, clinical supervisors must not be employed by the person being supervised. It could be a colleague in a large practice, providing you were confident that doctor understood the boundaries and was not going to collude with his colleague because he'd known him for 30 years and they brought up their children together." (Employer)

- Unwillingness of people to act as supervisors due to concerns about responsibility, risk, time commitment and lack of remuneration for time.
 - One employer also raised the issue that he felt that some individuals were deterred from taking on the role because it may affect their liability insurance.

- Lack of experience, or understanding of the process by supervisors:

"When you allocate somebody to be the clinical supervisor they've probably never done it before. So I think it's quite difficult for them to know what they

should be doing and how they should be doing it....I think some clearer guidance on what's expected of people would be quite helpful." (Employer)

- Attitude and reputation of a doctor making them an unattractive prospect as a supervisee. For example:

"Quite often the first barrier is the doctor whose perhaps attitude, behaviour, issues, lack of insight, aggression, general all roundness makes them unattractive." (Employer)

- Clarity about duty of care, resourcing and 'who pays.'

"I think up until now there's been a difficulty in that often doctors who need remediation have found it difficult to find appropriate placements to get the assistance and supervision they require, and often I think that's been a stumbling block, that nobody's quite seen it as their remit, either the employer or the Deaneries." (Employer)

- In the private sector particular difficulties in arranging clinical supervision which means in practice doctors often have to be suspended or have their contract terminated.
- Supervisory arrangements often being dependent on personal relationships and, in one secondary care-based ROs words, reliant on "calling in favours."
- Several employers mentioned the negative impact on team working and morale of accommodating supervisory requirements.

"I think everybody gets a bit frustrated with it and is that helpful to the any of the individuals involved, I don't think so because there almost becomes a bit of resentment about that doctor being around because it's more work for Clinical Supervisors, Educational Supervisors, for the other medical staff around, and I don't think it does morale for the individual concerned but for the whole team, I don't think it's a particularly helpful scenario." (Employer)

- The GMC's policy of confidentiality regarding health related restrictions meaning, from employers' perspectives, a lot of duplication of information requests and additional stress for doctors. For example:

"The problem with the health stuff is the GMC keeps it utterly and absolutely top secret from everybody, which kind of keeps us a little bit out of the loop. They just discuss it with the doctor and redact everything. So we usually learn more from the doctor who tells us things like 'the GMC said I can't go back to work until I'm not taking this medication', but the GMC won't have told us that. So we're worrying what's happening but we can't be told. So the GMC, issues around health and lack of communication really is a problem." (Employer)

4.8 What works well for employers relating to supervision arrangements

Examples given by employers of what can work well regarding all types of supervisory arrangements included:

- Cases where supervision and work plans might already be in place as result of NCAS involvement in a case prior to a GMC referral.
- Supervisor relationships which also have an aspect of mentoring, which in one employer's view can happen, but are unfortunately ad hoc and rare.
- A single point of contact within an organisation that doctors can be signposted to help arrange supervision.
- GMC checking with ROs on suitability of supervisors.
- ROs checking with doctors on suitability of supervisors.
- Existing practice of the GMC sourcing medical supervisors - some ROs felt an argument could be made for the GMC sourcing clinical and educational supervisors too, to prevent people slipping through the net.

The government department RO interviewed reflected on the fact that they have more responsibility for arranging clinical supervisors, and supervision packages, than in NHS. As a result, arguably fewer people 'slip through the net'. (This RO explained that responsibility for arranging supervision lies centrally with them, but that often a doctor might refuse supervision from a particular clinician who might be familiar to them. In this case they are able to approach civilian GPs, external to the government, to act as supervisors.)

One employer mentioned that they had recently acknowledged that they had been failing in terms of meeting supervisory requirements and introduced a formal system mentorship process.

"We recently developed a formal mentorship process within the Trust. We've trained up 80 mentors, so Senior Consultants who have been in the Trust, to be able to mentor individuals. So we choose from that pool of mentors and we choose specific individuals who we feel would be appropriate to do that. So at least there is some quality control over who's going to be supervising individuals." (Employer)

5. Impacts of warnings

Section highlights:

- Many doctors who received warnings report that their current and ongoing employment is adversely affected.
 - Employers also indicate that all things being equal they would prefer not to employ a doctor with a warning.
- Only a small minority of the doctors interviewed who had received warnings attributed positive behaviour change to the receipt of their warning.
- Positive behaviour change that is reported is often seen as being a response to the original issue or the mistake that led to the FtP investigation; or as a response to the investigation process itself rather than as a response to the warning per se.

It is extremely difficult to disentangle the impact of the warning given by the GMC from the wider impact of the events leading up to this outcome.

"I do have a scenario where a doctor got a warning but, interestingly, it's not the fact the GMC gave him a warning that was the problem, it's the fact that his GP partner referred him to the GMC which resulted in him getting the warning that was the killer, if you like, and he never went back to work, he was off work for four years sick and then retired from it all. But, like I said, it wasn't the warning on its own that was the issue, it was the way he got it that was the issue."
(Employer)

Doctors who had received a warning rarely attributed any changes in their behaviour to the warning itself. Some changes in behaviour were reported but these tended to be attributed to the original issue or error that led to the warning or the wider impact of having been through an FtP investigation, rather than being directly as a result of the warning itself.

There were mixed views on the impact of warnings on doctors among ROs and employers. One RO felt that they might have a more positive impact than restrictions, but that this may be to do with the fact that they were tackling less serious issues. Another employer felt that doctors who received warnings were often those who were more likely to successfully remediate in the long run, as they were more likely to be able to reflect and have insight, than doctors who had received conditions for example:

"I think most doctors who get a warning are doctors who've got insight, are really upset and sorry they've made a mistake and do really well, and never

make the same mistake again. There's that group of doctors usually do really well." (Employer)

However, others felt that warnings often had overly negative impacts on doctors' behaviour and future practice. Another employer felt that warnings tended to have a disproportionately negative effect; that if the doctor in question was diligent and conscientious and had just made a mistake, then they would learn from the case and change their behaviour anyway without the warning. But in these cases, these doctors in particular may take a GMC warning to heart and become demoralised as a result.

"The warning doesn't actually help in that respect. And then you have the people who don't think they've done anything wrong and they disregard the warning anyway, and that's really quite strange that in either circumstance it doesn't always help." (Employer)

Similarly, an NHS based RO held the view that the whole process (whether for warnings or restrictions) can have a damaging effect on doctors who have made a genuine mistake. Conversely they felt that for doctors who were unreflective, that there was often limited likelihood of a positive remediation outcome.

There was a general, anecdotal sense amongst employers that doctors with health-related warnings, particularly regarding alcohol or substance misuse, were more likely to successfully remediate than those with performance or misconduct related warnings.

"I was going to say about one in five in general practice successfully remediate. I'm not saying about people with health conditions, so people get treatment and they get back to work, but people where their clinical skills are poor I think it's not a very high percentage." (Employer)

Others were wary about drawing any generalisations about the longer term impacts of warnings on doctors:

"So it's very difficult to then be able to reflect back and say 'oh yes, I can see a change in behaviour in those doctors that have had warnings' because I suppose we need to go through the appraisal revalidation cycle before we can maybe see a change." (Employer)

5.1 Impact on behaviour and practice

The original mistake, error or issue that resulted ultimately in a warning for the doctor was often seen as the root cause for any change in behaviour. Some changes in behaviour were reported and often related very directly to the original issue, for example:

- A doctor who received a warning because of late payment of GMC fees and then working for a short period of time whilst not officially registered, reported that he now always pays his GMC fees by direct debit.
- A doctor who received a warning because of a one-off drink-driving conviction, with no implications of alcoholism, reported that he gave up drinking.
- A doctor who received a warning in a case where a follow up review appointment was not booked in with a patient and the patient was later diagnosed with cancer, the doctor reports that they now would always booking and ensure patients have follow-up appointments.

"I probably have a higher bring-back rate because one of the things I was chastised about was that I hadn't actually arranged a review appointment. I had just told her to come back if it changed. I should have brought her back in six weeks and re-examined her, so I do that now." (Doctor, Performance, Warning)

- A secondary care RO gave the following example of a surgeon with a performance related warning who had a successful outcome as they were willing to reflect and learn:

"One of our senior doctors in one of our hospitals got a warning because he'd been slow in producing a medico legal report and the patient, claimant, got disadvantaged by it, he was just being sloppy and didn't prioritise it. It didn't stop him being a really good surgeon and it didn't stop him doing his other work but just he got a warning. It was viewed quite severely but he really took it in the context of what had happened, he'd made a big mistake, he talked to us about it and said 'I shouldn't have treated this person this way, I should have listened to what they said, I should have reacted sooner', and he's a better person for it but we were happy to keep him on." (Employer)

Some doctors who have received warnings, in particular where the warning relates to a clinical error or issue, report that their general approach to practice is now **more cautious or 'defensive'**. Having once had the experience of an FtP case doctors state that they are much more aware of the possibility that patients can complain and issues can arise and they, therefore, behave in a generally more cautious, some say overly cautious, manner.

"If somebody has complained and I think it's probably fine to reassure them that this is something that is probably nothing to worry about, but if it continues come back in two weeks or something...or, alternatively, I could investigate it right away. Because my practice is defensive I might investigate it right away because I'm more anxious about it." (Doctor, Performance, Warning)

Whilst this doctor, along with some others who had received warnings, did recognise that their practice had become more cautious as a result of their FtP case and warning, they did not necessarily perceive this to be of benefit in terms

