

Understanding the rise in Fitness to Practise complaints from members of the public

Dr Julian Archer, Dr Sam Regan de Bere, Dr Marie Bryce,
Dr Suzanne Nunn, Dr Nick Lynn, Dr Lee Coombes, and Mr
Martin Roberts

30/01/2014



Funded by the General Medical Council.

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

Table of Contents

Table of Figures.....	5
Table of Abbreviations and Acronyms.....	7
Executive Summary.....	8
Introduction	8
Methodology.....	8
Data Collection.....	8
Data Analysis.....	9
Research Findings	9
The GMC and its public profile	10
The public and the profession	10
Interactions between patients and practitioners.....	11
The motivations of complainants	12
Access and opportunity: the internet and social media.....	12
Complaints and litigation.....	12
Wider healthcare complaint-handling system	13
Standards of Care.....	13
Conclusion.....	14
Next Steps	15
1. Introduction	16
2. Background	16
2.1 Methodology.....	20
2.1.1 Aims.....	20
2.1.2 Objectives.....	20
2.2 Methods.....	20

2.2.1 Literature Review	21
2.2.2 Statistical Analysis.....	22
2.2.3 Media Analysis	25
2.2.4 Interviews.....	26
2.3 Evidencing findings	28
2.4 Research Ethics	29
3. Findings	30
3.1 The GMC and its public profile.....	41
3.1.1 Media portrayals of the GMC	41
3.1.2 GMC public relations strategy.....	47
3.1.3 The public's understanding of the GMC/the GMC and the public	49
3.1.4 Conclusion	52
3.2 The public and the profession	54
3.2.1 The media and the medical profession	54
3.2.2 Perceptions of the medical profession	61
3.2.3 Comparisons with other professions.....	62
3.2.4 Conclusion.....	66
3.3 Interactions between patients and practitioners	67
3.3.1 The number of patient episodes.....	67
3.3.2 The nature of doctor-patient consultations	68
Case Study: Daniel Ubani in the media	70
3.3.3 Changes in the doctor-patient relationship.....	72
3.3.4 Conclusion.....	76
3.4 Motivations of complainants	78
3.4.1 Emotion.....	78
3.4.2 Death and the grieving process	78

3.4.3 Complaining as a civic duty	79
3.4.4: Conclusion.....	82
3.5 Access and opportunity: the internet and social media	83
3.6 Complaints and litigation	86
3.7 Confused complainants? The wider healthcare complaint-handling system.....	90
3.7.1 Confused complainants	90
3.7.2 Potential interventions	96
3.7.3 Conclusion.....	100
3.8 Standards of Care	101
4. Conclusion.....	103
5. References	105
6. List of annexes	115

Table of Figures

Figure 1: Issues in the data - discrepancies between published statistics and shared data ...	24
Figure 2: Issues in the data, Northern Ireland	25
Figure 3: List of interview participants	28
Figure 4: Evidencing findings	28
Figure 5: LOESS trend estimates showing the 'total allegation', 'unique enquiry' , and 'unique enquiry/reference number combination' rates of FtP enquiries in the UK, 2007-2012	31
Figure 6: LOESS trend estimates showing the 'unique enquiry' scaled rates of FtP enquiries in the four main regions of the UK, 2007-2012	32
Figure 7: LOESS trend estimates showing the 'unique enquiry/reference number combinations' scaled rates of FtP enquiries in the four main regions of the UK, 2007-2012.	32
Figure 8: LOESS trend estimates showing the 'total' scaled rate of FtP allegations in the four main regions of the UK, 2007-2012	33
Figure 9: LOESS trend estimates showing the 'unique' scaled rates of FtP enquiries in the SHAs of the UK, 2007-2012	34
Figure 10: LOESS trend estimates showing the 'unique enquiry/reference number combinations' scaled rates of FtP enquiries in the SHAs of the UK, 2007-2012.	35
Figure 11: LOESS trend estimates showing the 'total' scaled rates of FtP allegations in the SHAs of the UK 2007-2012	35
Figure 12: LOESS trend estimates showing the 'unique enquiry/reference numbers' rate of FtP enquiries per month, 2007-2012	36
Figure 13: LOESS trend estimates for 'unique enquiry/reference number combinations' scaled rate case data for UK regions, 2007-2012	37
Figure 14: LOESS trend estimates for 'unique enquiry/reference number' scaled rate for cases closed at triage, UK regions, 2007-2012	37
Figure 15: LOESS trend estimates showing 'unique enquiry/reference number combinations' scaled rate case data for SHAs, 2007-2012	38
Figure 16: LOESS trend estimates showing 'unique enquiry/reference number combinations' scaled rate for SHAs, 2007-2012	39
Figure 17: Fitness to practise complaint-making activity system	40

Figure 18: Timeline showing results of selected Lexis Nexis searches, of UK national and local newspapers	42
Figure 19: Newspaper article sample, by newspaper and year by publication.....	44
Figure 20: Unique visits to selected GMC webpages, 2011-2013	51
Figure 21: Nvivo word frequency search result showing the 100 most frequent words in the headlines of sampled articles (3 letters or longer)	59
Figure 22: Percentage increase in complaints received by healthcare professions regulators, 2008-2012	63
Figure 23: Notional percentage of registrants subject to complaint from members of the public.....	65
Figure 24: LOESS trend estimates showing the rates of FtP enquiries by allegation category, 2007-2012	74
Figure 25: LOESS trend estimates and raw counts showing the 'only benefit claim' closure reason for FtP allegations per month, 2007-2012.....	81
Figure 26: LOESS trend estimates showing the 'total allegation' and 'unique enquiry' rates of FtP enquiries in the UK, 2007-2012	94
Figure 27: LOESS trend estimates showing the closure reasons for FtP enquiries in the UK, 2007-2012	95

Table of Abbreviations and Acronyms

ASA	Advertising Standards Authority
AvMA	Action Against Medical Accidents
BMA	British Medical Association
CAMERA	Collaboration for the Advancement of Medical Education Research and Assessment
CHAT	Cultural-Historical Activity Theory
CQC	Care Quality Commission
DCS	Dental Complaints Service
ELA	Employer Liaison Advisor (GMC)
FtP	Fitness to Practise
GCC	General Chiropractic Council
GDC	General Dental Council
GMC	General Medical Council
GOC	General Optical Council
GOsC	General Osteopathic Council
GPC	General Pharmaceutical Council
HCPC	Health and Care Professions Council
LeO	Legal Ombudsman
LOESS	Locally-weighted scatter plot smoothing
MPTS	Medical Practitioners Tribunal Service
NALM	National Association of LINKs Members
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NMC	Nursing and Midwifery Council
PA	Patients Association
PHSO	Parliamentary and Health Services Ombudsman
PSNI	Pharmaceutical Society of Northern Ireland
PSOW	Public Services Ombudsman for Wales
RLA	Regional Liaison Advisor (GMC)
RO	Responsible Officer
SRA	Solicitors Regulation Authority

Executive Summary

Introduction

Handling fitness to practise complaints is one of the core functions of the General Medical Council, as it works to regulate the medical profession and to protect the public by ensuring that only those doctors who meet the standards set out in *Good Medical Practice* are allowed to work in the UK. However, in recent years the number of fitness to practise enquiries being received by the GMC has increased considerably, from 5168 in 2007 to 10,347 in 2012 (GMC 2011; GMC 2013g). Investigating all these enquiries thoroughly and fairly places a strain on GMC resources and risks drawing effort away from its other work as regulator.

Enquiries from members of the public rose from 3,615 in 2007 to 6,154 in 2012 (GMC 2011; GMC 2013g). This report provides an in-depth and independent evaluation of the social, political and cultural factors which have driven the increase in complaints from the public, focused particularly on the period 2007-2012. By understanding the impact of these factors, we have been able to map the landscape that has developed in recent years, in which people who are unhappy following treatment by a doctor are more likely to turn to the regulatory body. We have produced an analysis which will support the GMC's efforts to manage fitness to practise complaints, both in terms of its own decision-making processes and communication activities, and also with regard to its interactions with other key stakeholders.

Methodology

The empirical research upon which this report draws was conducted by a mixed-methods team, using quantitative and qualitative methodologies to produce an analysis with both breadth and depth.

Data Collection

We undertook an extensive narrative review of literature relevant to complaint-making behaviour and fitness to practise processes. This encompassed: documentation from the GMC and other regulatory bodies; government and parliamentary reports; and peer-

reviewed academic publications from a number of disciplines, including medicine, law, history and social sciences.

The GMC provided statistical data from its fitness to practise database covering the period 2007-2012. We identified overview statistics from other healthcare regulators to use as comparative data where appropriate.

Media coverage relevant to the GMC, fitness to practise cases and the medical profession more widely was identified using a number of search tools. Targeted searches of the LexisNexis newspaper database, the Box of Broadcasts database (BoB), and broadcasters' own websites were used to generate relevant samples of material for analysis.

In addition, we conducted 13 semi-structured interviews with representatives of key stakeholder organisations across the spectrum of interest, including the GMC, the BMA, patient representatives, legal groups, and other regulatory bodies.

Data Analysis

Initially the different datasets were analysed separately. This involved a thorough statistical analysis of the fitness to practise data and content, thematic and discourse analyses of the media coverage and interview data.

Our findings from each of these streams of analysis were then triangulated to identify significant trends over time. Further triangulation was achieved using Cultural Historical Activity Theory to model the roles of significant groups, FtP policies and processes, and to illustrate how they may interact to shape the increase in complaints.

Research Findings

Analysis of the GMC's statistical data established that the rise in complaints from members of the public has been largely consistent at regional and national levels throughout the UK, suggesting that the increase has been driven by wider social trends rather than localised factors.

We also found that other regulators have also seen increased numbers of complaints in recent years, again indicating social factors. However, within the healthcare sector, the GMC appears to receive a higher level of complaints from members of the public when judged

against its registrant base than other regulators which suggests that there may also be factors which are affecting the organisation more than others.

Our analyses highlighted a number of key factors that have created a context within which complaints increased.

The GMC and its public profile

The GMC has recently achieved a higher public profile than has been typical in the past. This has resulted from increased press coverage of medical malpractice and fitness to practise cases, and, in the last three years, from the GMC's own communications strategy.

However, this higher profile and likely increased 'name recognition' has not been accompanied by an increased level of understanding about the GMC and its remit, or the limitations of what can be achieved through a fitness to practise complaint. Although no causal link has been demonstrated between media coverage of specific cases and the rate of complaints, a strong media focus on fitness to practise panels appears to suggest that such panels are the likely outcome of a complaint. This means the media may have contributed to creating a perception of the GMC and its work which does not match the reality.

There are questions about how much the public needs to, or can be expected to, know about the GMC and its processes. Our findings suggest that 'knowledge' without understanding may be contributing to increased complaints, as public expectations of the GMC as the body which is responsible for disciplining doctors are not grounded in the reality of its fitness to practise procedures. The large number of complaints which do not progress through the fitness to practise system are indicative of this issue. A clear sense of purpose behind the GMC's communications strategy is important, and further dissemination of information to the public is a potential area for development.

For more information see section 3.1, p.40.

The public and the profession

In recent years, the public profile of the medical profession has been damaged by negative media coverage, focused on the supposed failings of foreign doctors, stories of criminality by medics and extensive coverage of high-profile fitness to practise cases. Although the reputation of the medical profession remains good according to other measures, this

sustained diet of negative coverage, conforming to a few stereotyped models, may feed the increase in complaints by contributing to a highly critical backdrop against which medical consultations are now experienced.

For more information, see section 3.2, p.54.

Interactions between patients and practitioners

Underpinning macro-narratives about the public and the profession are the enormous number of individual consultations between patients and practitioners which take place each day. The manner in which such encounters take place is clearly important, as an increasing proportion of complaints are focused on issues involving communication. Although speaking to individual complainants about their experiences was beyond the scope of this study, we have highlighted some significant factors which may be shaping how these encounters are experienced.

We have demonstrated that, whilst the number of patient episodes has increased during the period under examination, the increase in complaints from members of the public is far greater.

Changes to provision, particularly in the primary care sector, have impacted upon how patients see their doctors. There has been an increase in the proportion of consultations conducted by telephone and a decrease in the number of home visits. It is possible that phone consultations are convenient for some patients, but they may also be unsatisfactory to others. Out of hours care – and the reduction in services - has been the subject of particularly negative media attention, and therefore it may be poorly perceived by patients. Our analyses have suggested that there is nostalgia for a supposed golden age of medical care, in which patients always saw the same doctor, with whom they had an on-going relationship which engendered good care and interpersonal understanding between patient and practitioner.

There is also a general perception that the nature of the doctor-patient relationship has changed, with patients becoming less deferential, better informed and more willing to question the care they receive.

For more information, see section 3.3, p.66.

The motivations of complainants

Complainants are often motivated by strong emotions, such as anger, frustration and misery. Interviews identified a common perception that, for some, pursuing a complaint might be an outlet for emotion or a diversion from the grief of losing a loved one.

Additionally, there has been an increasing trend for complaint-making to be constructed as an altruistic activity. In this model, the complainant is acting to ensure that the poor care they feel that they experienced does not happen to other people in future. The influence of complaint networks or campaigns has been felt across the regulatory landscape, with complainants motivated by various agendas – often focused on stopping what they see as an injustice or wrongdoing – using targeted complaints to regulators in pursuit of wider social or political goals.

For more information, see section 3.4, p.76.

Access and opportunity: the internet and social media

Access to information about the GMC and how to make a complaint has increased dramatically during recent years, particularly with the advent of social media. Information is now available on an immediate basis via a variety of platforms and from many sources. Information about the GMC and its complaints procedures is no longer produced solely by the organisation itself, or even by organised patient groups, but may be received by a patient via Twitter or Facebook exchanges. Patient groups and others offer links to the GMC complaint pages online. Many people are also more accustomed to ‘speaking out’ about their experiences, either via social media or by using review websites.

These factors have contributed to an environment that provides potential complainants with numerous avenues to speak out about negative experiences and more access to information about how to seek redress.

For more information, see section 3.5, p.81.

Complaints and litigation

We have not identified any specific causal links between increased civil actions against the NHS and the rise in complaints to the GMC. However, there are indications that an increase in litigation against medical practitioners, and increased reporting of the same, may have contributed to an environment in which people are more likely to complain. Occasionally,

people may use a fitness to practise complaint as a ‘fact-finding’ mission prior to litigation. Furthermore, we have found that law firms specialising in medical negligence matters do contribute to publicity surrounding such matters by publishing information on their websites.

For more information see section 3.6, p.84.

Wider healthcare complaint-handling system

Looking beyond the GMC, we have identified a sense of considerable confusion surrounding the wider system of complaint-handling in place in the healthcare sector. Complaint handling is divided between the professional regulatory bodies, which focus on individuals’ practice, systems regulators such as Monitor and the CQC, and healthcare providers and the health services ombudsmen in each of the four nations who are responsible for health services complaint resolution. Our data clearly suggest that it is difficult for members of the public to know where to address their complaints, and that this confusion may be driving people towards long-standing organisations such as the GMC, as it may be more recognisable. Furthermore, as professional regulatory bodies may be seen as independent, people may complain to them rather than complaining to the service where they suffered a negative experience. Finally, people turn to the GMC out of frustration that a complaint initially made elsewhere has not been resolved to their satisfaction or in a timely manner. Our findings suggest that further clarification of the wider complaint-handling mechanisms in the healthcare sector could enable members of the public to direct their complaint to the appropriate body.

For more information, see section 3.7, p.88.

Standards of Care

We could not examine a rise in complaints without asking if the increase was simply symptomatic of a decline in standards of medical care. We asked our interview participants for their perceptions of this issue. Their responses suggest that some believe that budget restraints imposed in the NHS have contributed to an environment where quality of care has declined due to systemic pressures. However, this report can only record those perceptions not map the real impact, if any, of such factors.

For more information, see section 3.8, p.99.

Conclusion

It has not been possible to point to discrete causes for the increase in fitness to practise complaints from members of the public. However, we have clearly identified a number of trends which have contributed to an environment in which members of the public are more prone to complaining about their doctors.

- The increase in complaints has been seen across the UK, suggesting wider social trends are in action not localised causes.
- Although clinical care remains the largest allegation category, complaints about doctor-patient communication have increased more significantly than those in other categories, highlighting the importance of the doctor-patient relationship.
- A large number of enquiries were closed because the issues raised could not be identified. This suggests the GMC is receiving complaints outside its remit and points to issues within the wider complaint-handling system.
- No direct link between media coverage of high profile cases and spikes in complaint incidence was identified. However, media portrayals of the GMC and the medical profession may exert an influence on complaint-making behaviour.
- The GMC's own activities, particularly its public relations strategy, have contributed to its increased public profile, as has a high level of media coverage focused on the medical profession, and on the GMC and its fitness to practise processes. However, name recognition of the GMC and basic knowledge of its role being related to doctors, does not equate to a good understanding of the nuances and limitations of those fitness to practise processes.
- The reputation of the medical profession, though still apparently positive overall, may have been undermined in public consciousness by a barrage of negative press coverage.
- Increased usage of social media and other internet platforms has seen people become more acclimatised to discussing their experiences in public spaces, and has also allowed information to be more easily accessed and exchanged.
- Patients have taken greater ownership of their health, becoming better informed, developing higher expectations and treating doctors with less deference than in the past.

- Following a negative experience, members of the public can be upset, angry or grieving. Such difficult circumstances may enhance the frustration or confusion felt when faced with a complex system of different organisations with responsibility for different types of complaint. Complaining to the GMC, as a stable body with a considerable degree of name-recognition, may therefore be an easier step for members of the public to take.

Next Steps

This research has produced a number of interesting findings, with implications for both the GMC and the wider healthcare sector. Further exploration of these issues could focus on:

- Research with members of the public to investigate how macro-level social trends impact upon the behaviour of individual complainants.
- Consideration of the GMC's relationship to the general public and how it engages with them, including through the media.
- Investigating the feasibility of changes to the wider healthcare complaint-handling mechanisms or the potential for better signposting.

1. Introduction

This report details the findings of research into the increasing number of complaints being received by the General Medical Council (GMC) from members of the public about doctors' fitness to practise (FtP). Focusing on the period January 2007 to December 2012, our research sought to address several questions raised by the GMC:

- Why are members of the public choosing to complain to the GMC in larger volumes than they have done historically?
- Is this increase consistent across the board or are there local, regional or national differences?
- Is there any evidence to suggest that high profile public inquiries and increased public awareness of the GMC (if applicable) have contributed to this increase?
- Is this increase reflected in referrals to other healthcare professional regulators?
- Is there evidence to suggest that this increase reflects wider societal changes in the propensity to complain about public sector institutions?
- Does the increase indicate that there is a need for more guidance, targeted at patient interest groups, as to what types of enquiry should be referred to the GMC?

In order to address these questions, our research team analysed FtP relevant media coverage, statistical trends data provided by the GMC, and data collected in in-depth interviews with a number of stakeholders involved in or relating to FtP processes. Discussion of our findings, along with conclusions and recommendations, are presented in some detail within this research report.

2. Background

In the light of the Francis Report, which set out the findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry, questions about the oversight of health care provision and the reporting and investigation of concerns about standards in that provision have been at

the centre of renewed public discussion (Francis 2013). As the regulatory body for the medical profession in the United Kingdom, the General Medical Council occupies a key role in this landscape as it pursues its mission of ‘ensuring good medical practice.’ In order to achieve this, the GMC sets out the standards which doctors are expected to meet, in *Good Medical Practice*, and it has recently introduced licensing (2009) and revalidation (2012) to proactively monitor whether doctors are up-to-date and fit-to-practise. These developments came after years of debate about the role and focus of medical regulation (Archer et al 2012). Effective regulation of practitioners’ fitness to practise is now one of the five areas assessed by the Professional Standards Authority in its annual reviews of regulators’ work.

One of the core functions of the GMC is the maintenance of the List of Registered Medical Practitioners (LRMP), and this is underpinned by the ability to remove from that register doctors who are found to be unfit to practise. Figures published by the GMC state that there were 252,553 doctors on the medical register in the UK in 2012 of whom 236,238 were licensed to practise medicine (GMC 2013f). The Fitness to Practise regulations currently in force date from 2004, and are published online by the GMC (GMC 2004). The GMC also publishes guidance on how the system, which enforces the regulations, operates (GMC 2009).

There are several categories of impairment that the GMC considers which are, as set out in the Medical Act 1983, section 35C(2) (GMC 2009):

- a. Misconduct
- b. Deficient performance
- c. A criminal conviction or caution in the British Isles (or elsewhere for an offence which would be a criminal offence if committed in England or Wales).
- d. Adverse physical or mental health
- e. A determination by a regulatory body either in the British Isles or overseas

Concerns about a doctor’s fitness to practise can come to the attention of the GMC via a number of avenues: complaints from members of the public; complaints from co-workers or employers; referrals from the police or other regulatory bodies, both in the UK and abroad; and, if alerted by media coverage for example, the GMC can open an investigation at its own

instigation. Collectively, these complaints and referrals are described in the GMC's own terminology as 'enquiries'.

The number of enquiries that the GMC receives to its FtP procedures has increased significantly in recent years, from 5,168 in 2007 to 10,347 in 2012 (GMC 2011; GMC 2013g). Prompted by this trend, the GMC has commissioned research into the phenomenon. In 2011, Growth from Knowledge (GfK) reported that its research into increasing referrals to the GMC from 'Persons Acting in a Public Capacity' highlighted three main potential drivers behind the trend:

- A rise in professional standards and improved clinical governance
- A general sense of patient empowerment and willingness to voice concerns (partly driven by media reporting of high profile cases)
- Changes in colleague attitudes

However, these findings were based on the perceptions and experiences of NHS medical directors who had made referrals to the GMC. The research did not examine in more depth the potential drivers identified by the participants, nor did it include reference to the views of members of the public using the system. This research therefore highlights a broad spectrum of potential drivers, including the GMC's own policies, particularly with regard to the media, as well as external factors such as government policies and legislation, media coverage of the medical profession, and changes to the doctor-patient relationship.

Our research focuses on enquiries made directly to the GMC by members of the public. Statistics published by the GMC show that the number of such enquiries has increased from 3,615 in 2007 to 6,154 in 2012 (GMC 2011; GMC 2013g). While the amount of enquiries coming from the general public has decreased as a proportion of the total figure since 2007 from 69.95% to 59.5% in 2012, there has clearly been a significant numerical increase in complaints from members of the public. They remain the source of the majority of enquiries

received. The GMC reported that in 2012, 5,014 of the enquiries received from members of the public were about a doctor's fitness to practise (GMC 2013f).¹

The number of FtP cases ending in a hearing before a fitness to practise panel has not increased in line with the increasing number of enquiries being received. In fact, although more enquiries are leading to cases being opened against doctors and investigated by the GMC through its stream one process, an increasing amount of these are being closed at the end of the investigation stage, often with an outcome of 'no action' or 'no action with advice.'

On the face of it, a number of factors appear to be linked to complaint activity. These include: general cultural shifts in medicine and society, such as increasing public activity; the promotion of the public face of the GMC via high profile media coverage of medical scandals and inquiries; improved access to information via the internet, social media and other technologies; and changes to wider NHS complaint-handling mechanisms. The relevance of these matters is re-enforced by our initial literature review and so they are thoroughly analysed in this report. We also address the potential impact of changes to internal GMC policies and processes, such as responses to Court of Appeal decisions and the GMC's own media strategy.

Understanding the drivers behind this trend is important for the organisation as it seeks to fulfil its function as regulator. Handling fitness to practise matters efficiently and effectively requires manpower and resources, so a proactive approach to understanding the socio-cultural, political and structural drivers that are creating an environment in which complaint volumes are increasing will enable the organisation to develop appropriate responses.

It is important to note that the trend for increased complaints is not unique to the healthcare sector. Other regulatory bodies, such as the Advertising Standards Agency and the Financial Services Ombudsman, have also seen significant increases in the number of complaints that they have received during the period under review (ASA 2011; FSO 2012).

¹ In *The State of Medical Education and Practice in the UK 2013*, the GMC reported a figure for complaints specifically as well as overall enquiries for the first time. For consistency with older data, this report uses the figure for overall enquiries from members of the public when referring to published statistics.

This means that whilst we are specifically concerned with the trends affecting the GMC, we must also consider wider societal developments.

2.1 Methodology

The empirical research upon which this report draws has been conducted by a mixed-methods team, using both quantitative and qualitative methodologies to produce an analysis with both breadth and depth.

2.1.1 Aims

- To identify the social, cultural and political drivers behind the increasing number of complaints being received by the GMC from members of the public.
- To locate the increasing number of complaints within a wider context.

2.1.2 Objectives

- To inform decision-making processes within the FtP system
- To provide a foundation for improved partnership working with the various stakeholders of FtP
- To enable prediction/forecasting of future FtP trends
- To provide an evidence base against which the GMC can reflect on its own role
- To inform future research engaging the public

2.2 Methods

Our multi-method expertise has enabled the application of a number of analytical methods to a broad range of data, including:

- A review of literature relevant to complaints and fitness to practise processes, encompassing: documentation from the GMC itself and from other regulatory bodies; government and parliamentary reports; and peer-reviewed academic publications from a number of disciplines, such as medicine, history, law and sociology.
- A statistical analysis of the GMC's fitness to practise complaints data, as recorded in its Siebel electronic database during the period 2007-2012 inclusive.
- Critical analysis of relevant media coverage, in print and broadcast media, and online.

- Thematic and discursive analyses of 13 semi-structured interviews with key stakeholders, including representatives from the GMC, other regulatory bodies and patients' organisations.

Having initially conducted these strands of research independently of each other, we have triangulated our findings and brought them together using two key methods:

- Time series analysis of trends over time/genealogical analysis.
- Analysis using Cultural Historical Activity Theory (CHAT) to model the roles of significant groups, policies, processes and events in the FtP landscape and to illustrate how they interact to shape the increase in complaints (Engeström 1999).

2.2.1 Literature Review

An extensive and in-depth literature review was carried out in support of this original research. The review encompassed policy and procedure documentation published by the GMC on its website; consultation documents from the GMC and other bodies; annual reports from the GMC and other regulators, especially where these detail numbers of complaints; publications by patient groups and advice services; and relevant academic research literature from a range of disciplines, including social sciences, law and history. A number of key themes emerged from the literature review:

- The GMC and its FtP procedures:
 - This strand of the review examined the GMC's FTP policies and processes, as well as looking at Court of Appeal judgements which may have impacted upon them. We also looked at earlier research conducted using GMC complaints data.
- Wider healthcare complaints systems, especially NHS complaint resolution mechanisms:
 - We reviewed other annual reports from other healthcare regulators, health services ombudsmen, and selected non-health regulators to look at trends in their complaint data. We also investigated changes to NHS complaints systems, particularly those in 2009 which abolished the independent second-stage review process.
- The relationship between complaint-making behaviour and litigation:

- We looked at academic literature discussing the extent of the relationship between complaint-making behaviour and litigation. We found no clear evidence about this.
- Patients: changing patterns in patient behaviour; the role of patient advocacy and advice services, and of patient groups; patient feedback services.
 - This section of the review covered a wide range of academic literature, particularly research into why people complain and how they experience complaint-handling systems. We also looked at materials from patient groups, especially to see how they direct people towards complaint-handling bodies.

References to relevant content identified through this review are included throughout this report.

2.2.2 Statistical Analysis

The GMC provided statistical data about complaints received from members of the public during the period 2007-2012, as recorded in the organisation's Siebel electronic database. The dataset was examined, manipulated for analysis and analysed, with a full description of procedures provided in Annexe C of this report.

In summary, 'unique' enquiry rates were calculated which report the number of times members of the public have complained to the GMC. These were then split by case data, triage closure reason, region (e.g. England), and strategic health authority (SHA). In this report, we have described UK as 'total rate' or 'national', the four nations as 'regional' and the SHAs as 'local'. We also examined unique enquiry/reference number combinations, where reference number was a psuedoanonymised GMC registration number – this therefore recorded complaints against individuals doctors. In addition 'total allegation' rates were calculated which include all arising allegations against any number of different doctors within each 'unique' enquiry. These were then split by case data, triage closure reason, region, SHA, and allegation category. Where multiple allegations were of interest the 'total allegation' rate was used but otherwise the 'unique' was taken as the unit of analysis.

In order to compare rates of enquiries across geographical areas we scaled the data using postcode population data provided by the State of Medical Education and Practice (SoMEP)

research group within the GMC (GMC 2013f). We did not assess the data at a local level (below the level of SHA) due to the potential for individual practitioners or complainants to become identifiable once the statistical data was compared with, for example, the media data.

Specific analyses were then undertaken to answer each of the questions posed. These were:

- Is an increase in FtP enquiries consistent across the board or are there local, regional or national differences?
 - ‘Total allegation’ rate and ‘unique’ enquiry rate for the UK, region, and SHAs were calculated, where possible, using raw and scaled data.
 - Trends over the timeframe (2007-12) were explored again at each geographical level using decomposed time series, smoothed moving average and LOESS (locally-weighted scatterplot smoothing) analyses.
- Is the increase specific to certain categories of case (allegation types)?
 - Trends over the timeframe (2007-12) by allegation type were analysed using LOESS analyses.
- Is there evidence to suggest that high profile public enquiries and increased public awareness of the GMC may have contributed to this increase?
 - Multiple Pearson’s Product-Moment Correlation Coefficients, as a measure of linear dependence between media activity and corresponding FtP monthly rates, were carried out on six media searches. Monthly correlations were used to minimise the risk of influences from seasonal trends such as a dip in the enquiry rates during festive periods, or lag where the influence of one variable can only be seen in the other after a delay.

LOESS explained

Locally weighted scatterplot smoothing, known as LOESS (taken from LOcal regrESSion), is used throughout this report (Cleveland et al 1992). It provides a locally fitted estimation of each data point in our timelines. To calculate the LOESS estimates, we take the count data for each month and adjust it using the other data points in the neighbourhood, weighted by their distance from the point we are adjusting using a weighted least squares method to find the best fit for the data.

For this report we have used the R statistical program (v3.0.1) to provide smoothed timeline trends utilising the LOESS method that is part of the base statistics program/language (R Development Core Team 2008).

Issues identified within the data

Methodologically it is important to highlight two key findings prior to presenting the full analysis.

1. During triangulation of the findings from our multiple strands of research, it became apparent that there was some variance between descriptive statistics derived from the GMC's published annual reports (GMC 2011; GMC 2012c; GMC 2013g) and the statistical data provided to us for use in this research (figure 1).

		2007	2008	2009	2010	2011	2012
Complaints from public individuals	Data provided (enquiry/reference number combination)	3530	3511	3549	4486	5523	5857
	GMC published	3615	3569	3689	4525	5665	6239

Figure 1: Issues in the data - discrepancies between published statistics and shared data

The difference most likely arises from the fact that GMC published data is based on the date that the organisation completes its initial review (triage) of an enquiry whilst the data provided for analysis in this research was reported according to the date that an enquiry was actually received by the GMC. The point at which data has been extracted for analysis by each group may also have some impact. Furthermore, GMC published figures refer to cases that have been closed, where an allegation has been recorded. The statistical analysis presented in this report is based upon the data provided to the research team by the GMC. Where overall descriptive statistics have been used referencing published figures this has been clearly cited.

2. Within this dataset, data recorded for Northern Ireland contained an unusual and significant period of non-activity from Jan-2009 to Nov-2010 inclusive (figure 2):

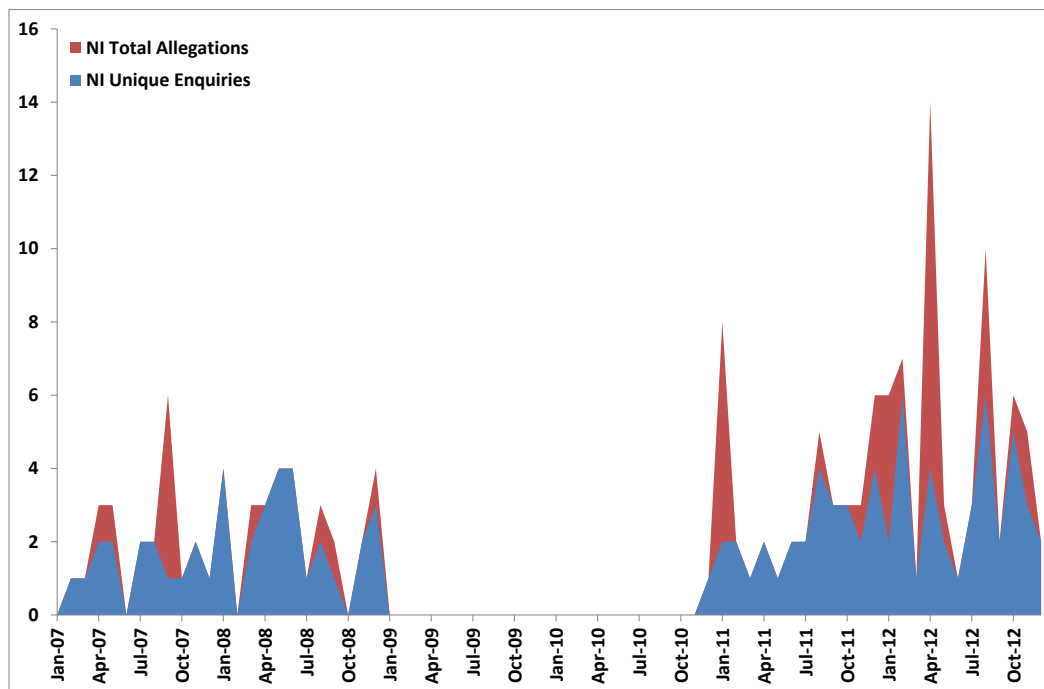


Figure 2: Issues in the data, Northern Ireland

Further investigation of this issue has revealed that data from Northern Ireland is included in the sample but has not been fully coded. This is a data entry issue and means that those data are likely to have been included in an ‘unspecified’ or ‘other’ groups.

2.2.3 Media Analysis

Media representations of the GMC and the medical profession are important as they form a common source of information about the organisation for the public and as such provide a reference point for potential complainants. The media has a long-standing interest in health and medicine (Karph, 1987). Viewing figures attest to UK audiences’ continuing appetite for both fictional and factual representations of medicine across a range of sources, primarily newspapers, TV and radio. *Holby City* and *Casualty* (BBC1), for example, are scheduled at ‘prime-time’ and regularly attract audiences of between 5 and 6 million viewers (www.barb.co.uk). Other programmes such as *Junior Doctors: Your Life in Their Hands* (BBC3) and *24 Hours in A&E* (Channel 4) seek to portray the ‘reality’ of the modern NHS. The high profile of the NHS as a service provider, an employer, and as a publically-funded organisation, mean that it, and those working within it, are inevitably the focus of a great deal of media attention.

Our critical analysis of relevant media coverage aimed to investigate how the GMC and the medical profession are portrayed in the public sphere, by understanding how representations of them are produced and circulated, and suggesting how the media may frame the public's understanding of the GMC and its fitness to practise complaints processes.

The level of audience analysis required to understand this relationship fully was beyond the scope of this research. However, by undertaking qualitative research into representations of the GMC and its FtP processes in the media we have been able to i) identify the discursive processes through which the media frames the public understanding of the GMC as the medical regulator, and ii) develop an empirical base from which to frame questions for further audience research. Our media analysis consisted of:

- Content and thematic analysis of newsprint media
- Analysis of broadcast media (including television and radio)
- Website analysis
- Discursive analysis of media coverage

Content analysis and thematic coding was carried out on a sample of 301 newspaper articles, sampled from the results of a search of the LexisNexis database using the search terms "General Medical Council" AND complain*. Codes were applied both deductively - using codes created because of prior knowledge of the subject area derived from the literature review and background research; and inductively - using codes arising from the content of the articles created during the coding process. Once this process was complete, data within each code was critically analysed for its relevance to the research questions.

A smaller sample of these articles were subjected to a discursive analysis, in order to further reveal the role of the media in creating portrayals of the GMC and the medical profession, which may potentially influence public perceptions. Further content from the media analysis is contained within Annexe B.

2.2.4 Interviews

Thirteen participants were interviewed (figure 3). Interviewees were approached on the basis of their experience working in relevant fields, and those approached included

representatives of: the GMC and other regulatory bodies, in healthcare and in other sectors; patient organisations, and a patient feedback service; doctors' organisations; and legal groups. Research with individual complainants was beyond the scope of this study.

Interviews were conducted between March and July 2013. The majority were carried out in person, but one was conducted by telephone. At the outset of each face-to-face interview, the interviewee was offered paper and a pen and asked to produce a visual response to the question 'Why do people complain about doctors?' Further questions discussed their response to this task, their experiences relevant to the research, their perceptions of the GMC, and other related subjects.

Participants were informed that they would be identified by name and by their organisational affiliation in this report and any further publications resulting from this research. This decision was taken as the participants had been selected for participation entirely on the basis of their personal expertise and/or the relevance of their organisation.