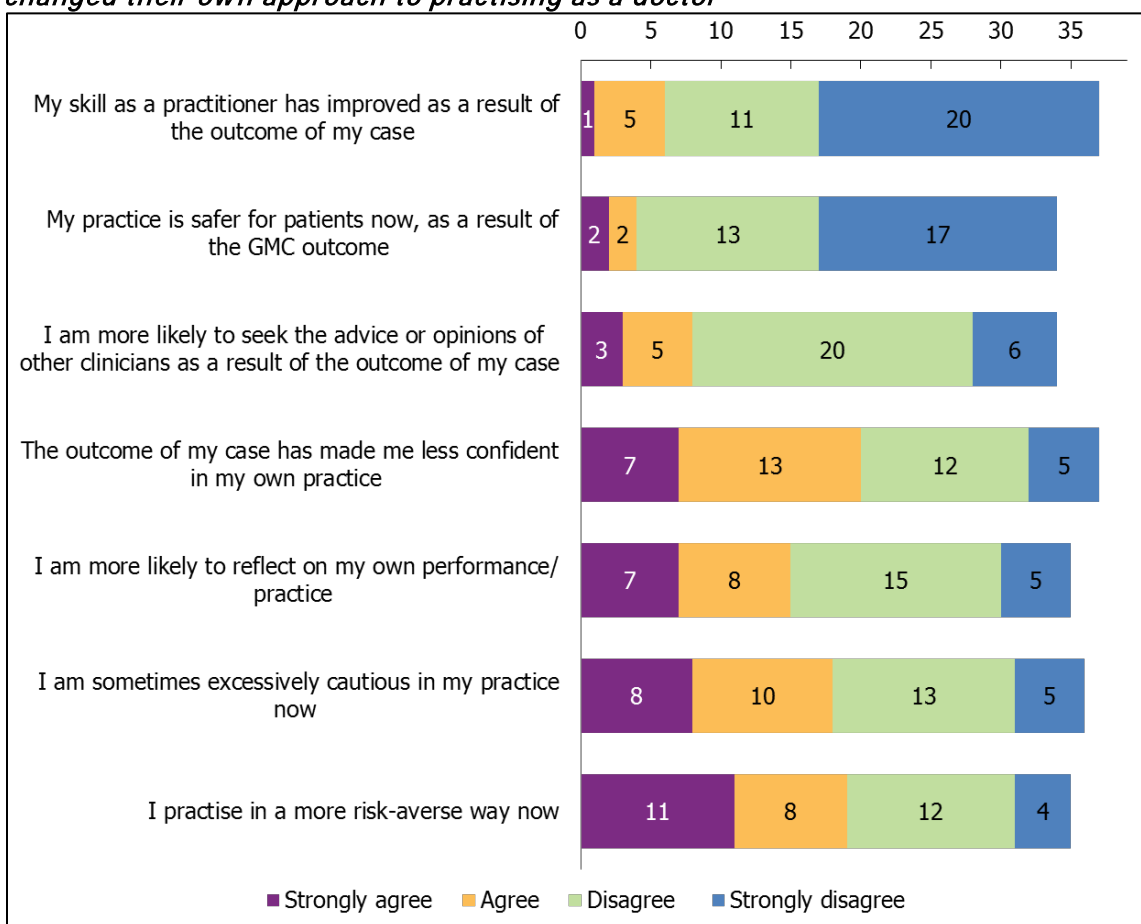
of patient safety. This is because such doctors did not perceive that patient safety had ever been compromised by their original practices.

"I've always been very patient safety aware and I think I still am, but I think I've gone beyond the level of normal patient safety, I think probably defensive beyond patient safety." (Doctor, Performance, Warning)

In fact, some of those interviewed perceived that this more defensive practice was actually having a negative impact for their patients as they were potentially being sent for tests they might not really need and because their doctor's time and NHS resources were not being as efficiently used as they should be.

Results from the quantitative survey reinforced the qualitative findings regarding the impact on behaviour and practice, in terms of perceptions of the propensity to be more risk averse and cautious. Respondents were asked to what extent they agreed or disagreed with a set of statements about how receiving a warning impacted on practice. Results show that low proportions believed that their practice was safer or that their skill as a practitioner had improved as a result of the warning. More positively, larger proportions of doctors agreed that the warning had made them more risk averse, cautious and likely to reflect on their own performance or practice. Results are shown in full in Figure 5.

Figure 5 – Level of agreement with a list of statements about how having a warning changed their own approach to practising as a doctor



Base: All doctors with a warning who practised as a doctor again following the completion of their case (38)

5.2 Impact on career and employability

Considering that warnings are intended to be the lowest level of action that the GMC can take following an FtP investigation, the reported impact on doctors' careers and employability in the short and long-term appears to be, in many cases, disproportionately and extremely negative.

Some of those who received warnings continued and their career remained relatively or completely unaffected. However, a number of those doctors who had received warnings reported that they had been unable to resume their careers.

Others reported that they had experienced great difficulty in gaining employment following the receipt of their warning. Doctors also reported having to completely change the direction of their career as a direct result of having a GMC warning on their record. Some doctors who were in training when they received their warning found it difficult to complete their training.

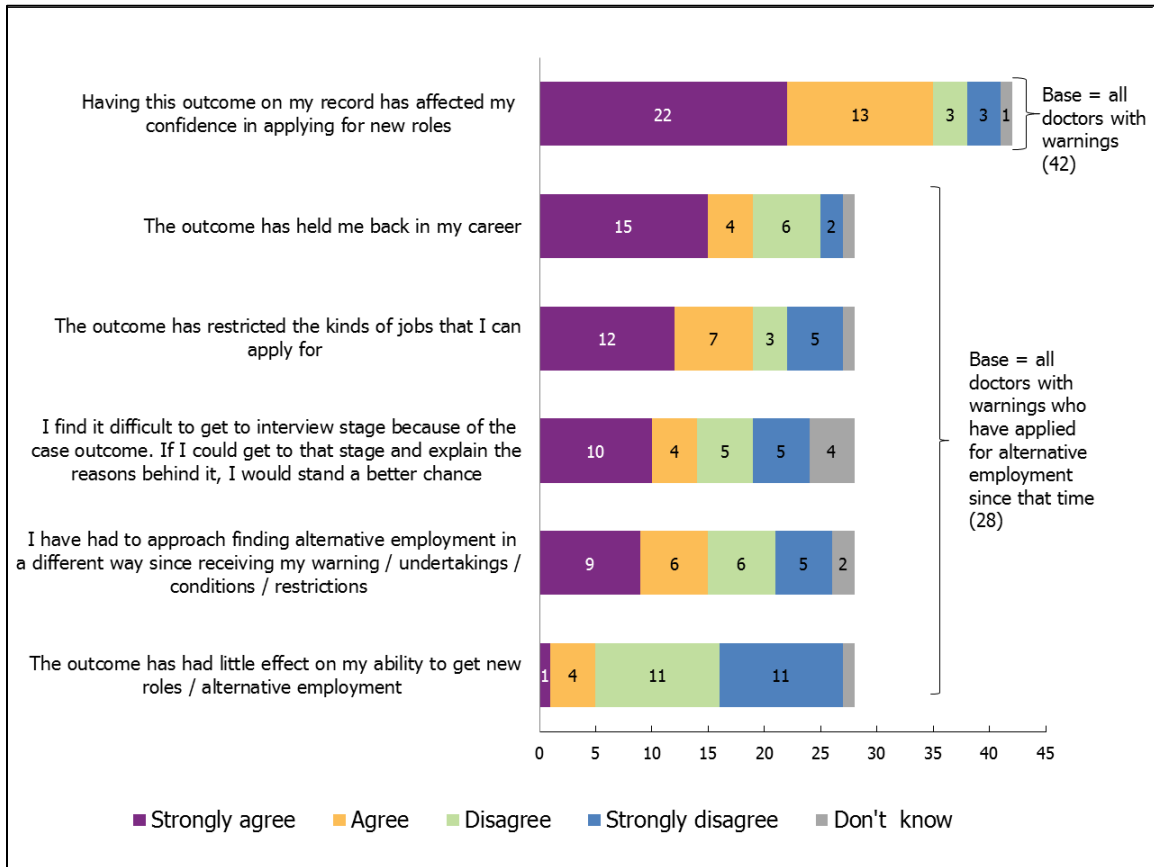
Whilst not all doctors who received warnings reported such a severe or devastating impact on their careers, many had nevertheless experienced at least some difficulties in gaining employment with the existence of a warning on their record. Doctors with a warning described having '*a monkey on their back*' and bemoaned the fact that it was necessary to jump through additional hoops in order to gain employment once the warning was on the record.

In the quantitative survey, 8 of the 42 respondents with warnings indicated that they had changed their employment as a direct result of the case or the outcome. Also, 15 of the 42 respondents indicated that they had either never worked again (4) or they had had unwanted interruptions to their career (11) as a result of receiving the warning.

When asked an open question about the impact of the warning on their long term career as a doctor, around one quarter indicated that the warning had prevented them from gaining employment (10 out of 42), prevented them from progressing and/or had negatively affected their career (9 out of 42), had tainted their reputation (11 out of 42).

When respondents were further asked to what extent they agreed or disagreed with a set of statements regarding their career, it became clear that many doctors felt that having a warning greatly affected their confidence when applying for new roles, held doctors back in their career and restricted the kinds of jobs applied for. See Figure 6.

Figure 6 – Level of agreement with a list of statements about how the existence of a warning on their record has impacted on them applying for and getting new employment.



Base: As shown in chart.

Many doctors were also extremely negative about the fact that the warning remains on their record for five years regardless of its nature and that they continue to have to declare the fact that they have a history with the GMC even once the public record of their warning has expired.

“So the rest of my career it's my legal responsibility to inform any future employers that a warning's on my record, so 20 years' time I have to say that 25 years ago I paid my fees late and had a warning on my record. And that has to be part legally as my declarations to future employers for the rest of my career, and the long term impact.” (Doctor, Misconduct, Warning)

Doctors perceived that employers dismiss applications from those with a warning on their record out of hand, with little or no understanding or recognition of the fact that a warning does not mean that a doctor has impaired fitness to practise. Put simply, doctors perceive that where an employer has a choice between two equally qualified doctors one with a warning and one without they will always choose the one without a warning.

Employers confirm that this suspicion is true:

"So if you've got two candidates: one's got a warning and one hasn't, and they're very close, you might say, 'Why do we want the bother of employing this person?'" (Employer)

Once again, for doctors with skills that are in short supply warnings will have a less devastating impact on their career than those whose skills and experience are more common. This in turn means that doctors whose career has been impacted feel that a warning is disproportionately impactful and therefore very unfair for some doctors. Depending on the employment situation, and the specialist skills of the doctor the impact can range from none at all to the complete ending of a career.

"I've been absolutely clobbered by having a warning whereas, if I was in general practice and I was a principal partner, it wouldn't make the slightest bit of difference." (Doctor, Misconduct, Warning)

One employer reflected on the severe impacts that warnings could have on individual doctor's practice, giving examples of the impact this has on relations with colleagues, as well as their private lives, personal finances, confidence and mental health. Another employer also commented that GPs, in particular, can be faced with the financial implications of having to pay for locums to cover their work. This can occur if the doctor cannot work themselves, because of interim restrictions imposed by the GMC or NHS England, during an investigation process that ultimately results in a warning.

5.3 Personal impacts

Doctors who received warnings reported a range of personal impacts. Again doctors found it very difficult to differentiate the impact of the FtP process and investigation from the receipt of the warning itself. Many of the reported personal impacts related closely to the FtP investigation and the stress involved in the process rather than specifically to the receipt of the warning. However the ongoing existence of a warning on the doctors' record also had implications for a number of doctors in terms of ongoing stress, psychological and emotional impacts.

A number of doctors who had received warnings reported suffering from mental and physical health problems. Many also described experiencing a huge loss of confidence in their own ability.