Organisation	Role	Interviewee
National Association of LINKs Members (NALM) Action against Medical Accidents (AvMA)	Chair Vice-Chair	Malcolm Alexander
Patient Opinion	Chief Executive	Paul Hodgkin
NHS Employers	Medical Pay and Workforce Team	Sean King
Advertising Standards Authority	Director of Complaints and Investigations	Miles Lockwood
Parliamentary and Health Services Ombudsman	Interim Executive Director of Operations (Business Transformation)	Gavin McBurnie
General Medical Council	Head of Media	Stephanie McNamara
Association of Medical Royal Colleges Patient Liaison Group	Former Chair	Sol Mead
British Medical Association	Head of Doctors for Doctors Unit	Michael Peters
General Medical Council	Chief Operating Officer and Deputy Chief Executive	Paul Philip

Independent Doctors Federation and DRC Locums	Responsible Officer GP in private practice	Stuart Sanders
The Law Society	Director of Legal Policy	Mark Stobbs
Nursing and Midwifery Council (NMC)	Screening Manager FtP	Michael Styles
Medical Defence Union (MDU)	Deputy Head of Advisory Services	Catherine Wills

Figure 3: List of interview participants

Interviews, which lasted around an hour in most cases, were recorded, transcribed verbatim and the transcripts checked for accuracy, before being thematically coded using Nvivo qualitative data analysis software (Saldana 2013). Our analysis focused on exploring the attitudes, perceptions and behaviours of stakeholders, see Annexe A for our coding scheme.

2.3 Evidencing findings

Inevitably in research drawing on a range of materials, some of the findings presented in section three of this report draw more heavily upon one type of data than others (figure 4). All sections are underpinned by the literature review and by the core findings of the statistical analyses set out at the beginning of section three.

Section	Title	Data types
3.1	The GMC and its public profile	Media; interviews
3.2	The public and the profession	Interviews; media; comparative data from other regulators
3.3	Interactions between patients and practitioners	Interviews; statistical data; media
3.4	Motivations of complainants	Interviews; statistical data
3.5	Access and opportunity: the internet and social media	Interviews
3.6	Complaint and litigation	Interviews
3.7	Confused complainants? The wider healthcare complaint-handling system	Interviews; statistical data
3.8	Standards of care	Interviews

Figure 4: Evidencing findings

2.4 Research Ethics

Ethical approval was sought and obtained from Plymouth University Faculty of Health, Education and Society Research Ethics Committee. See Annexe A for relevant documentation.

3. Findings

Our analysis identified a number of key factors which have driven the increase in fitness to practise complaints during the period 2007 to 2012. These are discussed here under thematic headings, and focus on:

- The GMC and its public profile
- The public and the profession
- Interactions between patients and practitioners
- Motivations of complainants
- Complaints and litigation
- Access and opportunity
- Confused complainants and the wider complaint-handling system
- Standards of care

Core statistical findings

This analysis is underpinned by the core findings of the statistical analysis of the GMC's complaint data, which tell us as much about what has not happened as about what has. For instance, analysis of trends in the 'total allegation' rate, 'unique enquiry rate', and 'unique enquiry/reference number combinations' at UK, regional and SHA levels show that the increase in complaints has been seen across the board geographically. Therefore, there is no notable localised explanation for the increase.

LOESS trend estimates show that enquiries have increased, although the 'unique enquiry/reference number combinations' and 'unique enquiries' rate show a slower increase than the 'total allegation' rate. This indicates that enquiries have become more complex over the study timeframe with both 'unique enquiry/reference number combinations' and 'unique' enquiries including more allegations and/or doctors. While the LOESS trend for 'unique enquiry/reference number combinations' and 'unique' enquiries appears to be steadily increasing, the 'total allegation' rate begins to drop during 2012 (figure 5). This is a pattern that is repeated throughout the data. However, this pattern is

misleading as the 'total allegations' rate data is incomplete for more recent data. In the GMC process, allegations may not be added to an enquiry until later in the investigation process. Therefore the data in this category becomes increasingly incomplete for more recent enquiries as many of these may still have been under investigation and awaiting the addition of allegation data when this data was extracted for analysis.

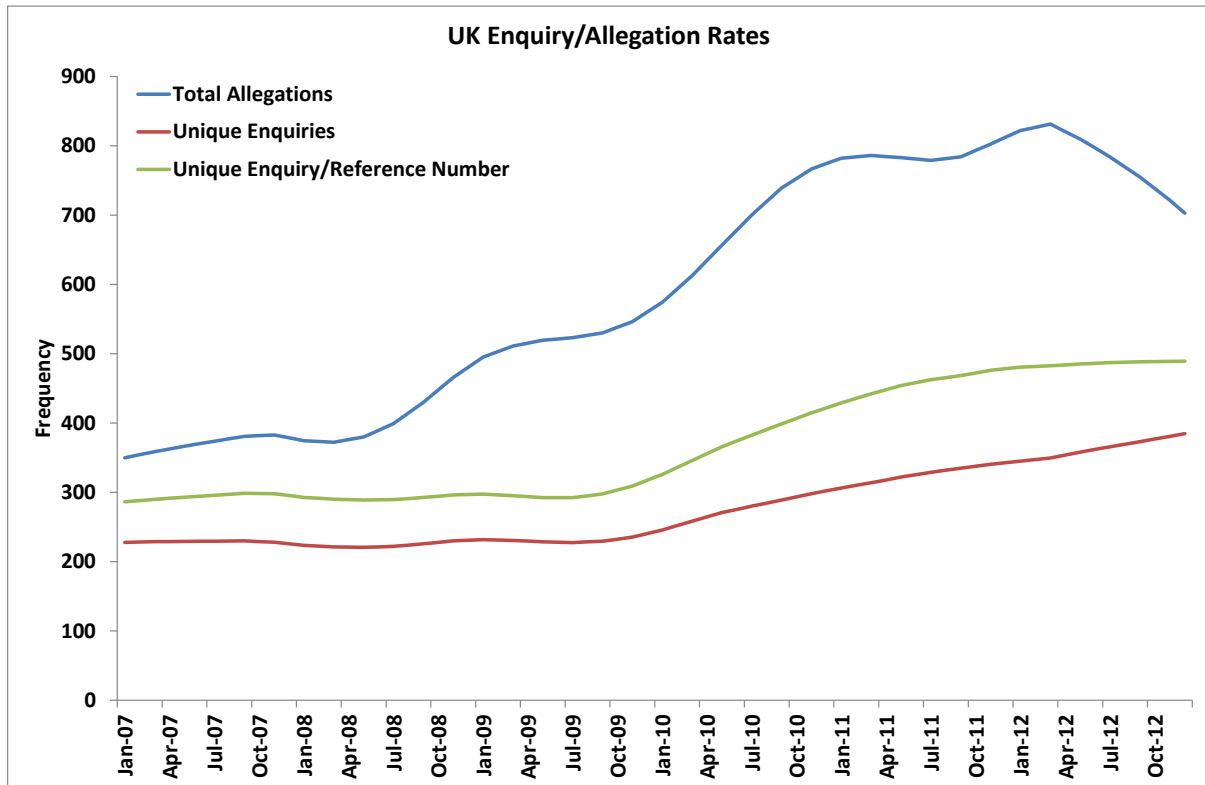


Figure 5: LOESS trend estimates showing the 'total allegation', 'unique enquiry', and 'unique enquiry/reference number combination' rates of FtP enquiries in the UK, 2007-2012

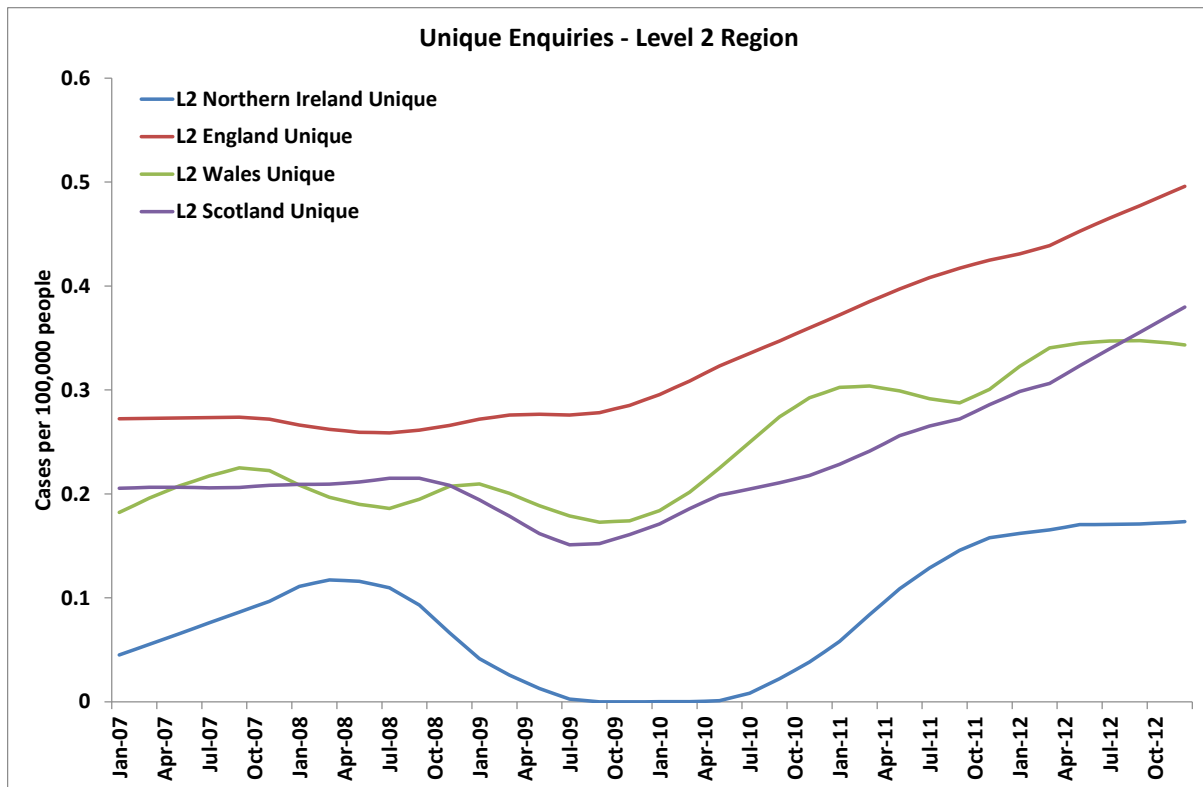


Figure 6: LOESS trend estimates showing the 'unique enquiry' scaled rates of FtP enquiries in the four main regions of the UK, 2007-2012

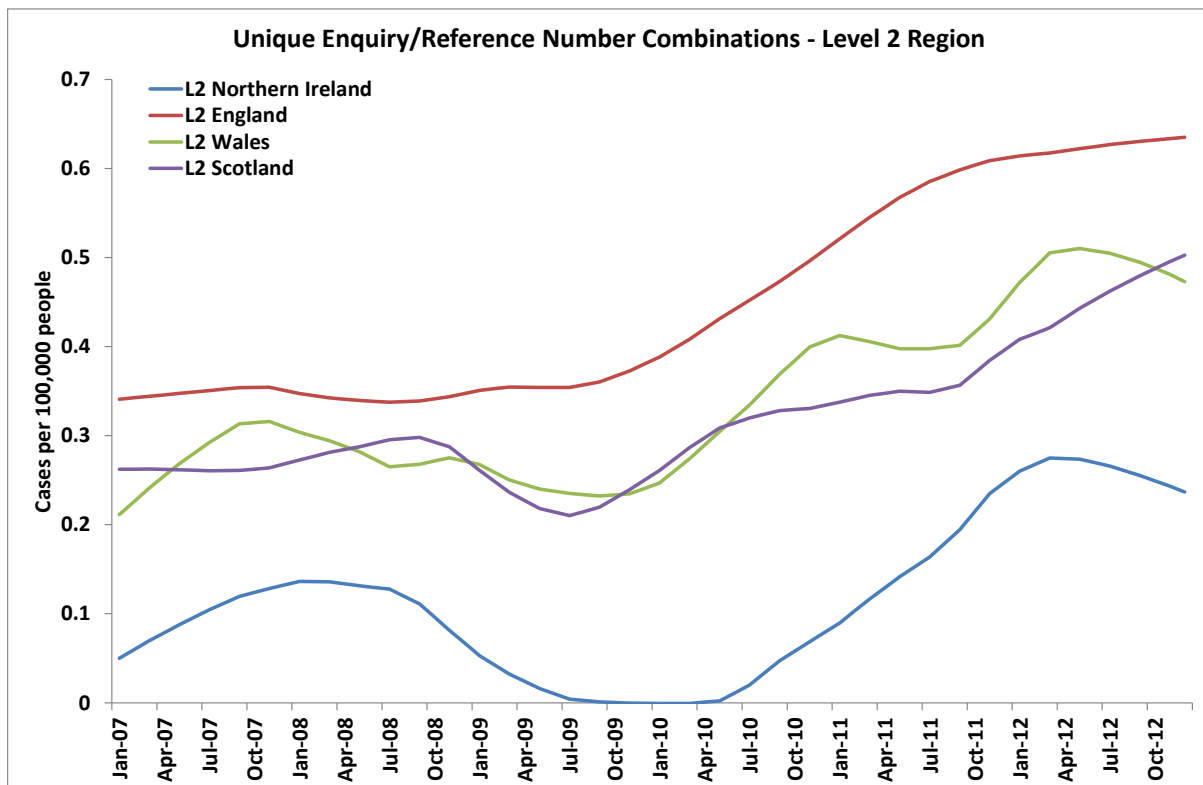


Figure 7: LOESS trend estimates showing the 'unique enquiry/reference number combinations' scaled rates of FtP enquiries in the four main regions of the UK, 2007-2012

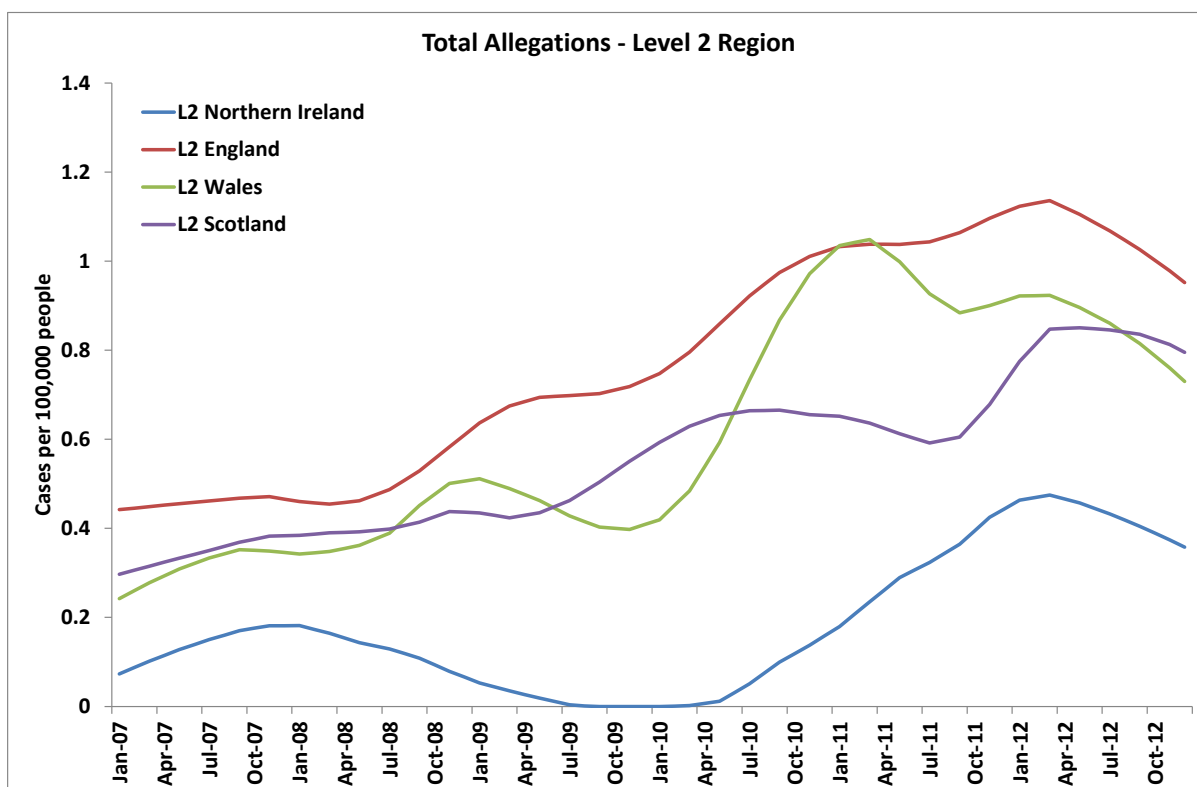


Figure 8: LOESS trend estimates showing the 'total' scaled rate of FtP allegations in the four main regions of the UK, 2007-2012

The LOESS trend estimates by UK region for 'unique' enquiries and 'unique enquiry/reference number combinations' data demonstrate a steady increasing trend while 'total allegations' data show a much sharper increase (Figures 6, 7 and 8). The data for 'total' enquiries show that the trend across the last year has decreased in the number of complaints. This again reflects that the GMC's process is to add some allegation data to enquiries at later stages of their investigations meaning that these are yet to be added to some more recent enquiries.²

There is a sharp increase in the unique enquiry and unique enquiry/reference number rates from Wales during 2010-2011, and this mirrors an increase noted by the Public Services Ombudsman for Wales, who wrote in his annual report for 2011-12 that complaints about

² The Northern Ireland data presented here should be treated cautiously (see Methods section 'Issues identified within the data'). Unspecified data is excluded as it is not aligned to a single country, while Channel Islands data is excluded because of the negligible numbers of enquiries originating there (two unique enquiries, leading to seven investigations across the six year period of interest).

health services were increasing as a proportion of his workload and noted that the NHS Redress Measure³ came into force in April 2011, however he stated that this was only a partial explanation for the increase and that:

‘I also believe that people are now more inclined to complain about poor service in the NHS than was previously the case and it is notable that almost half of health complaints are about clinical treatment in hospital.’ (PSOW 2012).

Exploring regional variations by investigating the LOESS trend estimates for each of the Strategic Health Authorities that existed at the time, the UK level and regional pattern is repeated. There has been a general increase in complaints as shown by the number of ‘unique’ enquiries of ‘unique enquiry/reference number combinations’, and a much sharper increase in the ‘total allegation’ rate during the period for which this data is complete.

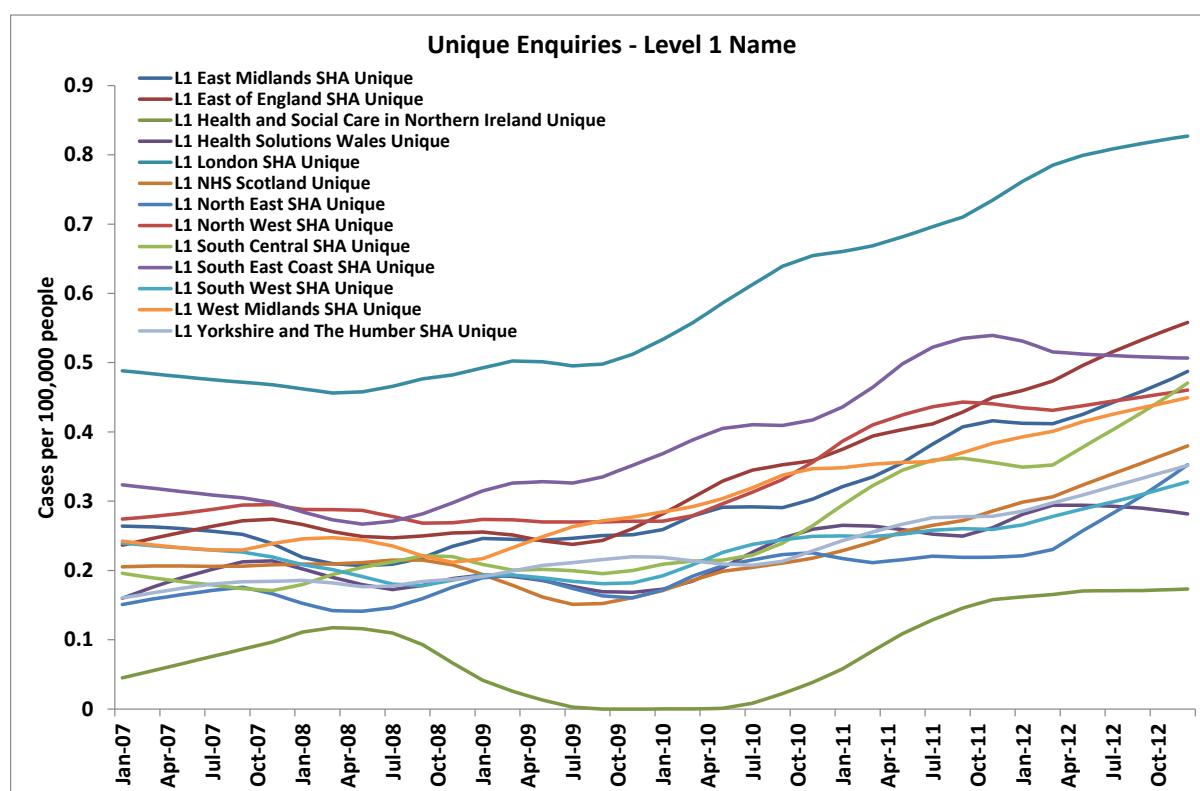


Figure 9: LOESS trend estimates showing the 'unique' scaled rates of FtP enquiries in the SHAs of the UK, 2007-2012

³ NHS Redress Scheme is a pilot in Wales only which looks at implementing the NHS Redress Act 2006. The scheme aims to reduce litigation costs by settling small value claims (under £20,000) without recourse to lawyers/the courts.

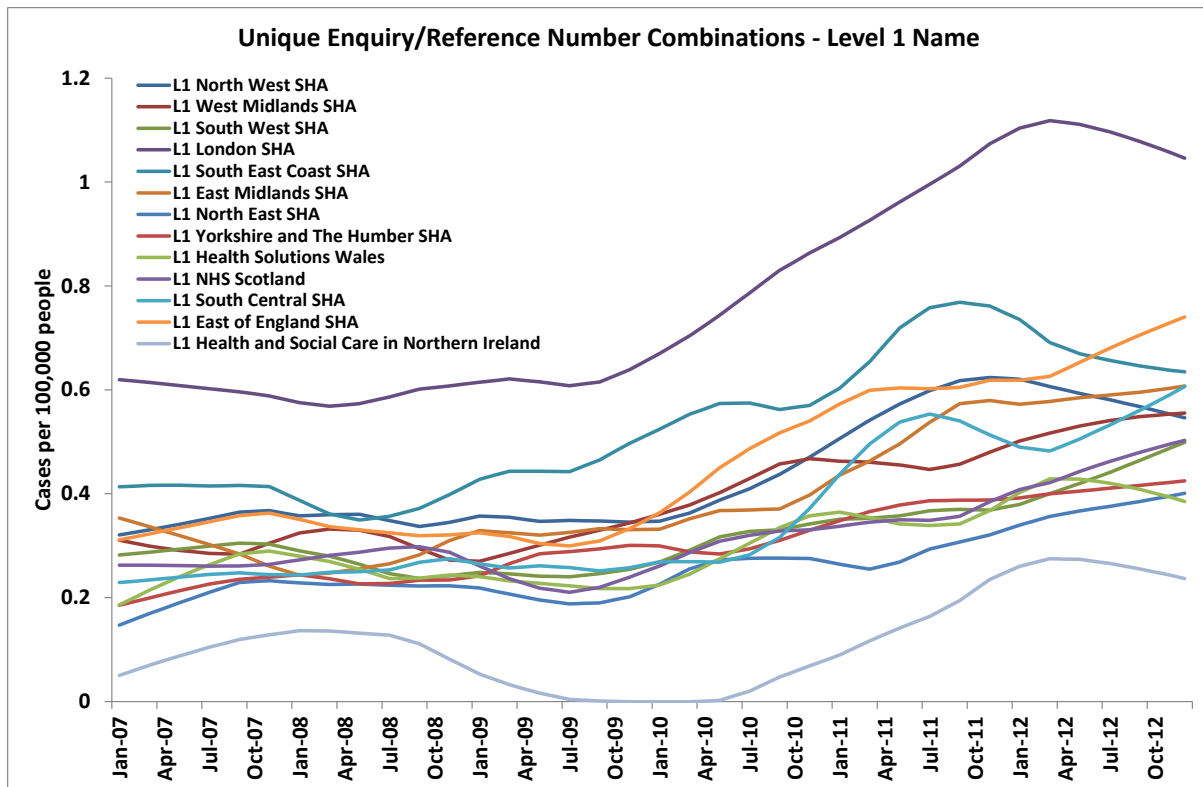


Figure 10: LOESS trend estimates showing the 'unique enquiry/reference number combinations' scaled rates of FtP enquiries in the SHAs of the UK, 2007-2012.

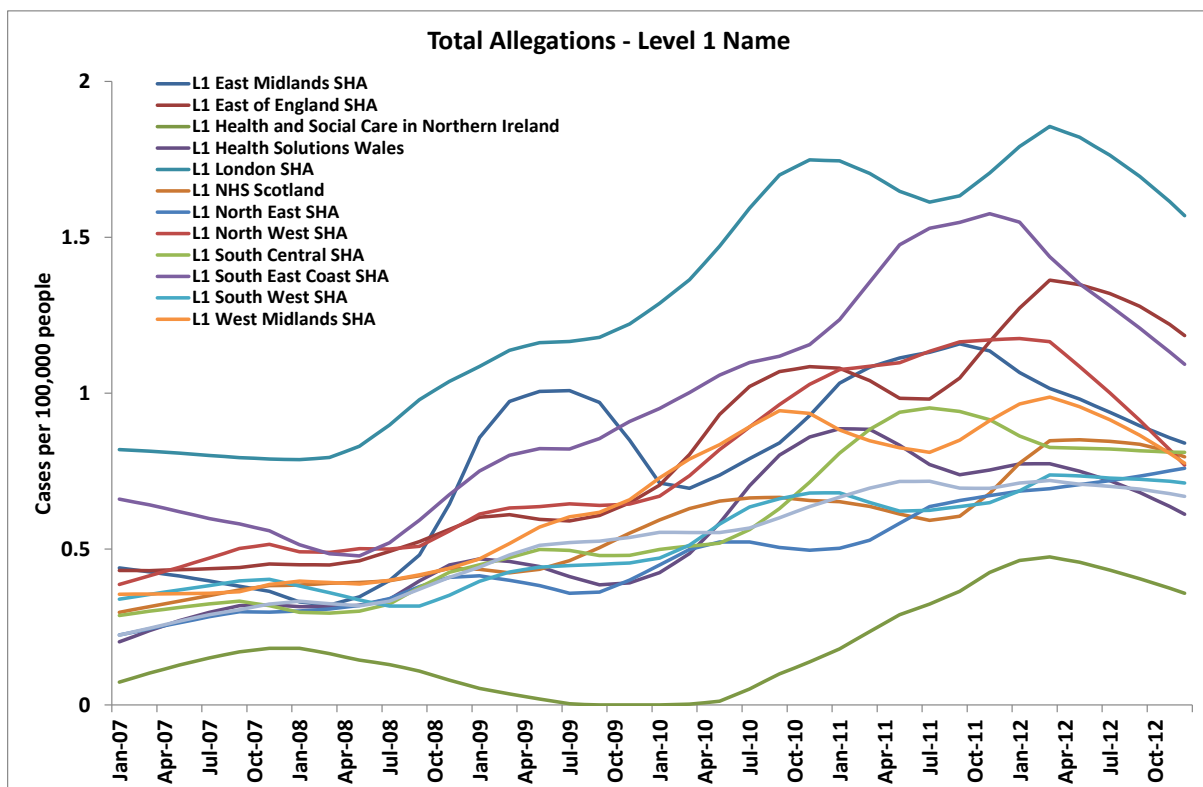


Figure 11: LOESS trend estimates showing the 'total' scaled rates of FtP allegations in the SHAs of the UK 2007-2012

It is therefore clear that, while there are some minor regional variations within the timeframe, the overall increase in complaints from members of the public seen during the 2007-2012 period followed a similar pattern throughout the UK.

Further investigation of 'unique enquiry/reference number combinations' reveal that the source of the increasing number of complaints arises from increasing Triage Case Closed data, rather than Case Data, and this can be clearly seen in Figure 12.

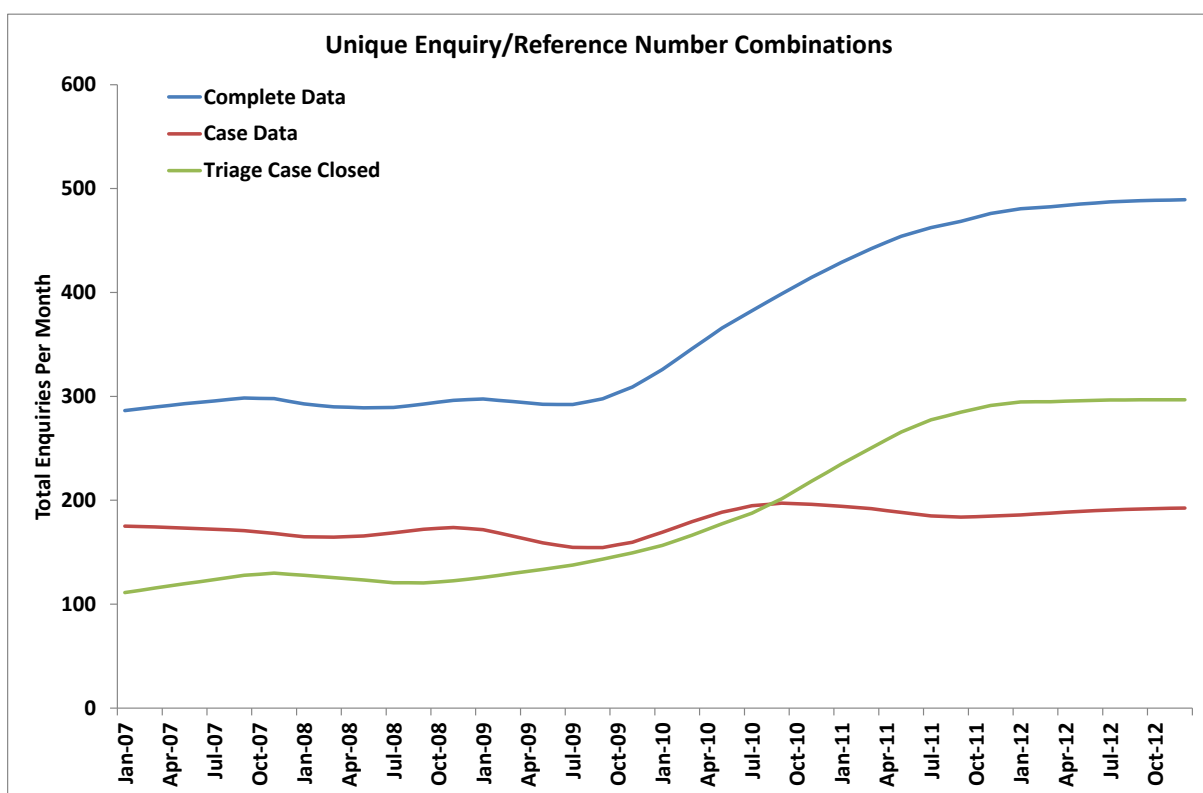


Figure 12: LOESS trend estimates showing the 'unique enquiry/reference numbers' rate of FtP enquiries per month, 2007-2012

When we examine the difference between Case Data and Triage Case Closed data for 'unique enquiry/reference number combinations' at regional level we can see that this trend persists. While there are fluctuations in the trends for Case Data (figure 13) the overall levels recorded remain generally similar across the six years being examined. This is in contrast with the data for Triage Case Closed (figure 14), where we can see a steady increase from around 2009.

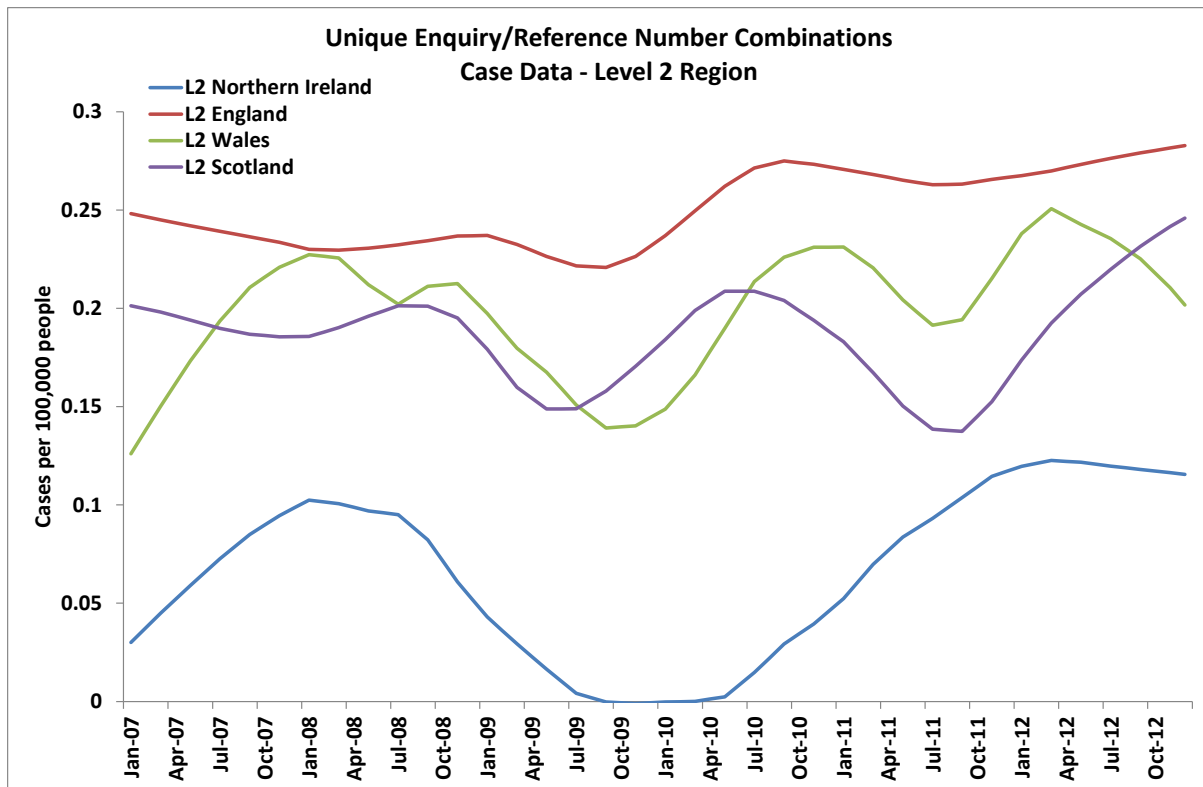


Figure 13: LOESS trend estimates for 'unique enquiry/reference number combinations' scaled rate case data for UK regions, 2007-2012

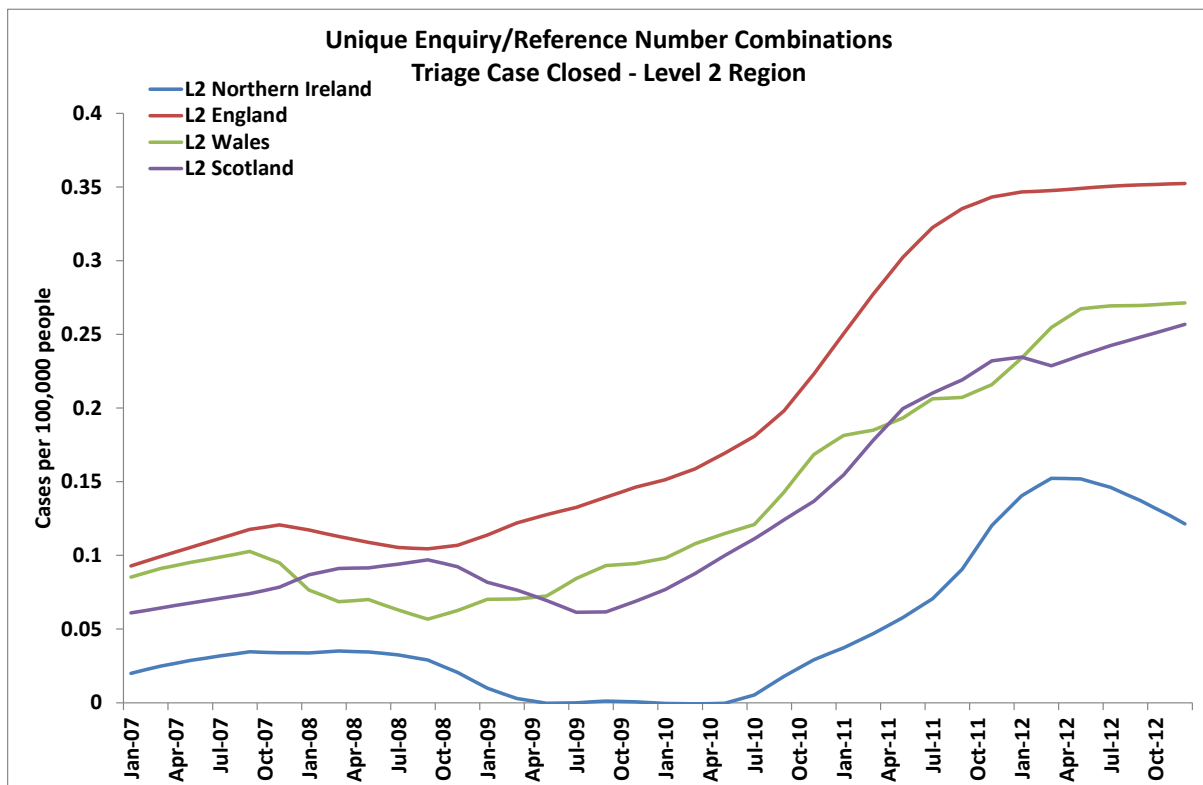


Figure 14: LOESS trend estimates for 'unique enquiry/reference number' scaled rate for cases closed at triage, UK regions, 2007-2012

Looking at the SHA level data for 'unique enquiry/reference number combinations' also shows this trend, with Case Data remaining fairly similar throughout, while the Triage Case Closed data shows the same steady increase from around 2009 onwards (figures 15 and 16). This supports the assertion that differences seen in the data are broadly similar across geographical regions, and the increase originates from an increase in the recoded numbers of Triage Case Closed data rather than an increase in Case Data.