"Your self-confidence, your belief in yourself, the emotional impact, massive. And I ended up with clinical depression."
(Doctor, Misconduct, Warning)

Doctors who received warnings talked about their feelings of shame and embarrassment resulting from the existence of the warning on their public record.

"To get something like this, I will never accept it, it's like breaking my dignity and honourability. I didn't feel that this decision was purely correct and they didn't give me a chance to speak."

(Doctor, Misconduct, Warning)

Doctors with warnings also described negative impacts on their personal and family relationships as a result of the FtP process. The process was described as being life-changing and highly traumatic, not just for the doctor themselves but for their wider family:

"Throughout the process, because I'm involved in trauma psychotherapy, a colleague has given me trauma psychotherapy throughout. I've seen my GP, I've been able to avoid having medication. My wife has not, my wife remains on antidepressants as a part of this, because there is a huge family impact on this."

(Doctor, Misconduct, Warning)

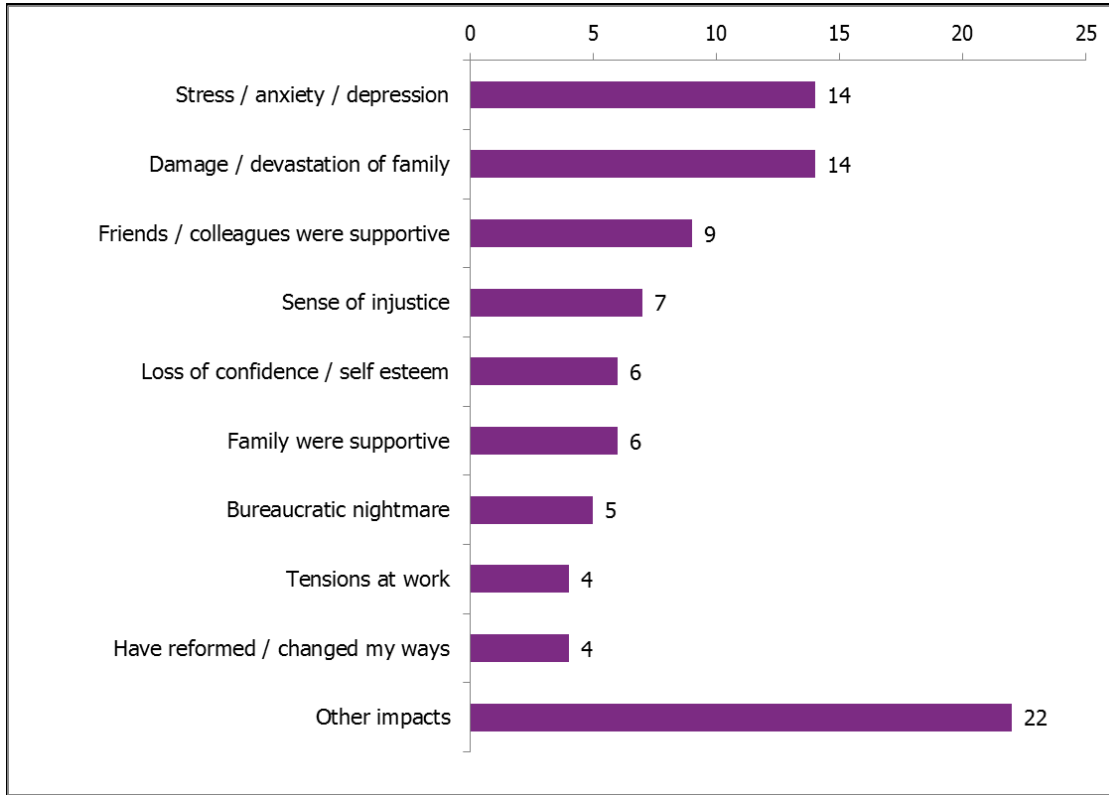
Many of the doctors who received warnings were extremely angry and felt a strong sense of injustice about the existence of the warning on their record. A number expressed that they would have liked to contest their FtP case and that they did not accept that the warning was justified. However, such doctors had been advised by their medical defence organisations to accept the warning rather than take the risk of going through a panel hearing which might subsequently lead to more severe sanctions. The perceived unjust nature of the warnings in these cases continued to rankle with doctors making it more difficult for them to overcome the psychological impact of their case.

The quantitative findings echo this sense of injustice felt by a number of doctors in the qualitative research. Results show that over half of doctors with warnings felt that their FtP case was not justified / completely unjustified (22 out of 42); and that the two-thirds felt that the outcome was unreasonable / completely unreasonable (26 out of 42); and/or the consequences of the outcome were disproportionate / completely disproportionate (27 out of 42).

Doctors were also given space in the survey to write about the wider impacts that the FtP case and subsequent warning had had on their personal life, relationships and health and how this had affected their ability to practice medicine. Results echo the qualitative interviews in terms of the negative impact on mental health and family life and highlight the importance that doctors place on having supportive family and friends throughout the process. There were two references to suicidal feelings in the verbatim comments which highlight that, in

extreme cases, the mental stress of the FtP case and warning can be overwhelming. Figure 7 shows the results.

Figure 7- Wider Impacts of FtP case and outcome – doctors with warnings⁶



Base: All doctors with a warning (42)

⁶ Other impacts includes Financial loss (3), Loss of social status (3), Process took too long (3), Humiliation (2), Haven't recovered/lasting trauma (2), Angry bitter (2), Suicidal (2), Found out who my real friends were (2), Affected my health (1), Lack of support (1), My health has improved (1)

6. Impacts of undertakings and conditions

Section summary:

- Doctors make little distinction between undertakings and conditions.
 - Undertakings have often only been accepted under the strong direction of the doctors' medical defence organisation.
- For many of the doctors' interviewed the undertakings and conditions were felt to be unworkable making remediation a difficult and, sometimes, impossible process.
- It appears that undertakings and conditions are more likely to achieve a successful picture of remediation in health cases, than is true for performance or misconduct cases.
 - Doctors with health issues are more likely to accept and proactively engage with the restrictions put in place, than is true for performance or misconduct cases.
 - Colleagues and employers tend to be more supportive of doctors with health-related undertakings and conditions than is true for doctors with performance or misconduct related cases.

As is the case with warnings, it is extremely difficult to disentangle the impact of the conditions and undertakings from the wider impact of the events leading up to these outcomes.

6.1 The crucial role of acceptance

The survey results revealed that over half of doctors who were issued with undertakings or conditions (31 out of 57) felt that the restrictions they had placed on their practice were an unreasonable (8) or completely unreasonable response (23) to the issues involved in their case.

Feelings about whether the restrictions were reasonable certainly seem to have a strong relationship with doctors' own views of whether the restrictions are effective or not. Almost half (12 out of 25) doctors who felt the restrictions had been reasonable, also felt they had been effective in achieving their intended outcome⁷. This compared to just 2 doctors of the 31 who felt the restrictions were unreasonable / completely unreasonable.

Employers agree that one of the key influencing factors when judging if undertakings or conditions have a positive impact on behaviour, is the level of

⁷ The intended outcome was described within the survey as follows: "The minimum action necessary to protect patients and the public. They are designed, where possible with the appropriate support, to provide time and space for doctors to remediate their practice and return to full practice once it is safe for them to do so."

acceptance of the restrictions on the part of the doctor. According to one of the Responsible Officers:

"In my experience it's the ones who actually recognised themselves that they'd made a mistake and what it was, are the ones who makes the biggest and the most effective changes." (Employer)

Whilst it might be expected that those doctors who have accepted undertakings may have greater levels of acceptance of the restrictions overall, this does not appear to be necessarily the case. Doctors rarely made the distinction between undertakings and conditions. In most cases, the doctor was advised by their medical defence organisation to accept, rather than challenge, the undertakings being offered by the GMC. Therefore doctors with undertakings very often felt that the undertakings had been imposed on them.

"I was offered undertakings which, they say are voluntary but it's like a Hobson's choice. You take the undertakings, which is where the solicitor comes in handy. You agree the undertakings or you don't agree the undertakings. If you don't agree the undertakings you go to Manchester, to the panel. So while they call them voluntary, they're not. The solicitor's advice was if you go to panel, that they will put undertakings or conditions on. They'll put conditions on and to get the conditions lifted you have to go back to panel, so it's a much more difficult procedure so I agreed the undertakings." (Doctor, Health, Undertakings)

The type of case appeared to have more influence on the level of acceptance and the associated remediation outcome, than the type of sanction (undertakings as opposed to conditions.) Doctors who had received undertakings/conditions for health related cases tended to be more receptive to the undertakings/conditions - some even welcomed them. Many doctors recognised their health had been impaired at the time of the case and didn't dispute the subsequent undertakings/conditions.

"I'd absolutely love this to be a quote – the GMC were incredibly supportive and understanding and prompted me in getting back into health and back into medicine." (Doctor, Health, Undertakings)

"After hearing my evidence and hearing the evidence from the psychiatrists who had seen me and all the reports that I've had from my PHP psychiatrist and workplace reports from the simulation centre and all that sort of thing, they collated it together and they said, 'Look, you have been sober for a year, you've been doing a lot of the right things, people are fairly confident that you're heading in the right direction so we will allow you back to work. We will allow you to have your registration under workplace and health conditions.' I was overjoyed with that result; that was the best possible outcome for me." (Doctor, Combined, Conditions)

However, undertakings/conditions relating to health were not universally welcomed or accepted, and at the other end of the spectrum reactions could be very negative:

"I'm not being judged on my technical expertise. I'm not being judged on my ability to do my job. They just think that because I've been done for drink driving and I've got the abnormal blood test that I must have such a problem that I'm bound to slip up at some stage." (Doctor, Health, Undertakings)

Doctors appear much more likely to have a negative response to undertakings/conditions in a performance/misconduct case, as they often reported that the case was unjustified in the first instance: either reporting that it had come about as the result of professional rivalries; that it was the result of a one off incident that had failed take into account an unblemished track record; or that it was down to unavoidable 'skills fade' after a period of suspension or sickness. Undertakings/conditions for some doctors then represented a further injustice to the doctor and were simply not regarded as an opportunity to remediate.