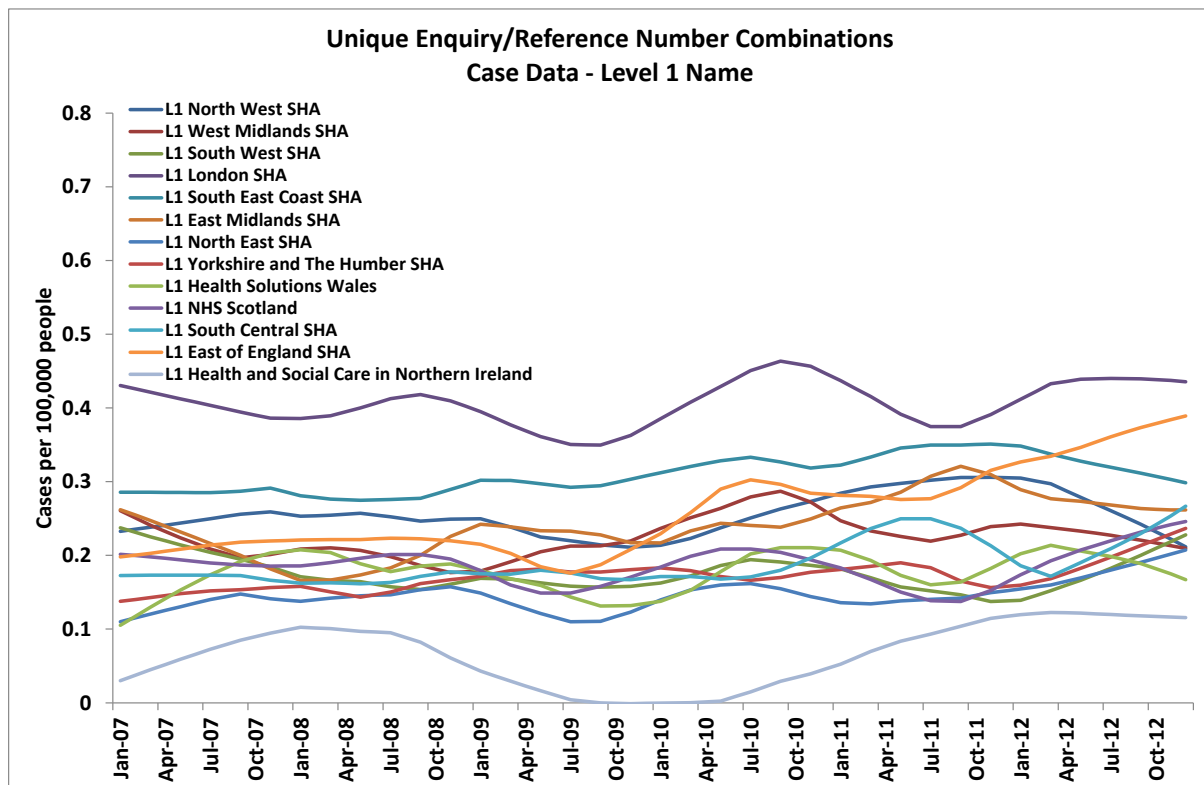


Figure 15: LOESS trend estimates showing 'unique enquiry/reference number combinations' scaled rate case data for SHAs, 2007-2012

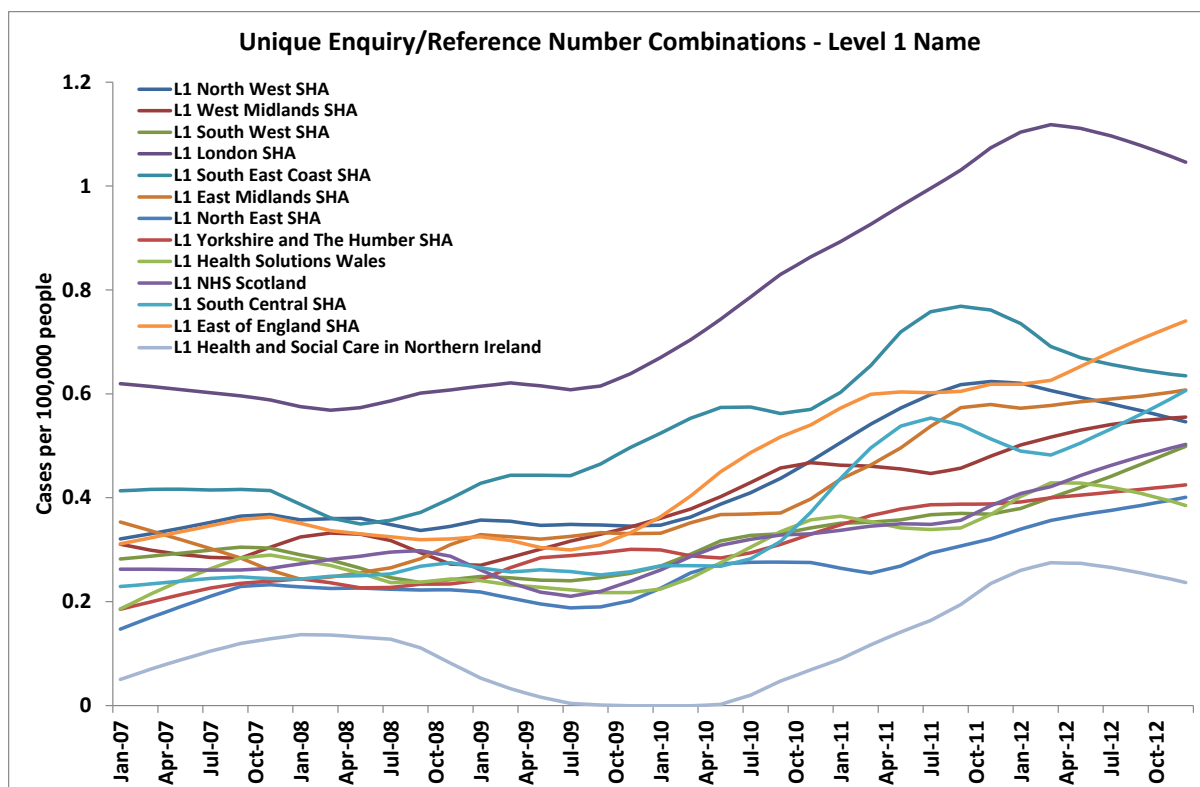


Figure 16: LOESS trend estimates showing 'unique enquiry/reference number combinations' scaled rate for SHAs, 2007-2012

Having established this outline landscape of complaint-making behaviour, we were able to use further statistical analysis alongside our analyses of other types of data to establish what has driven this trend.

Cultural Historical Activity Theory

Key elements which our analyses have shown to be significant were mapped onto a CHAT model providing a conceptual framework for fitness to practise complaint-making activity (figure 17). This process helped to order our research data and facilitated the triangulation of our results. Setting out all the organisations, rules and regulations, and other data in this way enabled us to consider many different angles during our analysis. We have considered how all the elements included in the activity system relate and engage with one another, and our understanding of those multiple relationships underpins the thematic findings presented within this report.

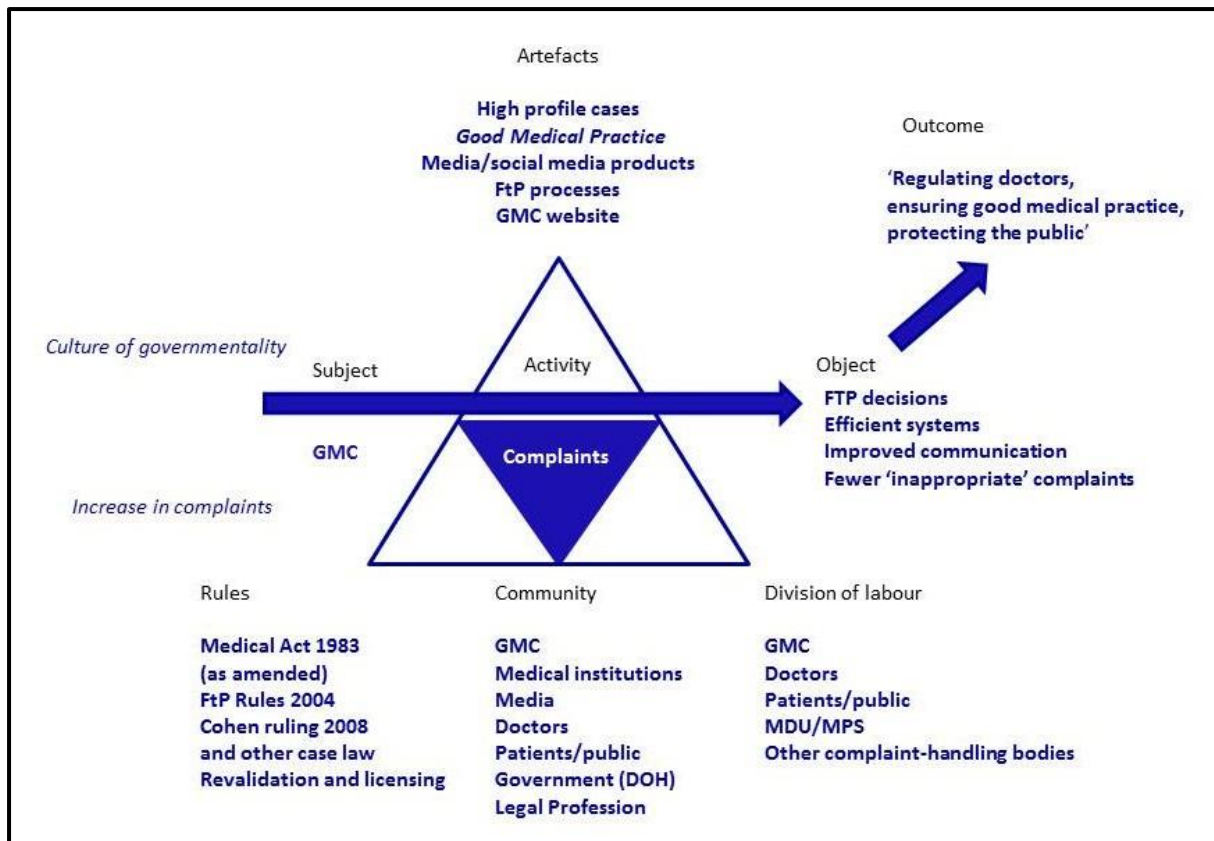


Figure 17: Fitness to practise complaint-making activity system

3.1 The GMC and its public profile

How far the general public understands the role and remit of the General Medical Council is central to understanding why and when members of the public may choose to make a complaint to the organisation. One of the research questions we set out to answer asked if there was increased public awareness of the GMC and if a higher GMC profile had contributed to the increase in complaints. It has been suggested elsewhere that the Health and Social Care Act 2008 re-defined the GMC as a ‘stakeholder regulator’, meaning that it must engage both the public and the profession in the regulatory process (Chamberlain 2013: 147). Here, we investigate the nature of the GMC’s engagement with the public and seek to identify how the GMC is perceived by stakeholders, how they feel it is understood by the public, and whether it is necessary or desirable for the GMC to be well known and well understood.

There are three core aspects of the public profile of the GMC and its creation which merit examination here:

- Media portrayals of the GMC
- The GMC’s public relations strategy, including its social media usage.
- The public’s understanding of the GMC

Our thematic, content and discourse analyses of media coverage are central to the analysis of how the GMC is portrayed, by itself and by the media, whilst thematic analysis of our interview data has been used to establish how the organisation is actually perceived.

3.1.1 Media portrayals of the GMC

The GMC receives a significant amount of attention in the media, and much of that attention focuses on its disciplinary function as expressed through FtP procedures. Indeed, media coverage is one of the main ways the general public encounters information about the General Medical Council, without actively seeking it.

Searches of LexisNexis for “General Medical Council” AND complain* in all UK newspapers returned 683 articles in total across the period, once high-similarity duplicates were removed (figure 18). In comparison, equivalent searches returned 209 results for the

Nursing and Midwifery Council (NMC) and 122 for the General Dental Council, showing that the GMC has a much higher media profile than those organisations.

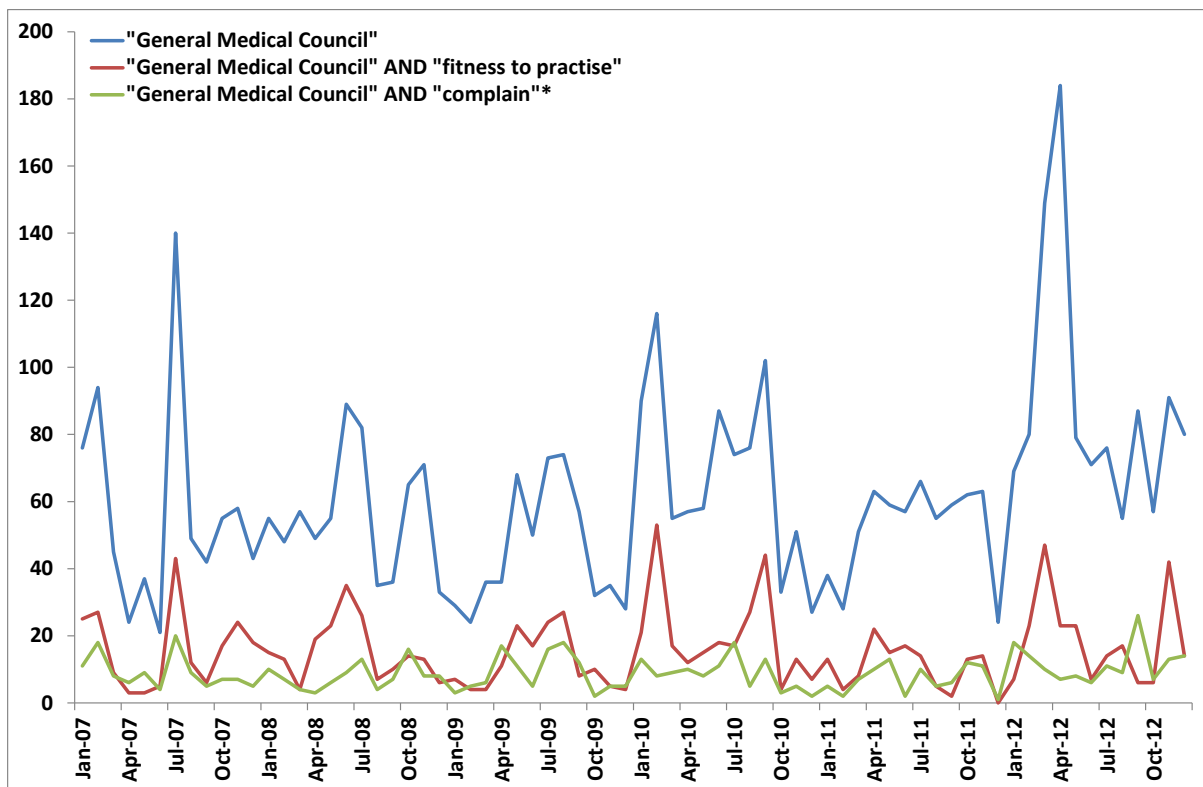


Figure 18: Timeline showing results of selected Lexis Nexis searches, of UK national and local newspapers

Using a series of Pearson's Product-Moment Correlation Coefficients as a measure of linear dependence between two variables, we performed a number of correlations between media search term results and various enquiry rates, see Annexe C. A total of 247 correlations were carried out on each of six media searches, covering total and unique enquiries, unique enquiry/reference combinations, UK, national and regional (SHA) level data, as well as count and proportioned data. While correlations between the same paired groups for count and proportioned data are the same, statistics such as confidence intervals will be specific to the scale on which the data is placed. This meant that in total we tested 1482 pairs of data. While there were some positive correlations, again please see Annexe C, significant R^2 values tended to be in the 0.2 to 0.5 range, indicating that only a low amount of variance from one variable could be explained by the other. It should be noted that we did not adjust our p-values for multiple tests as we are focussing on the variance demonstrated by the R^2 values as an indicator of the relationship rather than the p-value itself. In other words, this analysis did not demonstrate a correlation reliable enough to be

able to predict the behaviour of one variable based on the behaviour of the other.

Therefore no direct causal link between a specific media 'event' and public action/reaction in terms of complaining can be established.

That is not to say that there is never a causal relationship on an individual level between a media 'event' and a complaint, just that there is insufficient evidence from our statistical data to justify such a conclusion. However, there are clear suggestions from other sources that media attention does prompt an increase in complaints, a trend identified by Michael Styles, Fitness to Practise Screening Manager at the Nursing and Midwifery Council (NMC):

'...there are certain trusts say like Mid-Staffs which are struggling and it's sort of a vicious circle really where once a hospital becomes famous for bad care or bad service, we do get more referrals from them and then the more people know about certain trusts then we get more member of the public referrals and so press attention just increases that really. But the trusts where they don't really feature in the news at all, we don't really get as many referrals, it does have an effect on our referral rate.'

Michael Styles, FTP Screening Manager, Nursing and Midwifery Council.

Furthermore, Kieran Mullan of the Patients' Association gave evidence to the House of Commons Health Committee in 2011 in which he explained that the Patients Association had, in around 2009, campaigned with the Daily Mail on poor care and stated that whenever the organisation conducted media activity in this way it received more calls from dissatisfied people, and therefore he imagined that media coverage could increase complaints to other organisations (House of Commons Health Committee 2011b: 3).

Despite the absence of a direct causal link between media coverage and complaint incidence in the statistical evidence, the amount of media content focused on the GMC and on FtP cases in particular makes a significant contribution to the organisation's public profile.

The LexisNexis search for ("General Medical Council" AND complain*) in UK national newspapers identified 301 articles, which provided an extensive but still manageable sample for further analysis, and whose content was relevant to our research questions. This sample forms the basis of our analysis of newspaper coverage of both the GMC and the medical profession more widely in relation to complaints. As shown in figure 19 below, the articles were spread across a range of publications, but by far the most extensive coverage was featured in the *Daily Mail* and the *Guardian*.

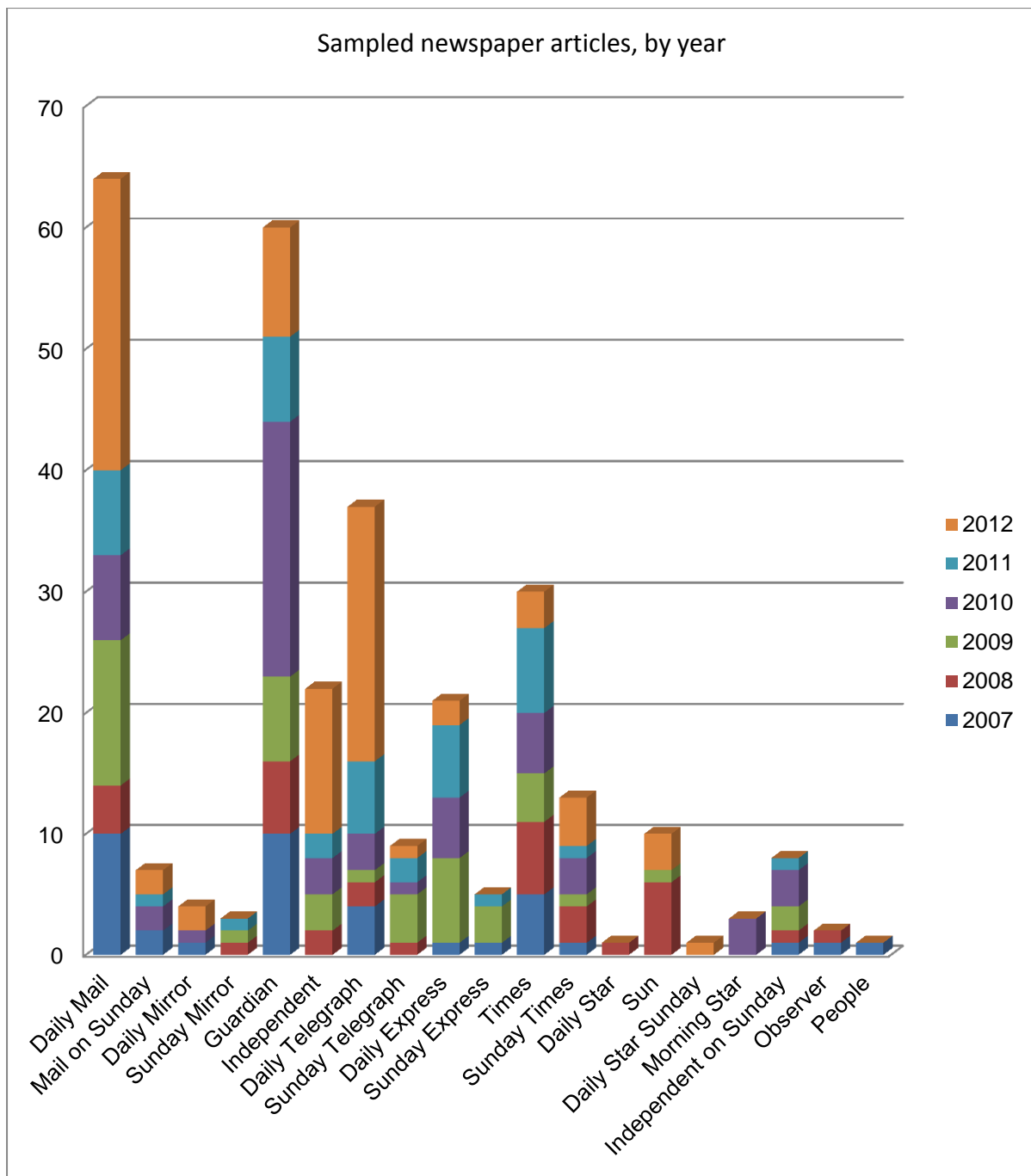


Figure 19: Newspaper article sample, by newspaper and year by publication

Coverage of FtP cases mostly focuses on clinical negligence and sexual misconduct cases, and a lot of the coverage centres on a few key high profile cases, such as those of the pathologist Freddy Patel, the paediatrician David Southall, and the German locum doctor Daniel Ubani. The significance of the Ubani case is discussed further in section 3.3.2, but it is worth noting here that coverage of the fallout from this case represents a rare show of sympathy for the GMC's position as it expressed a frustration at being unable to test the language skills of EU nationality doctors which chimed with the anti-EU or anti-immigration

stances of newspapers like the Daily Telegraph and the Daily Mail (Leach and Donnelly 2012; Macrae and Levy 2012; Martin 2010).

Common across all newspapers is a tendency to refer to the GMC and to its role as medical regulator, using a variety of terms such as ‘watchdog’ or ‘the body that oversees’, but without much explanation of what that role entails. There is also a clear tendency, particularly in the reporting of the Daily Mail, but also in other newspapers, to imply that the GMC is ineffective, incompetent or biased towards doctors (Bentley 2010; Naish 2012; Macrae 2011; Robinson 2012). These assertions are often based upon an apparent failure to take action against a doctor or a costly delay in doing so. This is compounded by the frequent assignation of panel decisions to the GMC as an organisation, not to the FtP panel so that it is reported as the GMC having decided not to strike off a doctor but to agree undertakings or impose a suspension instead (Attewill 2007; Verkiak 2012; Wainwright 2008). This signals to the public that the GMC has more power over the outcome of panel hearings than it actually does, even when it is portrayed as choosing not to use those supposed powers. The creation of the quasi-autonomous Medical Practitioners’ Tribunal Service in 2012 may resolve this issue (MPTS 2012).

Furthermore, news reports often state the outcomes of cases using FtP terminology such as ‘fitness to practise’ and ‘impairment’, but omit any explanation of the nuances of those words and phrases. There is an assumption that such terms are generally understood and that their significance is obvious. However, this does not allow the precise legal meaning of such terminology and its applications to be transmitted to the readership of these articles. Evidently, newspaper editors are unlikely to consider the dry, legalistic definitions of the terms as worthy of publication, but the omission does mean that readers may not become aware of the GMC’s obligation to focus on current and on-going fitness to practise (Case 2011), or of the implications of case law such as the Cohen ruling (Cohen vs GMC 2008).

Aspersions about the GMC’s efficacy might be thought a potential deterrent to complainants, but they are often part of articles that highlight how the GMC is the only body with the power to stop doctors from practising, and in which the GMC’s actions are placed in sharp relief by the inclusion of first-person narrative accounts by patients or their families (see for examples: Elkins 2009; Feinmann 2012; Johnston and Halle 2007). Such emotive

and compelling testimonies *may* carry added weight and have the potential to prompt others to consider reporting their own negative experiences.⁴

Many of the articles about individual cases focus on FtP panels and their outcomes, even though only a minority of cases – ten percent in 2012 (GMC 2013g) - ever reach that final stage of the process. Panel hearings have also been the focus of storylines in the BBC series *Mistresses* and *Casualty*, both programmes with large audiences. In early 2012, the popular medical soap opera *Casualty* (BBC1) included a narrative thread over three episodes about a complaint made by a patient to the GMC. The focus of the narrative was on the individual characters and the interrelationships between the *Casualty* ‘family’ of characters, as you would expect, but the seriousness of a Fitness to Practise hearing was emphasised.

Over three episodes, which did not run consecutively the tension builds from the initial complaint, through the GMC representative coming to the hospital to gather evidence in the form of witness and character statements from staff through to the final ‘trial’. Indeed in the final episode the FtP hearing dominates the programme. In the 54 minute programme a total of 16 minutes took place in the hearing. This was made up of 10 clips of between 30 seconds and 3 minutes in length. This was intercut with other scenes which related to the hearing and propelled that narrative forward, by providing further context, but took place in the hospital.

In a 2008 episode of *Mistresses*, a female doctor was investigated and suspended after a GMC hearing, following an affair with a patient.⁵ Paul Philip, Chief Operating Officer at the GMC, cited this as an example of a stereotyped portrayal of the organisation and its FtP processes:

‘...it was all white elderly men with dandruff, and there was lots of them and they were all peering over their glasses in an oak panelled room, and this was a young female doctor who was dragged up in front of them, and that type of stereotype is

⁴ Interestingly, in some articles the GMC is portrayed as an accurate and reliable arbiter of competency - such as in articles about the Freddy Patel case, where his having been suspended and later struck off by the GMC is cited as incontrovertible evidence of his incompetence; and in a commentary on parliamentary standards, where the GMC is held up alongside industrial tribunals as an example of strong complaint-handling processes and thorough investigative workings (Meikle, 2012; Preston, 2011).

⁵ http://www.imdb.com/title/tt1170990/plotsummary?ref=tt_ov_pl

just, I know why they did it but it's just so far from the truth today...' Paul Philip, Chief Operating Officer, General Medical Council.

The disproportionate focus on FtP panels may feed into a general belief that the GMC exists 'to strike off doctors' and suggest to the public that this is a far more frequent occurrence than is in fact the case. It also serves to suggest that complaining to the GMC about a doctor results in a public hearing or 'day in court' at which the offending doctor's poor practice is exposed – this may be an attractive prospect to potential complainants.

3.1.2 GMC public relations strategy

In an effort to mould its public profile the GMC has, in recent years, changed the way in which it engages with the media, and has endeavoured to become more proactive in presenting its work and its perspective on its work to the media (Lloyd-Bostock 2010).

The establishment of the quasi-independent Medical Practitioners' Tribunal Service (MPTS) has removed the GMC from the quandary of having to act as 'judge and jury' in FtP cases, which Stephanie McNamara, the GMC's Head of Media, explained had in the past made it *'really difficult for the GMC to comment on the GMC.'* This change has freed the GMC to comment more robustly on the outcome of fitness to practise cases.

Though only operational since June 2012, the MPTS may allow the GMC to explain through the media its role in putting cases forward and the limitations of what it can achieve (MPTS 2012). Also indicative of a changed media policy, is the frequency with which the current Chief Executive and Registrar, Niall Dickson, provides comments to the media. Since his appointment in 2010, 42 of the newspaper articles in our sample featured comments from Dickson, whereas his predecessor Finlay Scott was cited in only one published during the part of his tenure falling within our research period. Chairmen of the GMC during this period, Graeme Catto and Peter Rubin, were cited in two and three articles respectively. Paul Philip, Chief Operating Officer and Deputy Chief Executive of the GMC, explained that this was a deliberate attempt to focus attention on the GMC's work beyond FtP – such as the introduction of revalidation and its roles in education and medical ethics - and to explain its remit where necessary:

'So what are we trying to do in terms of our profile? We're trying to raise it, particularly with the profession, but ultimately with the public, to say this is what being a professional is about, it's much more than fitness to practise [...]' So what

we're trying to do and what Niall's trying to do is to raise our profile in other areas...'
Paul Philip, Chief Operating Officer, GMC.

Furthermore, the GMC has sought to make use of social media by launching accounts on a range of platforms, including Twitter, Facebook, Youtube, amongst others.⁶ However, an examination of the GMC's Twitter feed (@gmcuk) suggests that, of its nearly 5,000 followers, a large proportion are doctors, medical students, allied health professionals or other institutions operating within the healthcare sector. This is not a means through which the GMC is significantly engaging with the public, although this seems to be anticipated with Stephanie McNamara, GMC Head of Media, stating that:

'...more patients or non-doctors will engage with us on Facebook [...] more doctors engage with us on Twitter.' Stephanie McNamara, Head of Media, GMC.

However, the use of such media is relatively recent and will no doubt be developed further in future. Operating in fast-moving and often informal environments such as Twitter and Facebook may be problematic for an organisation with a statutory function such as the GMC, as there are obvious dangers for communications staff when making comments on the internet which may then be circulated as 'official' pronouncements or position statements.

However, the use of social media, alongside Niall Dickson's high public profile, does highlight that the GMC is moving into the spotlight - or perhaps is seeking to direct the spotlight already shined upon it by the media. Malcolm Alexander, Chair of the National Association of LINKs Members, and Stephanie McNamara, GMC Head of Media, both expressed the view that the organisation's level of public engagement had increased in recent years:

'...I think they've been on a very, very long journey from being considered to be an utterly contemptible organisation to one where over recent years they have gained much more respect.' Malcolm Alexander, Chair, NALM.

'The organisation is radically different from the one that I joined, so the organisation is much more outward facing and wishing to be more so...' Stephanie McNamara, Head of Media, GMC.

By seeking to raise its profile and explain its functions through media activity, the GMC may have unwittingly contributed to the increase in complaints it has received as these may be a

⁶ <http://www.gmc-uk.org/about/contactus/14342.asp>

result of more people hearing about the organisation. However, it is clear that FtP proceedings can attract a high level of media attention whether or not the GMC itself offers any comment.

3.1.3 The public's understanding of the GMC/the GMC and the public

Although some interviewees commented on the GMC's increased media profile and activity, a more common belief amongst our participants was that whilst the public may have heard of an organisation called the GMC, and may know that it has something to do with doctors, they are unlikely to understand its role and remit in regulating doctors:

'Well I think many people know what the GMC is, it's that body that looks after doctors and makes sure you know, Dr Crippen and Dr Shipman get their just desserts, they don't know all the educational stuff that goes on and all the other sides of it, and why should they [...] but they know it's there and they know it's probably a good thing. And so do they understand it, no.' Paul Hodgkin, CEO Patient Opinion.

'I don't think they do, I think they think the GMC's role is to strike doctors off, or to punish doctors, when that's not what the GMC's here for.' Gavin McBurnie, Interim Executive Director of Operations (Business Transformation) , Parliamentary and Health Services Ombudsman.

That the GMC closes a large number of the complaints it receives immediately – in 2012 some 2,755 complaints from members of the public were closed at the triage stage, meaning that there was no cause for the GMC to investigate the issues raised, indicates that many people complain to the GMC in circumstances in which it cannot act and points to a lack of understanding about its role (GMC 2013f). Furthermore, in recent years the proportion of cases closed at triage has increased, as shown in figure 14 in section 3 p.36, suggesting that the GMC is receiving more and more complaints which do not fall within its fitness to practise remit. When asked how well the public understood the GMC, six of our interviewees suggested that members of the public could or would confuse the GMC with the British Medical Association (BMA), including Dr Michael Peters, Head of the Doctors for Doctors Unit at the BMA, who stated that:

'I'm not sure they do, I mean we sometimes get phone calls here at the BMA thinking that we're the GMC.' Michael Peters, Head of Doctors for Doctors Unit, BMA.

Both participants from the GMC queried whether it was important for the GMC to be known and understood by the public – suggesting that people find out about it when they have

cause to do so. Discussing the results of a survey on this topic carried out on behalf of the GMC several years ago, Paul Philip stated that:

'...most people didn't know who we are and most people thought we were the BMA, and we had to ask ourselves is that ok, and we came to the conclusion at the time that that probably was ok because you know, you don't really need to know the name of the parts in your car, you just need to know that your car works and if it's broken down you need to know who you can take it to.' Paul Philip, Chief Operating Officer, GMC.

Stephanie McNamara, GMC Head of Media, also made similar points, saying that:

'...my own personal view is people don't need to know who the GMC are [...] people don't have to keep all this stuff in their head but when they go to find it they should find it really quickly...' Stephanie McNamara, Head of Media, GMC.

These comments, and the focusing of much of the organisation's media engagement on the profession as its primary audience, suggest that the GMC's relationship to the public may be conceptualised by some as an 'arms-length' or indirect one. However, the more proactive media strategy adopted by the organisation seems to be, to an extent at least, at odds with that stance. Raising the organisation's profile, even in an attempt to combat misrepresentation of its FtP work or to heighten awareness of its other functions, risks attracting more attention to it and may have contributed to more people knowing enough about the GMC to know that it handles complaints about doctors.

Again then, we return to the issue of knowing the organisation's remit and whether the public understands the limited circumstances in which the GMC can act – that is, only in cases where it is possible that action may be taken against a doctor's registration. The GMC has attempted to clarify directly to the public the complaints it can be involved in and what outcomes are possible by producing an information guide explaining the process, entitled *Patient's Help*, and information leaflets describing what patients should expect from their doctor and how to complain.⁷ Furthermore, the GMC has also ensured that its online complaint form asks questions about the nature of the complaint and the complainant's desired outcome, and that it generates a clear red warning text to appear if these are not

⁷ http://www.gmc-uk.org/concerns/making_a_complaint/3841.asp; http://www.gmc-uk.org/What_to_expect_from_your_doctor_a_guide_for_patients_English_0413.pdf 51776352.pdf; http://www.gmc-uk.org/How_to_complain_about_a_doctor_in_England_0713.pdf 48911926.pdf

possible – i.e. if a complaint is not within its remit, or if the desired outcome is financial compensation or an apology.⁸

The GMC tracks visits to individual webpages of its website (figure 20). Unfortunately, the number of people who actually open the online complaint form is not recorded, but visits to the pages ‘before’ this, which detail what to do if you have concerns about a doctor, on the website are available, although only since December 2010 when the GMC’s new website was launched.⁹

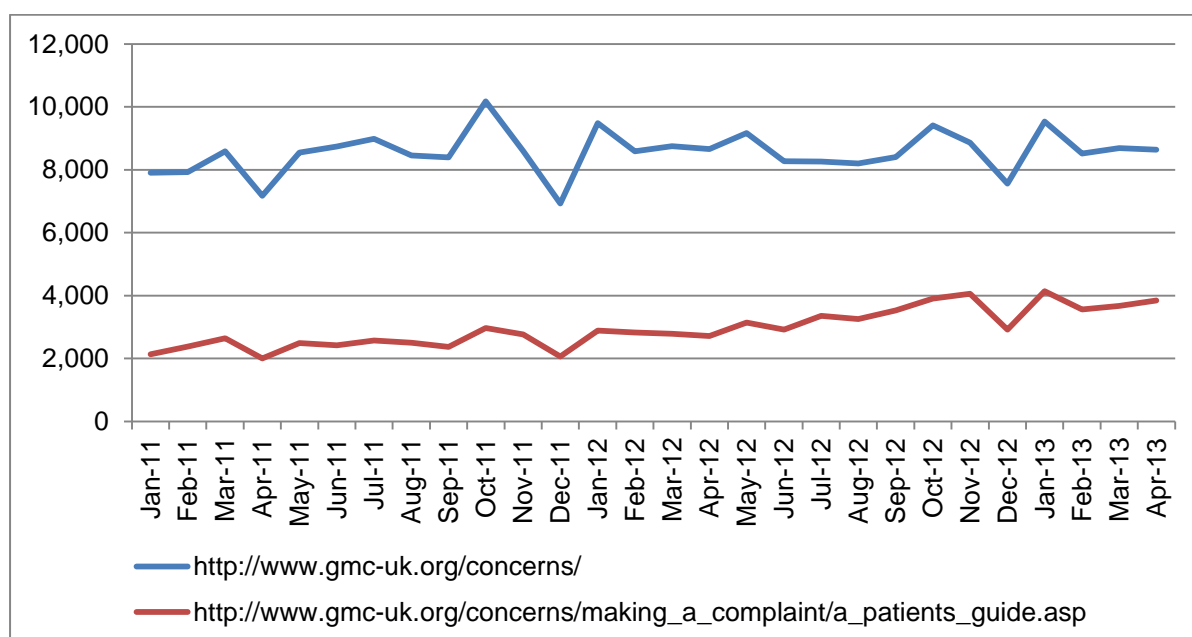


Figure 20: Unique visits to selected GMC webpages, 2011-2013

This data shows that the GMC webpages giving advice on what action people can take if they have concerns about a doctor receive considerably more visits annually than the number of complaints the GMC receives. It also shows that fewer people visit the more specific page on how to complain than view the more general ‘concerns’ page. This could mean that the GMC’s guidance about the circumstances in which it can act do work to deter

⁸ Further changes to this online form are imminent and aim to improve the clarity of the form and to ensure that the information required to investigate a complaint properly is gathered at the outset (information from conversation with GMC liaison contacts for this research).