There were some specific examples from employers of individual doctor's positive remediation following restrictions placed as a result of misconduct. However, these were seen as being the exception rather than the rule:

"It can definitely be a road to Damascus conversion; I've seen it a couple of times. So somebody who's been referred for misconduct-type things, say, I think going through the GMC process and as part of that gaining insight into their own behaviour, so people who don't have any insight. There is the odd one or two that suddenly go, 'Oh, I get it now; I get what other people think of me and actually this is really serious'. So I have seen, a couple of times, people dramatically change their professional behaviour. Most of the time I would say not ... and the experience is damaging and bruising and makes them more defensive in their practice, if anything." (Employer)

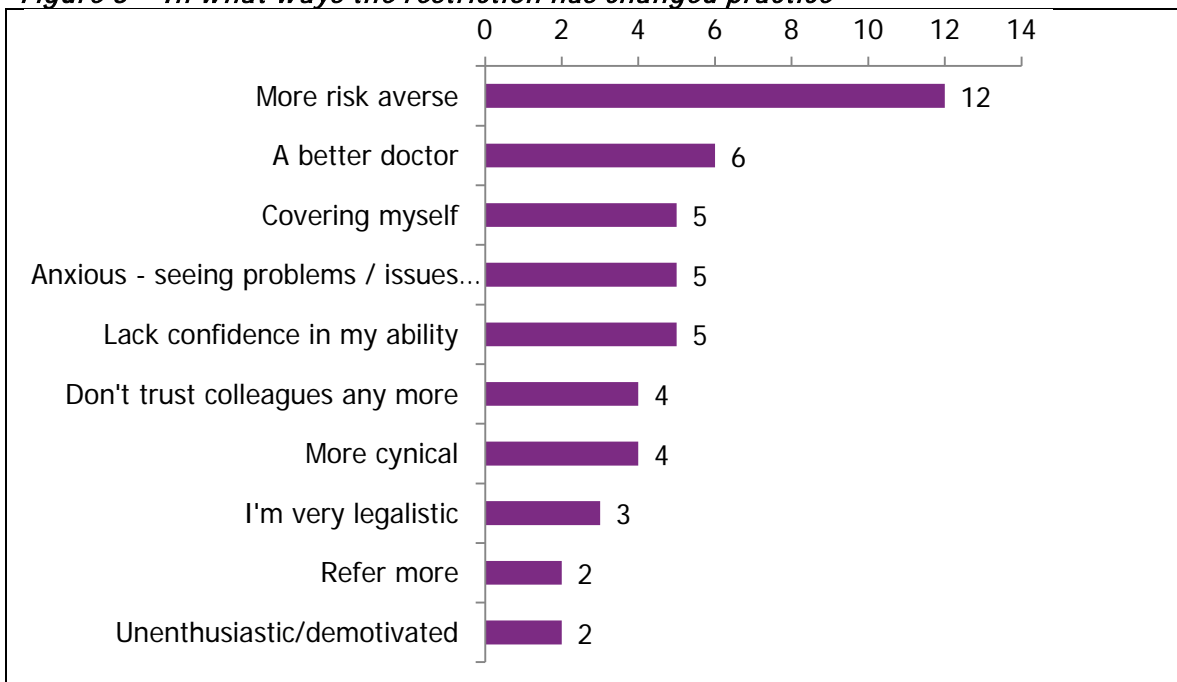
6.2 Impact on behaviour and practice

As with warnings, doctors with undertakings/conditions were likely to report being more risk averse with their practice. They reported making referrals more readily than they would have done previously. However, doctors reported that they didn't feel that they needed to do this from a clinical perspective but rather to insure themselves against any future involvement with the GMC – which they believed they would always be vulnerable to.

"I think everybody's getting more risk averse but I think with that undertakings over your head certainly would make me more cautious." (Doctor, Health, Undertakings)

Results from the quantitative survey reinforced the qualitative findings regarding the impact on behaviour and practice in terms of perceptions of the propensity to be more risk averse and cautious. Figure 8 shows doctors spontaneous comments (subsequently coded) when asked to explain how restrictions had changed their approach to practice. Some positive changes were identified, with 6 mentions of being a better doctor.

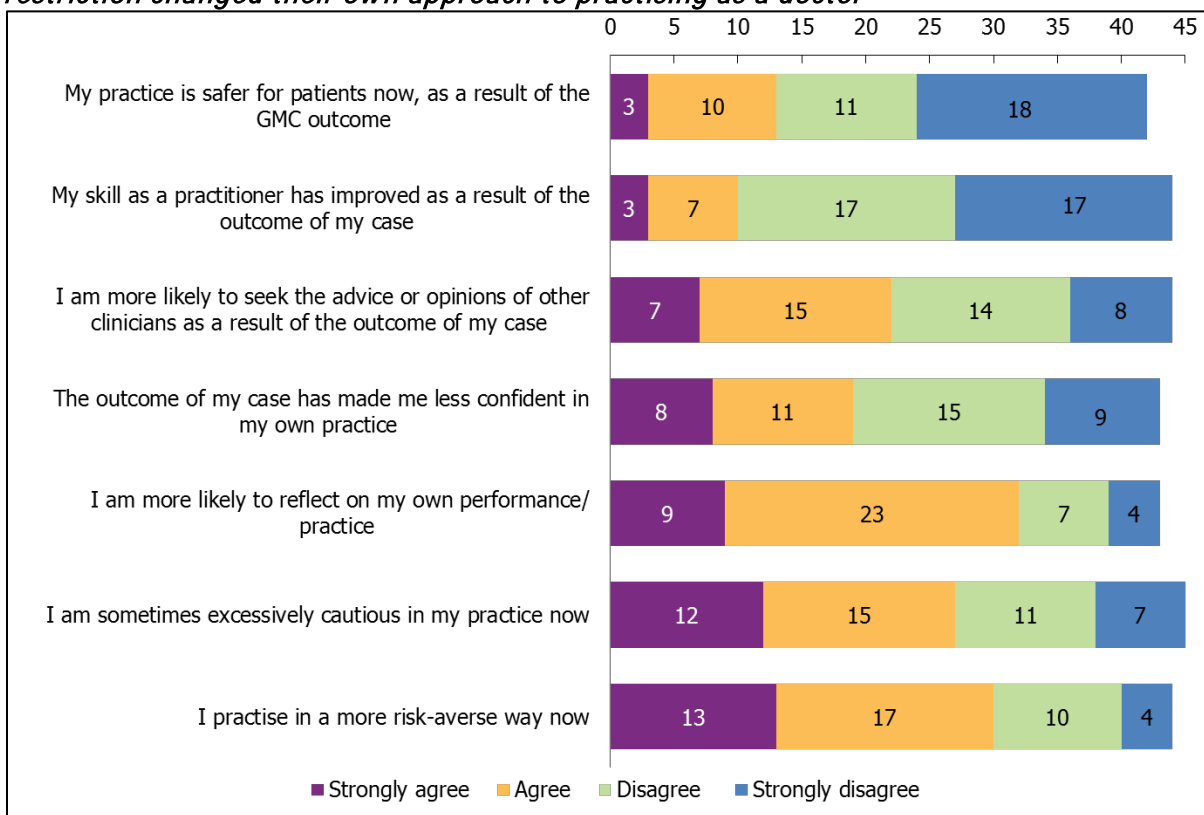
Figure 8 – In what ways the restriction has changed practice



Base: All doctors with restrictions who indicated that their practice had changed (24)

When doctors with restrictions were further asked to what extent they agreed or disagreed with a set of statements, most did not agree that their practice was safer or that their skills had improved as a result of the GMC outcome. However, when asked whether the restrictions had made them more risk averse, cautious or more likely to reflect on their own performance or practice, more agreed than disagreed. Results are shown in full in Figure 9.

Figure 9 – Level of agreement with a list of statements about how having a restriction changed their own approach to practising as a doctor



Base: All doctors with a restriction who practiced as a doctor again following the completion of their case (45)

6.3 Impact on career and employability

Almost a quarter of doctors with undertakings/conditions interviewed in the qualitative sample were no longer practising. One doctor indicated that they did not want the humiliation of seeking employment with restrictions on his practice, others had not been able to secure an appropriate post or were suffering on going health issues.

More than half of the doctors interviewed with undertakings/conditions had to find new employment with undertakings/condition in place, and several others would have liked to. Doctors described that it was very difficult to secure a new post as they believed that employers did not want to have to fulfil the supervisory requirements of undertakings/conditions and they did not want to be 'tainted' by taking on a doctor who had a history with GMC.

"You might say that as an outcome of the GMC undertakings, and also not just the undertakings but also the whole story that led up to it. I lost my post as a Consultant and I'm finding it difficult to get a new one..... My impression is that as long as there's anybody else interested they'll take that one rather than

a woman who's got this bit of history with the GMC and Fitness to Practice investigation." (Doctor, Combined, Undertakings)

Doctors who had succeeded in securing employment with undertakings/conditions in place had generally had to pursue a number of avenues to secure a post. Success appeared to be dependent on the tenacity of individual doctor and having contacts that were willing to 'give them a chance'.

"So, I then had to ring around practices to say, this is me, this is what's happened and I'm keen to come back to work; would someone supervise me for nine months, as a GP returner? So, I had to get off my own back and do that. I approached several practices and, actually, the one I liked most they all, to a tee, were very supportive; no one said 'no'. Everyone said, come and talk to us. I talked to about four or five practices, locally. They then said, 'we'll take you'. The practice I'm in now, said they'll supervise me, because one of the GPs there was a trainer." (Doctor, Combined, Conditions)

A number of doctors subject to conditions/undertakings felt that they remained stigmatised even after they had successfully remediated and had their conditions/undertakings removed. Whilst, they felt confident that they would continue to find employment they also explained that they no longer had all the career choices that were once open to them.

- One doctor explained that they would find it difficult to return to the same geographical location they had been living in at the time they received the undertakings/conditions.
- Another explained how their history of undertakings/conditions had made it difficult to take on a more managerial role.

Many employers concurred that for doctors to return to practice and continue their careers after having had conditions or undertakings could be very difficult.

Several doctors who took part in the qualitative interviews had been unable to secure work with their conditions/undertakings in place, others remained in employment but were unable to undertake certain procedures. Some doctors expressed concern that they were becoming de-skilled, which coupled with their GMC history was seen as highly detrimental to their career.

The quantitative survey results broadly supported this qualitative feedback. In fact, over half (29 of the 57 respondents with conditions or undertakings) indicated that they had experienced a change in their employment situation as a direct result of the case or the outcome.

Also, 34 of the 57 respondents indicated that they had either never worked again (12) or they had had unwanted interruptions in their career (22) much higher

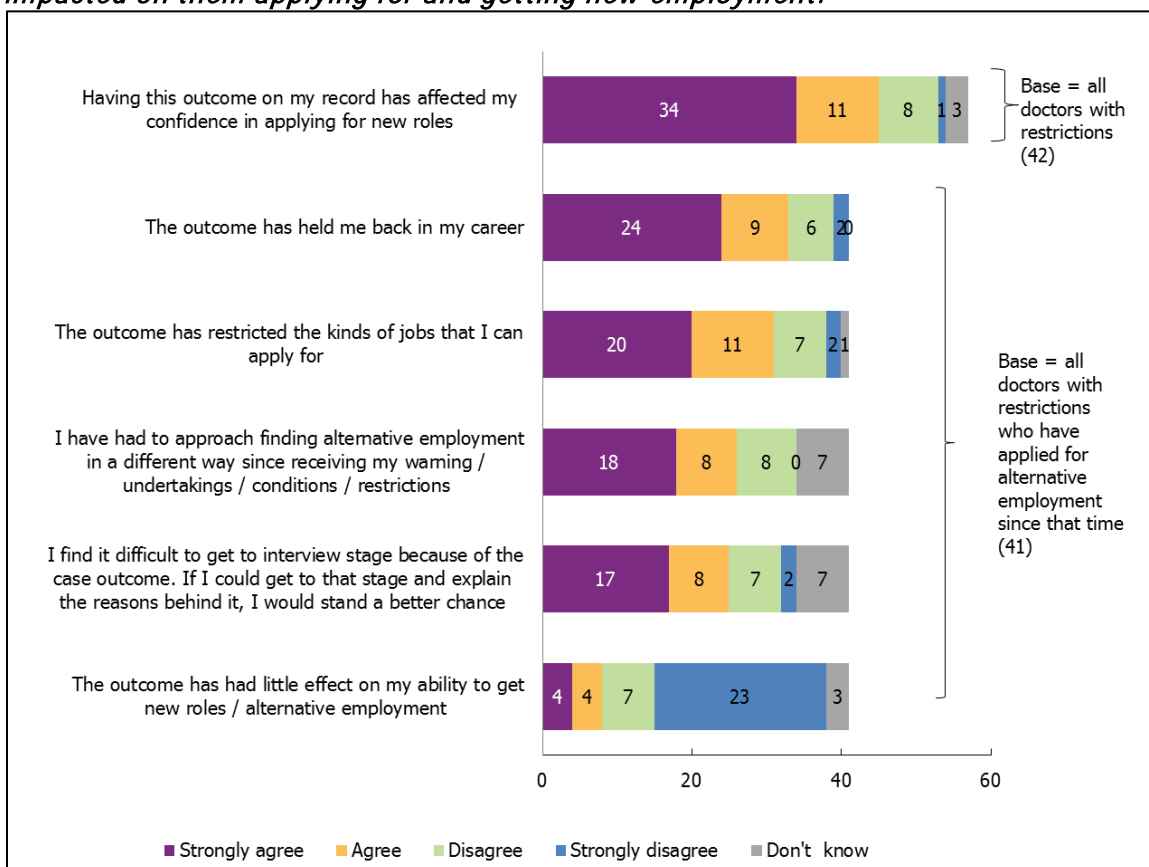
proportions than those seen amongst respondents with warnings (as might have been expected.)

Verbatim comments from the survey highlighted that this was largely attributed to strained relations with employers and colleagues, employers misinterpreting the nature of the restrictions or employers adding further restrictions of their own and the health of individual doctors making it difficult to maintain work.

"I could not do private practice anymore as the agreed undertakings limited my practice to NHS only. My employing trust refused to let me return to work and has put me on a "gardening leave" for the last 52 months even though this is not allowed under maintaining high professional standards in modern NHS." (Survey respondent.)

In keeping with the findings amongst doctors with warnings, when asked to indicate their agreement or disagreement with a series of statements about the impact of restrictions on their career, significant proportions of doctors with restrictions felt that the outcome in their case had affected their confidence in applying for new roles. Many also indicated agreement that restrictions had held back their career; restricted the types of jobs they could apply for and changed the way they need to go about applying for jobs (see Figure 10.)

Figure 10 – Level of agreement with a list of statements about how restrictions have impacted on them applying for and getting new employment.



Base: As shown on chart.

6.4 Personal impacts

A significant personal impact for doctors who experienced restrictions on their practice is a loss of confidence, both professionally and personally.

“So I think that affected my confidence, it didn't just affect it, it greatly affected it, and I think it made me feel, ‘do you know, I don't think you should actually apply for any permanent jobs because I don't think you're good enough anymore’. Probably the confidence ability meant that I was less keen to apply for interviews for jobs, meant that I wasn't keen to take on other roles, I thought I'll just stick to locuming.” (Doctor, Health, Undertakings)

Some doctors with health related conditions/undertakings described feeling that they were living under a 'cloud of suspicion'. Because the publication of their health related undertakings/conditions was not specific in order to protect their confidentiality, people made assumptions about their health issue. Those who had a mental health issue such as a severe bout of depression or who had received successful treatment for an ongoing condition felt that this was unjust and stigmatised them even further. Doctors can consent to the GMC publishing

fuller information about their health but many doctors interviewed were not aware of this.

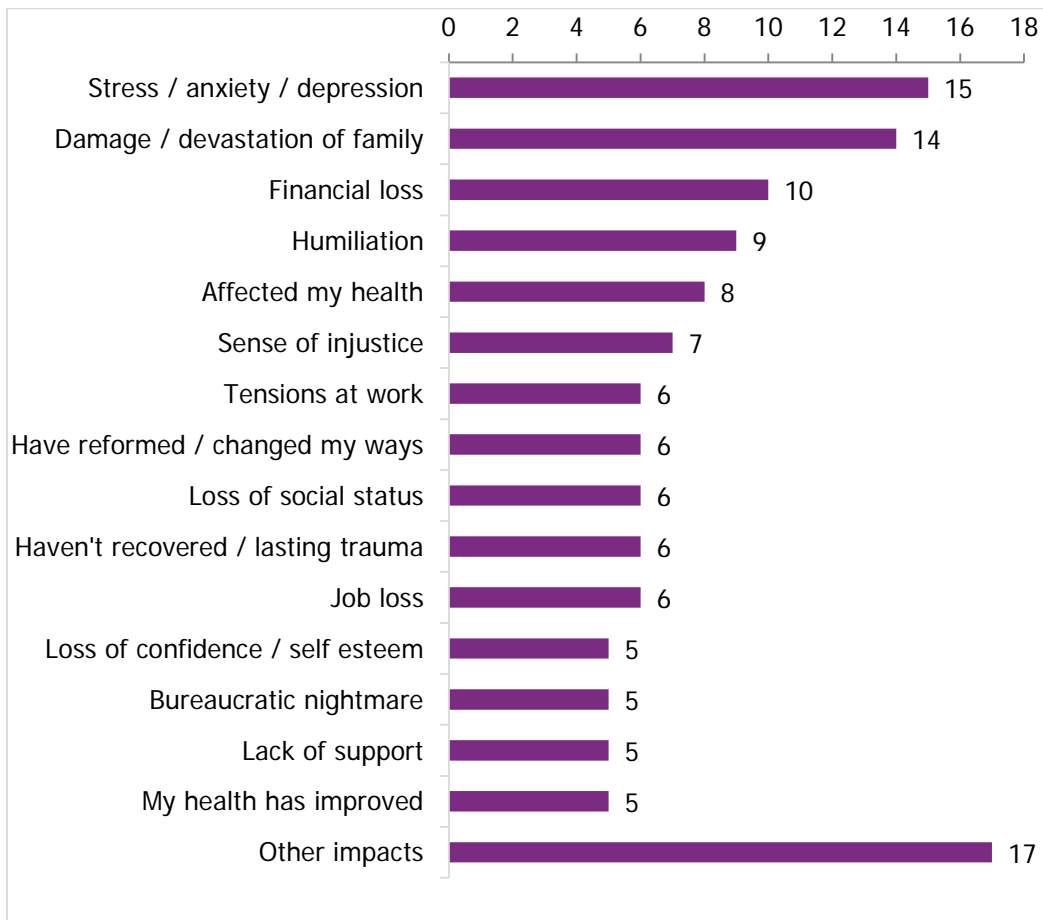
“So obviously in the back of their minds there’s the suspicion that, despite the fact I told them it was mental health grounds, they were kind of ‘is this a drug or alcohol addiction, do we have to scrutinise everything she does and then tell the GMC every little action?’” (Doctor, Health, Undertakings)

When working under conditions/undertakings doctors explained how they felt that it was very difficult to challenge decisions, working practices or any issues with how they were being managed. They reported that they felt that they had no choice but to keep a low profile or they could be subject to unfavourable reporting to the GMC.

“Even if I was treated unfairly at work, which I was, I couldn’t express that because anything I potentially flagged with them would be probably viewed adversely towards me.” (Doctor, Health, Undertakings)

In the quantitative research doctors were also given space to write about the wider impacts that the FtP case and subsequent restrictions had on their personal life, relationships and health and how these impacts had affected their ability to practise medicine. Similarly to the personal impact of warnings, Figure 11 highlights the detrimental impact that the FtP case and outcome often has on an individual’s mental health and family life, with one respondent referring to feelings of suicide.

Figure 11 – Wider impacts of FtP case and outcome – doctors with restrictions⁸



Base: All respondents with restrictions (57)

⁸ Other impacts include - Process took too long (4), Angry/Bitter (4), Friends/colleagues were supportive (3), Family were supportive (3), Suicidal (1), Found out who my real friends were (1), Dreaded receiving letters (1)

7. Suggested improvements

Section highlights:

- Both employers' and doctors' suggestions for improvements to the system of warnings centred on suggestions of more sophistication and flexibility. This would mean taking into account, for example, different types of cases, different settings, and the individual doctor's response to the FtP investigation.
- Questions were also raised about the appropriateness of warnings always being on a doctor's record and in the public domain for five years.
- The suggestion was made that the term 'warning' be changed as this word suggests something far more serious and dangerous to the public than is actually the case.
- In terms of undertakings and conditions, suggested improvements focussed on the need for greater dialogue between all of the parties involved, in order to ensure that the restrictions are much more individually tailored, workable in practice and genuinely negotiated with the doctor's acceptance and buy-in.