⁹ Figures given here were shared by the GMC. The pages included are: http://www.gmc-uk.org/concerns/making_a_complaint/a_patients_guide.asp ; <http://www.gmc-uk.org/concerns/>

In addition to these pages, data shows that a new mobile web version of the /concerns page has been visited by c.120-140 people monthly between Jan-April 2013. The software used to track this data, Webtrends, excludes repeat visits made to the same page within 30 minutes.

people who might otherwise have made a complaint which would have been better dealt with elsewhere, although the 'concerns' page also includes other information in addition to that about making a complaint. However, the increased number of cases being closed at early stages of the FtP process suggests that there may still be people making complaints to the GMC that may have been better placed elsewhere or that people do not wish to use other mechanisms (see section 3.7).

Although clearly intended to deter people from complaining if the GMC is not the appropriate body to deal with their issue, these webpage interventions may not be enough to deter some emotional or frustrated complainants, determined that someone should hear their complaint. Moreover, it also assumes that people will acquire information about the GMC from the GMC itself rather than from other sources – further research set out in section 3.5 suggests that the processes that lead people to the GMC may be far more complex than this.

3.1.4 Conclusion

The GMC is at a crossroads in terms of its public profile. It seems likely, through media reporting focused on FtP cases and panel hearings, as well as its own increased PR activity, that the organisation has reached a certain level of 'name recognition' amongst the general public. However, it also appears that an understanding amongst the public about the circumstances in which the GMC can act, and the outcomes that can be achieved through its FtP procedures, has not been concomitant with that higher level of recognition. A strong media focus on the most serious cases, and an emphasis on panel hearings, may have driven the public to expect that this is the likely outcome if they make a complaint.

It is therefore possible that a situation has developed in which people know about, but do not well understand, the GMC. This may have increased the likelihood of the organisation receiving a greater number of complaints from members of the public, and perhaps also a greater number that are not true FtP cases and so are closed at early stages of the process.

Moreover, there are clearly questions to be raised about the nature of the organisation's relationship to the public. The GMC works to protect the public by maintaining professional standards, so perhaps it is appropriate that its primary audience should be doctors themselves. However, members of the public who complain to the GMC place themselves in

a direct relationship with the organisation, and by accepting complaints directly from the public the GMC's procedures identify the public as a constituency with whom the organisation interacts. Some changes to the style and content of the information produced by the organisation have been made and continue to be made. However, changes in patient behaviour, as members of the public become more engaged and better informed about their healthcare, and developments in relation to accessing information may also drive a need for further development of the GMC's approaches to engagement with the public.

3.2 The public and the profession

Looking beyond the GMC and its public profile, our analysis has highlighted shifts in the public's perception of the medical profession as being an important factor likely to have had an impact on complaint-making behaviour.

In order to draw out the nuances of the relationships involved, we have drawn a distinction between the general public profile of the medical profession as a whole, and individual patients' experiences of interacting with their doctors. This section details the analysis at the macro level, whilst section 3.3 assesses the significance of the micro or individual level.

Drawing on data from the media, interviews and other regulatory bodies, this section considers three main aspects of the relationship between the public and the medical profession:

- Media coverage of the medical profession
- Perceptions of the medical profession
- Comparisons with other professions

3.2.1 The media and the medical profession

Media portrayals of health services generally, of the medical profession, and of the actions of individual doctors are overwhelmingly negative (Greenslade 2007). The trend towards negative coverage of the medical profession has been linked in the literature to changed attitudes following crises such as those involving Bristol Royal Infirmary and Alder Hey Children's Hospital in the 1990s (Harpwood, 2007: 111).

Two interviewees noted that there were sometimes references to the life-saving actions of heroic medics, but the majority of news stories about medical doctors are concerned with malpractice, ranging from professional incompetence to outright criminality:

'...the problem with the media and the health service is they spend most of their time just highlighting bad practice and bad news stories, and spend very little time actually talking about good news stories.' Sol Mead, former Chair, Association of Medical Royal Colleges Patient Liaison Group.

Negative news reports are characterised by a repertoire of discernible and recurring features that lend them a formulaic quality. While such features are to be found in both broadsheet and tabloid news stories, there is variation in how this discursive repertoire is employed. In working-up or emphasising particular aspects of the malpractice involved, newspapers choose those elements that suit the in-house style and therefore the intended audience. Thus, papers such as the Daily Mail or the Sun are more likely to use provocative language and to give greater emphasis to the salacious elements of a story than the broadsheets.

Notwithstanding this in-house variability, our research demonstrates that the representation of medical doctors in British newspapers may be divided into four broad narrative genres. These may be labelled according to the dominant rhetorical ‘theme’ drawn upon by the producers of the stories:

- Criminal doctors
- Foreign doctors
- ‘Maverick’ doctors
- The patient-victim’s perception of doctors

These narratives have overlaps with one another and the margins are fuzzy. Even so, in spite of these overlaps, each story genre has a discrete and identifiable narrative core.

Criminal doctors

Criterion for inclusion in the ‘Criminal doctor’ genre is that the doctor(s) concerned have been involved in criminal activity *and* that they have been dealt with by the criminal justice system – without exception, their guilt will have been established in a court of law. Most of the stories in this genre are reported from the law courts; although some are also reported (perhaps for a second time) from FtP hearings.

The criminal activity that makes these doctors newsworthy usually involves offences such as rape, sexual assault, physical assault, child abuse, child pornography, high value fraud and theft (Bentley 2012; Horn 2009; Ford 2011; Pyrah 2011). Crimes with a sexual element are inclined to receive a lot of coverage in both the tabloids and broadsheets, and the strong focus on this subset of story is a long-standing feature of FtP coverage (Bradby et al, 1995).

Foreign doctors

News stories involving clinical negligence or other wrong-doing by ‘foreign doctors’ have been common during the period under examination (Leach and Donnelly 2012; Macrae 2007; Macrae and Levy 2012). Some newspapers, especially those whose ideological and political standpoint is heavily weighted towards matters of immigration, asylum, and the purported criminal activity that is said to go with these issues, devote considerable space (including features) to this narrative genre. Undoubtedly, the current political obsession with immigration provides newspapers with the opportunity to tap into the assumed zeitgeist of public opinion. The two principal discursive strategies pervading this genre are that immigration and a non-British ethnicity are synonymous with criminality (Lynn & Lea 2003) and/or professional incompetence.

‘Maverick’ doctors

A further narrative genre of newspaper story about medics is less common but still notable, as it often marks the reporting of high-profile FtP cases. In this genre, medics are characterised by the press as ‘mavericks’ (Jardine, 2010). This genre appears only sporadically and almost always at the point when the alleged maverick’s practice is subject to an FtP hearing and/or vociferous criticism by peers (Aston 2012; Jardine 2010). The personal characteristics of the maverick, as the media depict them, are more fluid than those in the previous genres. There is no obvious archetype for the maverick doctor – although arrogance, experience, expertise and disregard for rules or procedure feature in the reporting. Unlike the criminal or foreign doctor, those characterised by the media as mavericks may have some public support.

Assuming there has been no prior reporting about the doctor’s activities, these stories usually become newsworthy at the point when an FtP hearing begins. In the early stages at least, they are dealt with in the same way as court reports: journalists report the views and counterinterviews of each side as the hearing unfolds. The level of coverage depends upon the issues involved and whether these fit the criteria for a ‘good’ news story. The Andrew Wakefield inquiry for example generated a lot of press coverage because of the emotive subject matter and the support he had from some sections of the public.

Maverick doctors have also featured prominently in television coverage of the medical profession during the period, especially in TV news coverage and in flagship documentary

strands. For example, between January 2007 and November 2012 the 3 main UK news channels featured 48 'stories' on the paediatrician David Southall.¹⁰ In 2009, the BBC broadcast a Panorama documentary entitled *A Very Dangerous Doctor* (08.06.2009) exploring the complex chain of events since 2000.¹¹ In 2011, Channel 4's Cutting Edge broadcast a programme about David Southall also called *A Very Dangerous Doctor* (12.05.2011) which took two years to make and again explored the controversy around Southall and the mothers he accused of abusing their children.

Doctors from the perspective of patient-victims

Superficially, the patient-victim perspective appears to offer a 'voice' to patients injured or wronged by doctors. Although there is no logical reason why this genre cannot also present positive or celebratory accounts of doctors, but such stories are an exception.

Almost exclusively, the 'human interest' stories that this genre showcases are concerned with malpractice, abuse, and injury (SWA News 2010; Mostrous 2011; Halle 2009). The fundamental difference in this genre is that the actions and behaviours of the doctors concerned are detailed from the perspective of the patient-victim. The 'human interest' angle personalises what has taken place, inviting readers to empathize or sympathize with the patient(s) involved. In addition to the patient-victim stories describing the physical and psychological effects of poor clinical practice; others detail the struggles of patient-victims involved in legal disputes against the doctors concerned. The foregrounding of an individual story, told in the words of the patient-victim or their relatives, serves to add weight to their account and strengthens the negative portrayal of the practitioner in question. Such stories are symptomatic of an imbalance in media coverage of medical malpractice, as doctors are often unable to publically defend themselves due to the constraints imposed by their professional duty to maintain patient confidentiality (Harpwood, 2007: 119).

Still more stories are of the crusading variety: especially when the doctor(s) involved appear to have evaded sanction from the regulator or the courts. The crusade or campaign stories often fit with the ideological (and political) stance of the newspaper driving them. Some of

¹⁰ He had been in the news since 2000 when Dr Southall's intervention in the case of Sally Clark, the mother convicted in 1999 of killing her two infant sons in 1996 and 1998.

¹¹ <http://www.bbc.co.uk/programmes/b00l6ds5>

the crusade/campaign stories within this genre lack a specific patient-victim; instead, the newspaper concerned campaigns on behalf of ‘the public’ or a specific section of the public e.g., NHS whistle-blowers or elderly patients etc. It could be argued that this type of self-serving public campaigning news copy is sufficiently distinct from the individual human interest story to warrant a separate narrative genre. The case for retaining it as part of the patient-victim genre is that despite being a vehicle for the newspaper to promote its ideological and political agenda, it still has the patient-victim perspective at its core.

Newspaper reports about medical professionals are often introduced by provocative and paradoxical headlines such as “The Sex Offender Doctors Allowed to Keep Working” (Daily Mail 2012) and these frequently involve, as here, the assigning of individuals to categories (McHoul 1982). Figure 21 shows the words most frequently used in the headlines accompanying the sampled newspaper articles analysed. The high level of coverage given to some particular cases is also evidenced here – ‘Ian’, ‘Tomlinson’, ‘post’, ‘mortem’, pathologist and G20 all feature and all relate to one case in particular, where coverage of the death of Ian Tomlinson and subsequent investigations of it frequently referred to the GMC and its decision to strike off the pathologist Freddy Patel. ‘MMR’ refers to the long-running controversy surrounding Andrew Wakefield, who was eventually struck off by the GMC in May 2010.

The negative tone of many of the reports is apparent from the appearance of words like ‘abuse’, ‘death’, ‘dying’, ‘failed’ and ‘botched’. Indeed, the frequent use of ‘botched’ in discussing cases of clinical error or malpractice, is an example along with ‘probe’ for investigation, of a specific terminology employed by many journalists when writing about fitness to practise matters.



as is out-of-hours care, particularly as provided to the elderly. Such stories display a clear focus on vulnerable patients, but also draw on the near universality of these areas of concern.

Stories are focused on bad doctors, as individual bad apples or single examples of bad doctors (except perhaps in the case of foreign doctors, though even these stories are illustrated with examples of individual cases). These doctors are shown as/understood to be 'bad' because their actions go against a code of behaviour which defines the medical profession – that is to say, a cultural model of medical professionalism that is explicitly stated in the GMC document *Good Medical Practice*.

It should also be noted that the medical profession is not alone in attracting largely negative media attention – Michael Styles and Mark Stobbs, of the NMC and the Law Society respectively, also noted that nursing, at least recently, and the legal profession received similar coverage. This supports the view that the media generally prefer to focus on 'bad' news.

Although the majority of media coverage about doctors is negative in tone, there are some indications that, more recently, there has been a slight change in the tone of some media coverage, particularly in the portrayals of healthcare professionals presented by reality TV documentary series such as Channel 4's *24 Hours in A+E* and the BBC's *Junior Doctors: Your life in their Hands*, *Great Ormond Street* and *Keeping Britain Alive: the NHS in a day*. These programmes all depict issues such as the difficulties faced by healthcare professionals when confronted with drunk or aggressive patients, and also highlight ethical dilemmas raised by treatment options, and the emotional impact of the work on professionals. Moreover, the programmes feature first-person commentary from those involved, allowing medics a voice which is often missing from other media coverage. This recent trend was noted by Michael Peters, Head of the Doctors for Doctors Unit, BMA, who remarked that:

'...a lot of it is about angry patients, patients getting angry with doctors, patients misbehaving in A&E and relatives, and you know it's actually changed, rather than these doctors who are making botch-ups it's actually what the doctor has to deal with, with you the public.' Michael Peters, Head of Doctors for Doctors Unit, BMA.

Set against a longer term and more widespread trend towards negative coverage, the possible impact of such programmes on general audiences remains to be seen.

3.2.2 Perceptions of the medical profession

As we have not conducted research amongst the general public, we cannot measure people's general perceptions of the medical profession. However, our participants have offered some interesting views about how the medical profession is seen by the public.

Asked about public perceptions of the medical profession, two interviewees (Michael Peters, of the BMA, and Mark Stobbs, of the Law Society) referred to 'Trust Surveys' which show that generally medics are rated as highly trustworthy by the public. The IpsosMORI 'Trust in Professions' survey sees around 2,000 British adults each year asked whether they generally trust various types of people (by profession) to tell the truth or not. In the 2011 results, 88% of respondents trusted doctors to tell the truth, a slight fall from previous years, but still the highest percentage of any category and far higher than some, including journalists who just 19% rated as trustworthy (Ipsos-MORI 2013).

Michael Peters, Head of the Doctors for Doctors Unit at the BMA, suggested that people's views of the profession would be based on their own personal experiences with their doctor:

'I mean you've still got doctors at the top of the list in terms of who people trust to tell the truth, right? [...] And that's not changed despite all the Internet and this and that. So I think as they say, there's a difference between your relationship with your doctor, assuming you have any continuity, and your impression of what the health service are, and what doctors do generally and I guess all these Mori polls if I'd known about them, would be saying something like the patient's own relationship with their doctors, ninety-nine percent positive, but their impression of what would happen if they had to go into hospital and it's lower.' Michael Peters, Head of Doctors for Doctors Unit, BMA.

A commonly positive view – perhaps an idealised view – of the medical profession may lead to individual dissatisfying experiences being more upsetting, as high expectations may be dashed (Peters et al 2001). People may, in general, have strong opinions/implicit beliefs on what a 'good' doctor should be like, and have high expectations of their healthcare experiences – this links to changing attitudes to healthcare and public sector provision more widely. Recent research conducted by the National Centre for Social Research, commissioned by the GMC, has suggested that people do expect doctors to lead generally

‘good’ lives outside their professional practice and that, in the focus groups used for the study, there was a good deal of agreement about the qualities that doctors should possess (Gill et al, 2012).

As discussed further below, a consumerist philosophy has become commonplace, which assigns healthcare professionals to the role of ‘service providers’ in the eyes of their patients and has perhaps also reduced the status of the medical profession in the eyes of the public from the esteemed position it once held.

3.2.3 Comparisons with other professions

The GMC are not alone in receiving an increased number of complaints from members of the public in recent years. Other healthcare professions regulators have also seen increases in the number of complaints that they are receiving, as shown in Figure 22.¹² This suggests that social drivers are affecting healthcare professionals across the board.

¹² This information was shared by the GMC, and comes from a survey of other regulators carried out by its Chief Executive’s Steering Group (CSEG). GMC data is from their *Annual Statistics: Fitness to Practise* reports (GMC 2010; GMC 2013g). Some of the data was not available for all years.