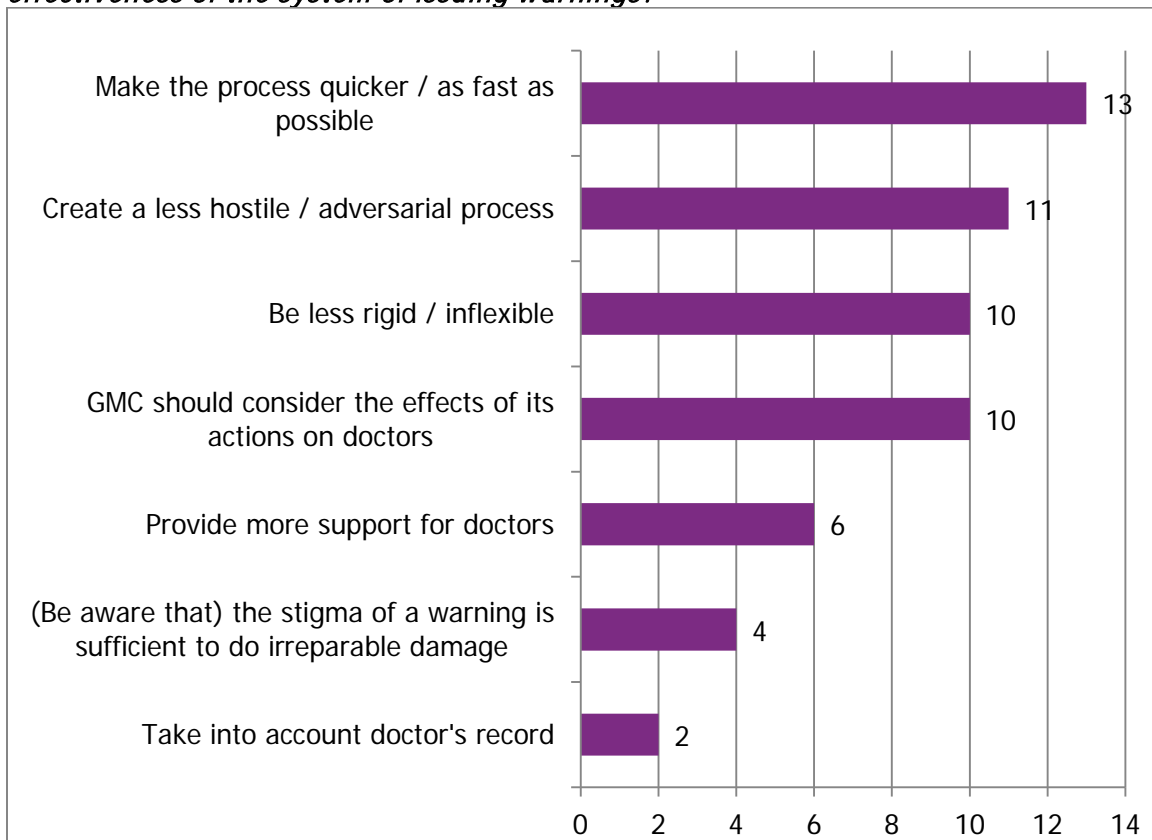
All participants were asked how the systems of warnings, undertakings and conditions could be improved to ensure that warnings and restrictions placed on doctors have a more positive impact.

It should be acknowledged that since the time that many of the cases being referred to in this research took place, the GMC has made some changes to its processes. A number of these may go some way towards the improvements suggested by participants and respondents. For example, the Doctors' Support Service has been introduced; there are face to face meetings with some doctors during an investigation; some changes are already being made and considered to warnings as a result of the responses to the recent consultation on the Indicative Sanctions Guidance, and the GMC's communications have been subject to a review to improve the tone of their correspondence with doctors under investigation.

7.1 Improvements to warnings

In the quantitative survey, doctors with warnings were asked for their unprompted suggestions of how to improve the effectiveness of the system. The most common responses were 'make the process quicker' and 'a less hostile/adversarial process.' Other frequent comments related to the inflexibility of the process, and the GMC giving greater consideration to the impact on doctors. Figure 12 shows the coded responses.

Figure 12 – What, if any, suggestions would you like to make to improve the effectiveness of the system of issuing warnings?



Base: All doctors with warnings (42)

More sophistication and differentiation.

Doctors and employers called for **a more sophisticated system of warnings** with greater differentiation between different kinds of cases and more flexibility in terms of how long warnings are placed on the public record.

Participants questioned why all warnings remain on doctors' records for a full **five years** and called for there to be different levels and types of warnings - some of which could be expunged more quickly.

"If you're warned you're warned, that's it, you've taken the warning, so why do you have to be continuously warned for five years. Why five years, why not just a year? Because five years is a massive amount of time." (Doctor, Misconduct, Warning)

"I think the one issue, certainly about warnings, if a case happened five years ago and it takes that number of years to get through the GMC process, yeah? Then you're given a warning and that stays on your record for five years. That just doesn't seem right, that doesn't seem fair, the fact that the process took so

long ... So often the distance between the event and the sanction is so long, it doesn't seem to be natural justice." (Employer)

Some suggested that there should be much **more differentiation** between different types of warnings. Those where the doctor has accepted the issue and remediated and visibly learned from the experience could and should be treated differently from warnings that are refuted or denied. One doctor reported writing a reflective essay following the events that led up to her warning, but this was not acknowledged or taken account of by the GMC.

One employer suggested changing the system to include a more graduated system of warnings, with the first step being a 'suspended warning':

"There are some people who it does need to be black and white, say you've been found wanting in this particular case but we just think you need to buck up and address this issue. You could even have like a suspended warning, that is that your RO will arrange for some local action within a sort of GMC guidance, if your next two appraisals don't demonstrate that you've made those changes your case will be escalated back up to the GMC who will then give you a formal warning at that." (Employer)

There were also calls from some doctors for differentiation between warnings with clinical implications and those that bear no relation to clinical practice (e.g. late payment of fees, one off drink-driving offence, unrelated police caution.) Such differentiation could be made clear to employers to discourage them from rejecting job applicants with warnings on their record out of hand.

Differentiation was also seen as important because it might allow for consideration of the vastly **differential impact** of warnings on doctors in different situations. It was pointed out that some doctors receive a warning and it will have absolutely no impact on their ongoing career or employability (for example where they are senior partner in a GP practice.) For others, however, the effect is devastating and respondents felt this was totally disproportionate considering that a warning is meant to be the lowest level of outcome available to the GMC.

Publication and visibility

Some participants questioned the value of the public nature of warnings, highlighting the adverse impact that this can cause for doctors' employability, their mental health, and their confidence in their abilities and status as a medical professional. Since warnings do not imply impaired fitness to practice, it was suggested that a warning could be given in a private letter. Some questioned the public benefit of the publicised warning, one doctor likened this to being like *'public corporal punishment'*.

"Because actually putting a warning on the GMC for five years, what does that do, what difference does it make? Other than embarrass the doctor, I suppose..." (Employer)

It was also felt by some that requirements obliging doctors to share details of a warning with an employer at the job application stage were not necessary and that such requirements should be removed. Doctors said that they would still be transparent about the existence of a warning in their history at interview, but that being able to explain the nature of the warning and the reasons why it occurred might make automatic dismissal of them as a candidate less likely. This would make it less likely for a warning to ultimately result in an inability to continue to working as a doctor.

Monitoring and remediation

Some employers thought that it would in fact be useful to have more concrete actions and monitoring processes in place attached to warnings. This could then link to a more sophisticated approach to warnings and lead to early removal:

"As far as I can see if a doctor is given a warning and they accept it, it just goes on a record for five years and that's that. What I think would be rather useful is for offer the doctor a warning and, if the doctor accepts the warning, before it's actually given I think the doctor should be invited to reflect on the warning and to indicate what they intend to do in terms of changing their practice, in terms of taking account of the warning... I think a more limited period time for the warning, combined with reflection, insight and a plan of change, and then the change is declared and they remove the warning would be much more effective."
(Employer)

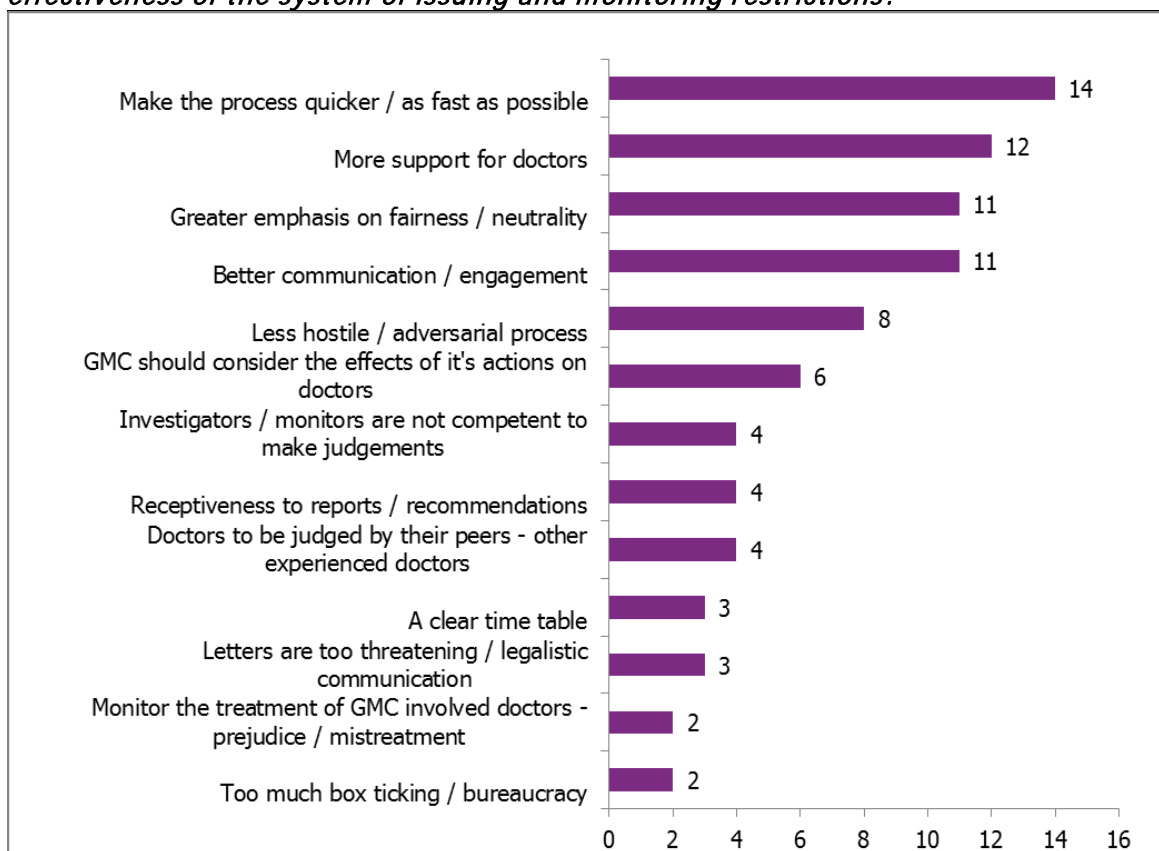
Language and terminology

The term 'warning' was seen as extremely negative and misleading by a number of the doctors interviewed. Given that it is not intended to suggest impairment of the doctor's fitness to practice it was seen by some as misleading. A warning in layman's terms is clearly something to be deeply concerned about - a warning implies a significant hazard and in the perception of many of the doctors taking part in this research this is how GMC warnings are perceived by many. This perception is partly what leads to the considerable impact on some doctors' careers.

7.2 Improvements to conditions and undertakings

In the quantitative survey, doctors with restrictions were asked for their unprompted suggestions of how to improve the effectiveness of the system. The most common responses revolved around speeding up the process and providing more support for doctors. The coded results are shown in Figure 13.

Figure 13 – What, if any, suggestions would you like to make to improve the effectiveness of the system of issuing and monitoring restrictions?



Base: All doctors with restrictions (57)

Individualisation and greater dialogue

In a similar vein to the suggestions with regard to warnings, many of the suggestions for improvements to the system of undertakings and conditions related to the need for a more bespoke, sophisticated system. Calls from both employers and doctors were made for an improved system which takes more account of each doctor's individual case, their needs and the circumstances under which they will have to work with the undertakings or conditions in place.

"I think it does depend on your role, that if your role is a partner in a surgery or a salaried GP in a surgery or a Registrar then it's much more straightforward. But if you're a locum... my Case Examiner was being constantly inundated with reports, she said she would get about 20 different workplace report a month about me." (Doctor, Health, Undertakings)

It was suggested that the GMC needs to take a doctor's individual working conditions into consideration when setting restrictions on practice. In certain cases restrictions are so difficult to work with that the GMC are in effect forcing erasure.

"I think conditions can actually be useful but I think it would be nice if they were tailored to: 1) a particular doctor's professional setting, like what speciality area and what level they're at; and 2) that they have to be feasible. I think it's difficult when conditions are imposed on people and they are unfeasibly restrictive and it basically puts doctors in a situation where the conditions render them unemployable, so they can never demonstrate to a review panel that they've progressed. Then basically it's an erasure in everything but name. So, I think as long as they are workable conditions and they are tailored to the doctor's situation to make them feasibly imposed, I think they're a good thing really."
(Doctor, Combined, Conditions)

Linked to this was the call for undertakings and conditions to be less generic and formulaic and more flexible. Several employers suggested that this greater flexibility and individualisation could be achieved if there were more opportunities for dialogue between the employer and the GMC prior to restrictions being put in place. This would allow the restrictions to be sense checked and cross checked with:

- The realities of the working environment and support available on the ground.
- Any existing requirements in place, or improvements made, as a result of other investigations.

"Come back to the Responsible Officer and say 'here's where we are and this is what we've found, we're minded to do this, what do you feel?' That's something which would enable the Responsible Officer to take account of what was told at the GMC's enquiries, the way they're thinking, to say 'I think you're absolutely right, that will help', sometimes the Responsible Officer/Medical Director might say 'actually, the doctor's actually continued working for us for now, he's very good, you might be thinking of a restriction but maybe a warning would be better, it's your decision, it's just my view'." (Employer)

Doctors perceived that the GMC tends to impose restrictions in a very top down way, with little room for **dialogue and discussion**. There was a strong sense that the effectiveness of undertakings and conditions would be considerably improved if all parties engaged in dialogue to make sure that the chosen approach was appropriate. It was also felt that this would allow the doctor to 'buy-in' to the process more effectively. Although, in theory, undertakings are agreed between the GMC and the doctor, many of those interviewed did not perceive their undertakings to have been jointly agreed, instead feeling that they had had little choice in accepting them, based on the strong advice of the defence organisation.

This **greater flexibility and responsiveness** to individual circumstances and feedback was also raised with regard to the case review and monitoring process. There is a sense from doctors that undertakings and conditions are imposed with

little opportunity for practical issues and considerations to be raised with the GMC and solutions jointly negotiated.

The need for dialogue and flexibility – Example 1

One doctor who was working as a locum gave an example of where the desire for more flexibility and dialogue about individual circumstances led to her collaborating with her supervisor leading, in fact, to a breach of the agreed undertakings. The doctor and her supervisor did this because they both felt that her undertakings were unworkable in practice. As a locum she had many different employers and didn't know in advance which employers she would be working for. Her undertakings required her to get prior permission for every employment contract so her supervisor agreed that, instead, she could book contracts and let him know retrospectively who she had worked for, at the end of each month. In this way they 'worked around' the undertakings. The process they developed was still not easy and the doctor felt that she was very lucky that the supervisor was willing to work in this way. However, it is clear from our subsequent discussions with the GMC that they are extremely concerned about this breach of undertakings and do not support this approach. It has been included as an example of the need for dialogue about how undertakings can be made to work for doctors whilst still ensuring that the public is protected.

"One of the undertakings was 'you must obtain approval from the Educational Supervisor before taking on any role', as I said, I couldn't... if there's all these emails being sent out to me 'will you cover these shifts?', all these doctors then replying back, I would get no shifts." (Doctor, Health, Undertakings)

The need for dialogue and flexibility – Example 2

The doctor's undertakings required that he should attend Alcoholics Anonymous (AA). However, AA is a confidential and anonymous support group so it was very difficult to get a letter of assurance from them and uncomfortable for the doctor to ask and therefore disclose all his personal details in a place where he was known by his first name only. This difficulty was not accounted for in the way that the undertakings were set up. The doctor managed to negotiate around this by asking a colleague within a doctors' and dentists' support group to assert that 'as far as they know' the doctor does attend AA. However the doctor makes the point that no one really knows whether this is the case, since attendance is by its nature secretive.

"Alcoholics anonymous is run in such a way that there just is no roll call. No one knows that I've been there. It shows me that the GMC don't really understand what alcoholics anonymous provide. That is the only undertaking I have which I think lacks clarity." (Doctor, Health, Undertakings)

Another employer felt that the imposition of restrictions could be more tailored to those doctors in training, who have different needs to those who are qualified. They are more likely to be closely supervised already and so some of the restrictions typically imposed may not be appropriate. Also the employer had found some restrictions (for example, the trainee must only work in a GP Practice when according to their training schedule they are supposed to be doing hospital rotations) difficult to accommodate.

"I think where we've found challenges in terms of the GMC interaction with that is primarily around GMC restrictions, undertakings or conditions, not taking into account how training is structured, if you see what I mean." (*Employer*)

Treat health cases differently

A number of doctors whose cases had arisen because of health issues felt that an entirely different and separate system of conditions and undertakings should be constructed for such cases. Some doctors felt very strongly that a more pastoral, supportive and understanding approach needed to be taken with doctors who are suffering from health conditions. Handling such cases under what appears to be the same Fitness to Practice process as is applied to doctors who have performance or misconduct issues is perceived to be unjust and even insulting.

"From my own point of view, I would have found it far more devastating to have felt that this was about conduct or integrity or medical capability, diagnostic capability, those kind of things. The one thing that kept me going was that actually it was about health and I'm going to get better, once I was better I would be back to be like I was." (Doctor, Health, Undertakings)

Furthermore, some doctors felt that handling health cases in the same way as performance and misconduct cases made it less likely that doctors would come forward with such issues, seeking instead to hide them and avoid getting help because of the possible implications for their career.

"I think there's still an element of not admitting to mental health, addiction, what have you, problems within the profession. There's a perceived bias against it. You know, so there is very much still a problem in coming clean, as it were, and getting help." (Doctor, Health, Undertakings)

There was some recognition that health cases are already treated differently in terms of the information that is made public about the doctor's case. This was an issue that attracted a mixed reaction from doctors. Some doctors with health cases felt that their undertakings should have been entirely private, shared only with employers. Even the publication of the existence of their restrictions (albeit not with complete transparency) was reported as adding to their distress, which

in turn was particularly unhelpful for doctors already suffering from mental health issues.

"How could you make them more positive? Don't put them on the bloody website. That is distressing, making them public." (Doctor, Health, Undertakings)

However, one doctor felt that it would have been helpful if the GMC was in fact more transparent about the nature of her health case, since the lack of transparency in what is provided to employers can sometimes lead them to assume the worst possible scenario and steer clear of the doctor. This suggests doctors are not aware that they can waive confidentiality and agree that the GMC disclose or publish information about their health.

"Certainly if they'd written to them and said 'this doctor - there was never any concerns with drug addiction, alcohol addiction, her fitness to practice, we've never had concerns about, just really it was because of her mental health and we've just kept her under review, supportive measures', then I think that would have helped." (Doctor, Health, Undertakings)

One employer suggested that, in addition to health cases being treated differently, the various types of health cases should be treated differently. They suggested that the US system is adopted for substance abuse cases where there is much more formalised system of rehabilitation and testing.

"I think probably once the GMC has reasonably good evidence that you are addicted to a substance, then the American system for dealing with that is you go into a programme, that is the end of it and the programme monitors you and you have regular urine testing and blood testing, and it is done as part of a very formal process." (Employer)

Provide more support to doctors

Many of the suggestions for improvement made by doctors related to the provision of greater support. Doctors called for the GMC's own approach to be, in general terms, more supportive, more sympathetic, human and helpful and less punitive.

"No, no they don't offer any help at all. They don't. They don't offer any help at all. If the only person left in the whole world, if the only organisation left in the whole world to help me with the problem was the GMC, I wouldn't go to them. I don't want anything to do with them, ever, in my whole life ever again." (Doctor, Health, Undertakings)

They also suggested the idea of better signposting to peer support. In particular it was suggested that support for doctors starting out on the road of having undertakings or conditions could potentially be provided by doctors who have been through this process and successfully returned to full fitness to practice.

Since some doctors found it difficult to find and put in place the supervision and training necessary to adhere to their undertakings, there was also some suggestion that the GMC could provide more support in this particular respect.

"They can help with training, because I think a lot of places where, okay you have conditions and you're not able to find a place because people will say, 'I don't want to have anything to do with the GMC.....' If they're seen as good, the GMC would even say, 'Here's a job for you because you're involved in teaching' or something like that. Then a lot more people would be happy to." (Doctor, Performance, Conditions)

There were also mentions of the GMC being more supportive in aiding doctors with undertakings or conditions to find employment and to compensate doctors for the additional costs associated with adhering to their undertakings, particularly since they may have experienced a loss of earnings as a result of restrictions on their practice.

Several employers also suggested greater investment in Occupational Health Services to help mitigate against the stress of being involved in a fitness practise case.

"Once as a doctor you're in the system, if you weren't stressed when you went in the system, you're certainly stressed immediately. So from that point of view, doctors need access to good Occupational Health because doctors are notoriously bad at looking after themselves and so disinvestment from Occupational Health systems in Primary Care is an issue." (Employer)

Improvements to Medical Supervision

Qualitative participants made specific suggestions with regard to medical supervision including:

- Recruitment of a wider pool of medical supervisors to allow for more targeted assignment by location and / or specialism in the doctor's condition and a better chance of a consistent supervisor throughout the period of supervision.
- Speed up the process for getting an appointment with a medical supervisor.

One doctor's supervisor was located so far away that it took an entire day for the supervision sessions to be undertaken.

"Have more GMC Supervisors available locally, because it used to mean taking a whole day off work for me to go and see my GMC Supervisor, for him to say 'how are things going at work', for me to say 'fine' and for him to say 'how are you getting on with people at work' and for me to say 'fine', and to say 'how's your health', me to say 'fine' and have to look out the window and talk about other things." (Doctor, Health, Undertakings)

This doctor perceived that it was expected that all such supervision sessions had to be undertaken face-to-face. If in future the GMC might accept such supervision sessions to be undertaken remotely by telephone or over videoconference facilities, it would be helpful if this were made clear.

7.3 Improving the response of employers

Education of employers

Many of the improvements suggested by participants were aimed at trying to improve the response of employers to doctors with warnings, undertakings or conditions. There was a strong sense that, whilst some employers do react in a constructive and supportive way many others do not. Some doctors perceive a role for the GMC in persuading employers to take a much more positive approach:

“So, that would be my advice to the GMC is if you really want to help people deal with their issues, speak to all the stakeholders and look at your doctors as an asset, as an investment and don't discourage people away from the profession.”
(Doctor, Misconduct, Conditions)

A strong perception exists amongst doctors that employers do not differentiate sufficiently between warnings (which do not imply impaired fitness to practice in any way) and other sanctions which do. Doctors felt that the GMC could do more to educate employers about this and ensure that discrimination against doctors with warnings on their record does not continue.

Some employers also talked about a need for **clarity of language** to make sure that doctors, HR departments, and colleagues know what the difference is between warnings, conditions and undertakings. Some suggested that the system of sanctions could be reframed by changing the language used to terms that are less judgemental and punitive. For example:

“There's something about the language of it all, what does warning really mean, what's the consequence of that? And even phrases like undertakings, what does that mean?” (Employer)

Furthermore there was a sense from doctors that some employers simply do not understand the processes and systems that need to be put in place in order to support or supervise a doctor working with restrictions. This lack of understanding can leave the doctor struggling to find their own way to adhere to the restrictions with little or no support from employers or training organisations.

“There's just a lot that the doctors in the background are struggling, don't have a lot of people to turn to that actually know about these things.None of these people seem to have any idea apart from what's the standard, anybody who's

fallen through the net has to swim against the tide by themselves.” (Doctor, Misconduct, Undertakings)

Guidance and enforcement

Several employers suggested the provision of more guidance on dealing with doctors with warnings and restrictions, particularly for those who do not deal with many cases. They also called for more, and clearer, guidance for doctors in this situation.

“Let’s say, yes, when you allocate somebody to be the clinical supervisor they’ve probably never done it before. So I think it’s quite difficult for them to know what they should be doing and how they should be doing it, how trust mechanisms come into play, who they tell what and when. It’s always like a first time for everybody involved, so yes, it’s good that it’s individualised. But I think some clearer guidance on what’s expected of people would be quite helpful.” (Employer)

Greater clarity was specifically called for regarding the duty of care to the doctor, and it was felt that in particular the question of ‘who pays?’ needs to be answered.

Employers also suggested that the GMC should take a strong interest in whether employers are taking their duty of care seriously and providing the necessary support to doctors:

“Surely the GMC should also be looking to ensure that those doctors are being cared for, in a compassionate and appropriate way, in the interim. And I do think they should almost challenge organisations like ours to demonstrate how we are dealing with things locally, in an appropriate way.” (Employer)

One doctor suggested the need for enforcement whereby the GMC writes every month to check the undertakings are still being adhered to and could get involved if an employer is in some way blocking their implementation, in addition to ensuring the doctor’s adherence:

“They need to have that power, I think to not only castigate the doctor and deal with that performance, but also when we have a situation where retraining is happening and I have been as constructive as possible but then not equally the {employer} are not doing what they’re supposed to do.” (Doctor, Performance, Conditions)

Practical support for employers

Employers suggested that the GMC could provide further practical support for employers who are facing the need to provide supervision for an employee working under restrictions. Given that employers vary in terms of their level of experience and their readiness to support doctors with undertakings and

conditions, this practical support might be particularly important to target towards employers with less experience of these matters.

Several employers suggested the creation of a pool of accredited supervisors to help alleviate the challenge of finding an appropriate individual to take on this role. Another employer took this idea one stage further and suggested accredited units specialising in remediation.

"What I would like to see would be a network of accredited units, or hospitals where they had a bit of extra resource in order to provide high quality remediation, and they were experienced in it and there was extra staff who knew what they were doing and had done it a lot, where these doctors could go." (Employer)

Several employers suggested that the GMC might provide a service of facilitated meetings between the doctor and their colleagues/manager to help remediation / reintegration:

"Maybe a specialist team that goes around doing it, because it's sometimes having that third party who hasn't got a local bias on what's been going on, can be useful to bring some balance to the discussion.....So I think having a team that can facilitate that reconciliation is useful. Because if you can't go back to what you had before, or at least to 90% or so of what you had before, is it actually doomed to failure anyway?" (Employer)

Several employers suggested setting up a type of clearing house system where doctors can move elsewhere within the local health system to get supervision support:

"I think that where relationships have broken down within an organisation, it would be really helpful to have some sort of system where these doctors can go elsewhere to be remediated." (Employer)"I don't know how many people are really ringing round at random and actually making enquiries of places which are totally inappropriate and they're wasting their own time as much as anything else, and getting further depressed. So some kind of clearing house arrangement might be helpful." (Employer)

Several employers suggested an enhanced role for NCAS in terms of the provision of support for employers dealing with doctors with restrictions:

"I think the role of NCAS has become quite muddled so I'm actually not quite sure what the role of NCAS is in all of these things now anyway. I don't quite know what they're supposed to be doing so it almost feels like that is a role for NCAS. I know they're in the middle of a restructuring, but my dealings with them are because I would expect them to be providing some of the help and support

in terms of remediation and helping people through this but in practice they don't seem to do that." (Employer)

7.4 Improvements to the FtP process

This research was not focused on the FtP process itself. Nevertheless, when asked to suggest areas for improvement a number of suggestions were made that relate to the FtP process and investigation rather than to warnings, undertakings or conditions per se. Many of the suggested improvements to the FtP process were the same as those uncovered in previous research commissioned by the GMC to examine doctors' experiences of the process itself.⁹ This previous research project looked at the process in far more detail and it appears that many of its findings and recommendations are still relevant. Any changes made by the GMC in response to that previous research are unlikely to have been put in place at the time that the doctors involved in this research were going through the FtP process.

Clearly whilst these suggestions do not bear a direct relationship to the objectives of this research, they are nonetheless relevant since acceptance and engagement with the FtP process is seen to have an impact on doctors' ongoing willingness to engage with and accept the warnings or restrictions that are applied as a result of the process.

Key issues that were raised with regard to the FtP process itself were as follows:

- The need to soften the GMC's language and communications within the FtP process making it less legalistic and adversarial in style. A number of doctors reported feeling extremely distressed by the wording of some of GMC's communications during the process with the impression of an assumption of guilt being given.
- The need for a more collaborative process whereby there is more discussion about systemic issues that contribute to individual FtP cases. This came out strongly in the employer interviews. Doctors too suggested a greater dialogue during the FtP process.
- Reducing the length of time that the process takes was also a key issue. A strong message from the employer interviews was that the timescales for GMC investigations were too long. There were widespread recommendations for how the process, and its timeframes, might be improved, especially to limit further detrimental impacts on doctors.

⁹"Exploring the experience of doctors who have been through the GMC's complaints procedures," research project undertaken by Community Research, Published: November 2014
<http://www.gmc-uk.org/about/research/25947.asp>

"So for that group of doctors who are insightful, who they immediately go and do the education work before they even get a communication from the GMC, the length of time those processes take, I think, is incredibly damaging for the doctors and, frankly, I think impacts on patient safety because they're so stressed. And we often talk to those doctors about taking time out just because their head's in a different place." (Employer)

- The need for a more compassionate and 'human face' to the process was also frequently raised. One employer suggested the nomination of a third person from the GMC, who is not a case manager or investigating officer, but who can provide advice around the process and signposting to support. Employers called for more compassion and support for doctors within the FtP investigation process and in the choice of the final outcome:

"And there are others who perhaps need a slightly more mentoring approach and say 'we realise this was a difficult time for you as well, mistakes were made and we'd like to help you get through this, to improve your practice and prevent it happening again'. And some people would respond better to that kind of approach than a warning that looks punitive rather than supportive...." (Employer)

- Some doctors also raised concerns about the FtP process in terms of the relevance of the investigation and, in particular, whether assessments and expert witnesses were sufficiently specialised. The perceived lack of specialist expertise within the investigation process undermined doctors' faith in the outcome and sometimes therefore their ability and willingness to accept the resultant undertakings or conditions.
- Several employers suggested that GMC should focus more on a whole system approach and place more emphasis on exploring and understanding systemic failures rather than blaming individuals.

"If they want to make the whole bloody thing safer, which is kind of more the revalidation side of things, the firm side of things, then I think they really need to look at making the whole body of professionals safer, and the places to look at are things like Air Traffic Control and airline pilots where they've got completely different processes and procedures put in place. It's much more about whole system safety and much more about bringing everybody on side." (Employer)

Appendix A: Qualitative phase participant profile

Type	Doctors with warnings	Doctors with undertakings	Doctors with conditions	TOTAL
<i>Gender</i>				
Male	9	8	7	24
Female	5	9	2	16
<i>Age</i>				
25-34	-	2	1	3
35-44	5	3	2	10
45-54	4	5	4	13
55-64	3	7	-	10
65+	2	-	2	4
<i>Ethnicity</i>				
White	8	13	4	25
Black African/Black Caribbean	1	1	1	3
Asian	4	3	3	10
Other	1	-	1	2
<i>Length since qualification</i>				
Less than 2 years	-	1	-	1
2-5 years	1	-	1	2
5-10 years	-	2	-	2
10-20 years	5	3	5	13
Over 20 years	8	11	3	22
<i>Place of qualification</i>				
UK	10	11	4	25
E.E.U	1	2	2	5
Elsewhere	3	4	3	10
<i>Sector</i>				
Wholly NHS	7	8	4	19
Private sector	0	-	2	2
Both NHS and private	3	2	2	7
Not currently working	4	7	1	12
<i>Setting</i>				
Primary	5	2	3	10
Secondary	4	4	3	11
Community	1	2	-	3
Other	1	2	2	5
<i>Type of case</i>				
Health	0	10	1	11
Performance	4	4	5	13
Misconduct	10	1	1	12
Combined	0	2	2	4

Appendix B: Research instruments

Depth interview discussion guide for doctors:



Doctors discussion
guide FINAL.docx

Depth interview discussion guide for employers:



Employers discussion
guide FINAL.doc

Online questionnaire for doctors:



GMC online survey
questionnaire FINAL