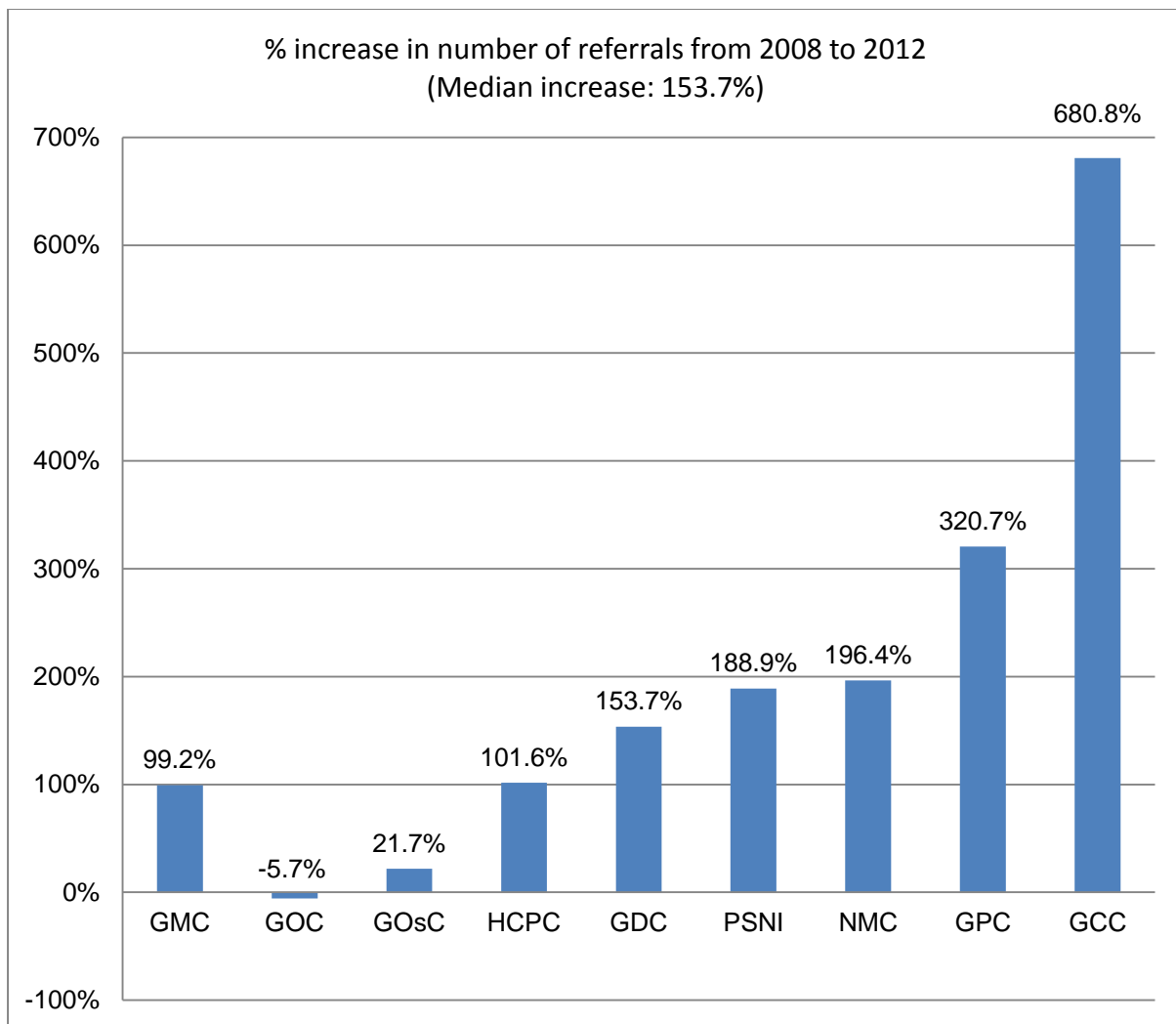


Figure 22: Percentage increase in complaints received by healthcare professions regulators, 2008-2012

Statistics published by the GMC suggest that it saw a 99.17% increase in the number of complaints it received, from all sources, between 2008 and 2012 (GMC 2011; GMC 2013g).

However, there are problems with comparing statistics from different regulators – for instance, different rule and regulations, different registrant bases, and different methods of collecting, classifying and recording complaint data. The General Pharmaceutical Council (GPC) only started to function in March 2010 so its increase has not been across the whole period. Some of these organisations receive very small numbers of complaints – such as the General Optical Council (GOC) and the General Osteopathic Council (GOsC) which each receive less than thirty complaints per year (GOC 2011; GOsC 2011). Obviously, this is a result of the fact that there are much smaller numbers of practitioners in these areas than in the medical profession. However, it does mean that any small fluctuation in the number of complaints to those bodies will appear magnified. The General Chiropractic Council (GCC),

which typically receives around 30-40 complaints per year, received over 600 in 2009 due to 2 individuals making complaints about large numbers of practitioners centring on the content of their websites (GCC 2009: 2, 19).¹³ In 2012, the Health and Care Professions Council became responsible for regulating social workers in England which represented a significant expansion of its registrant base (HCPC 2012a). Comparative data such as this is, therefore, of limited use without further background information. Such data is relevant though, because if complaints elsewhere were to be shown to be decreasing, then the GMC's experience would be notably exceptional.

However, the GMC does receive a higher rate of complaints when measured against its registrant base than is the case for other health care professions in the UK, as shown in Fig 15, compiled using available figures from individual organisations' published annual reports:

¹³ These complaints may have formed part of the same campaign, discussed in section 3.4.3, which saw a large number of complaints made to the ASA about claims by in advertisements by practitioners of complementary and alternative medicine.

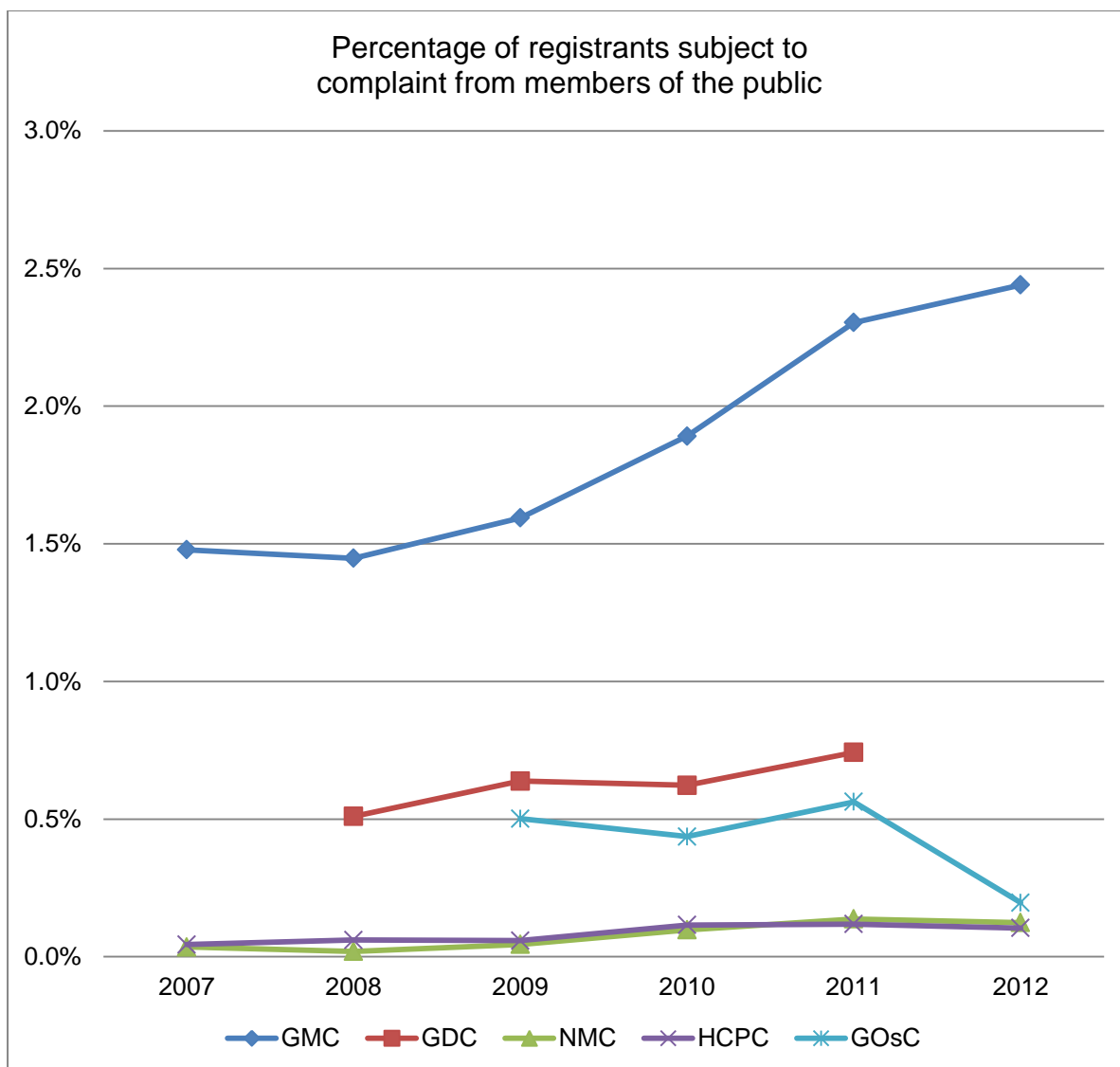


Figure 23: Notional percentage of registrants subject to complaint from members of the public¹⁴

Without research amongst patients, it is not possible to determine why this may be, although there are several potential factors. Firstly, different systems applied by regulators may have an influence – the NMC, for instance, encourages complainants to use the local complaint resolution process before submitting a complaint to its fitness to practise procedures and receives a high proportion of its complaints from employers (NMC 2012: 9).

¹⁴ The figures shown in Fig 23 are notional having been achieved by dividing the number of complaints each year by the number of registrants and multiplying by 100 to display a percentage rate. This method was selected due to the nature of the available data from other regulators' published reports.

Secondly, due to the prominence of doctors they may become the focus of patients' distress – they are responsible for key decisions and are, perhaps, the 'figurehead' of treatment.

Although international comparisons are also fraught with difficulty, due to the different systems of both healthcare provision and regulation in place, and the availability of comparable statistics, data from Ireland and France suggests that complaints made to medical regulators in those countries have also increased in recent years, with the MCI seeing complaints increase from 318 in 2008 to 380 in 2011 (MCI 2011: 71; ONM 2011: 40-41).

3.2.4 Conclusion

It is clear that there has been a strong media focus on negative portrayals of the medical profession during the period under examination. Media coverage frequently assigns doctors accused of wrong-doing to crude categories, labelling them as criminal, maverick or foreign, but it is not clear what impact such coverage may have on complaint-making behaviour. However, such coverage does create a backdrop against which the medical profession and the GMC must operate.

Furthermore, it appears that people may have a generally positive view or high expectations of medical professionals. An unsatisfactory experience of care may, when set against such expectations, prompt complaints. Further research amongst complainants would clarify these matters further.

3.3 Interactions between patients and practitioners

Lying behind macro-narratives about the general public and the medical profession, particularly those aspects emphasised by the media, are the enormous numbers of individual consultations between patients and doctors which take place each and every day. Although speaking to individual complainants about their experiences was beyond the scope of this study, in this section we highlight factors that have emerged from our other sources of data which specifically relate to patient-doctor encounters.

This section draws on documentary materials, interview data and media coverage, to examine the potential relationship between the increased number of complaints from members of the public and:

- the number of patient episodes
- the nature of doctor-patient consultations
- changes in the doctor-patient relationship

3.3.1 The number of patient episodes

Although it is very difficult to establish clear overall figures for the number of encounters between doctors and patients, we have identified some figures which suggest that the number of such encounters has increased during the period under examination. The Health and Social Care Information Centre's report *Hospital Episode Statistics: Admitted Patient Care, 2011-12* gives figures for the total number of 'Finished Consultant Episodes' (FCEs) from 2001 onwards in England. These show that between 2006-7 and 2011-12, the number of FCEs increased by just over 18%. In addition, The QResearch/Health and Social Care Information Centre's report *Trends in Consultation Rates in General Practice 1995/96 to 2008/9: Analysis of the QResearch database* estimates that the number of GP consultations in England rose from 224.5 million in 1995/96 to 303.9million in 2008/9, a 35% increase but over a 12 year period (QResearch/HSCIC 2009).

GMC published figures suggest that complaints from members of the public increased from 3615 in 2007 to 6154 in 2012 – a 70% rise. Complaints from all sources to the GMC increased by 100% over the same period (GMC 2013g; GMC 2012c). This suggests that complaints to the GMC from members of the public have risen at a faster rate than the

number of doctor-patient encounters, so though the increase in complaints may be partly assigned to increased care episodes, there are clearly also other factors involved as well.

3.3.2 The nature of doctor-patient consultations

As well as an increase in number, there have also been some changes to the nature of doctor-patient encounters which may have contributed to the increase in complaints. The QResearch/Health and Social Care Information Centre's report *Trends in Consultation Rates in General Practice 1995/96 to 2008/9: Analysis of the QResearch database* estimates that 87% of GP consultations were conducted at a surgery, 3% by telephone, 9% were home visits and 1% were conducted at other locations in 1995/6. By 2008/9, 82% were at surgeries, 12% were on the telephone, 2% were home visits and 3% were conducted at other locations (QResearch and HSCIC 2009). These figures suggest that there has been a clear increase in the number of telephone consultations and a decrease in the number of home visits.

Telephone consultations may be convenient for some patients, but there is also potential for some to find them unsatisfactory (Lattimer et al 2010: 235; NHS England 2013a: 72). Out-of-hours care, a category that many home consultations are likely to have fallen into, has been the subject of huge controversy in the media during the period examined in this report. Since 2004, following changes to the way in which out-of-hours care is provided, GPs have been allowed to decide whether or not to provide the care themselves. In many areas responsibility for out-of-hours provision transferred to Primary Care Trusts, who commissioned care from other providers, including GP consortiums and private companies. The true impact of such changes is complex and varies from place to place (Lattimer et al 2010: 165-195; 233-236). The provision of out-of-hours care is once again under review, and has been subject to renewed controversy in recent months.¹⁵

Negative coverage of out-of-hours care has often focused on the care of the elderly, as they and other particularly vulnerable patients are the main users of out-of-hours services. Care of the elderly has, with coverage of the crisis at Mid-Staffordshire Foundation Trust, for

¹⁵ Secretary of State for Health, Jeremy Hunt, has been reported recently as linking pressures on A+E services to the GP contract, see for example <http://www.theguardian.com/politics/2013/jun/06/a-and-e-crisis-jeremy-hunt>

example, been a key theme in media coverage of healthcare. With regard to out-of-hours care, much attention has been focused on the case of Daniel Ubani, a Nigerian-born German citizen who qualified as a GP in Germany.

As the strong focus on the Ubani case shows, alongside, and often intertwined with negative coverage of out-of-hours provision, has been sustained attention on locum doctors, and particularly on the apparent prevalence of foreign doctors working in locum positions.

Three of our interviewees referred to the case. Media attention has particularly focused on the inability of the GMC, because of legal restrictions resulting from the translation of an EU regulation into UK law, to test the English-language skills of EU-trained medics. Doctors trained outside the EU are already subject to such tests.

Case Study: Daniel Ubani in the media

As an out of hours locum working for Suffdoc in the UK Ubani administered a fatal overdose of diamorphine to a 70 year old patient, David Grey, in February 2008. The event achieved a high profile because:

- It was about a 'foreign' doctor
- It provided a 'face' onto which a number of less tangible ideas could be attached
- The sons of Mr Grey (one of whom was a GP) pursued a sustained campaign to keep the event in the media

Using Daniel Ubani as the search term between the dates 01 Jan 2007 – 30 Nov 2012, the Lexis Nexis database returned 817 results spread across 71 Sources (includes online). The coverage in the newspapers broadly followed the political orientation of the paper in question and 'pitched' the story to their readership. For example the politically conservative Telegraph which published the most articles (87) focused on Ubani tended to stress the 'threat' posed by 'foreign doctors' to patient safety if they could not speak English to an agreed standard. The paper shifts the focus from the specific (the local issue of a patient dying as the result of an overdose administered by a locum) to the general (the routine employment of 'foreign' doctors by the Trusts, the cost to the NHS annually, the lack of qualified UK doctors and standards of spoken English). We found three local newspapers used the Ubani story to reassure readers that they could have confidence in their local out of hours service (Peterborough Evening Telegraph, Lancashire Telegraph and Huddersfield Daily Examiner).

Many of the 74 online versions of the articles on the newspaper's websites included a hyperlink in the text to the GMC homepage, as did the majority of the online news sites. We found 20 TV news items, fairly evenly split between national and regional programmes (BBC Look East and Anglia News). In addition BBC1 East featured a 30 min documentary 'Killer on Call' broadcast on Friday 10th Dec 2010 at 7.30 pm which featured David Grey's sons' search to discover if their father's death had resulted in improvements in out of hours care. The programme includes the 'stories' of other 'victims who survived' being treated by Ubani and patients who have been 'failed' by doctors who are still practising. The media uses highly emotive language both about and around Ubani including: victims; death jab; killer Doctor; foreign Doctor; German Doctor; EU rules put patients at risk; crisis; incompetent; potentially fatal. The language links existing concerns about patient safety to nationalist agendas in terms of confidence in non-UK medical qualifications and the command of English of 'foreign' doctors.

The media, as discussed above, creates 'events'. Repetition of the 'event' through different media genres, but using the same limited frames of reference, creates a specific 'Truth' about the event. Once established, the repetition of this Truth can be used to legitimise personal agendas. For example, Steve Barclay, Conservative MP for North East Cambridgeshire, in whose constituency Mr Grey lived wrote a blog (28.02.2013) about foreign doctors needing to be 'able to speak English to a safe standard.' Barclay used the case of Ubani as a point of reference for his argument and to emphasise his proactivity in tabling questions about the regulation of foreign doctors. The blog is appended with 38 supportive comments from members of the public. The Law firm Harrison Clark pick up on this story in their regular blog. 'Ministers say NHS foreign Doctors must speak English!' (26.03.2013) begins, "You will no doubt have recently heard or read" to create an atmosphere of intimacy and inclusivity. It then continues by relating the 'story' of Ubani before ending with an endorsement to seek legal advice if 'you have suffered a medical accident'. This format and narrative style is typical with 'quotes' from senior figures, citations of key policy documents and other court cases.

Additional sources: <http://www.bbc.co.uk/programmes/b00wcqwt>; GMC press release - <http://www.gmc-uk.org/news/7359.asp> HoC health committee report on overseas doctors www.officialdocuments.gov.uk/document/cm79/7904/7904.pdf

Changes in the nature of doctor-patient consultations were also referred to in interviews, with depersonalisation of the relationship becoming a recurring theme. For example, Michael Peters, Head of the Doctors for Doctors Unit at the BMA, stated that:

'I think what we do know is that somebody's much less likely to complain if you know the individual [...] we are far more accommodating [...] and accepting of somebody whose conduct might err in terms of medical care if we've known them and if they've been part of a family. But what's happened with the health service now with the advent of day surgery, all the outpatient investigations where people would have been admitted [...] General practice is becoming much more fragmented so the idea of continuity of care I think is, especially again in urban conurbations, is going, or gone [...] Locums are really quite vulnerable in that type of way because they're again, the handy receptacle for somebody to make a complaint [...] So I think it's the way healthcare is delivered now, less personal contact, less continuity, shorter periods of time almost make it, and what goes with that is the relationship between the patient and the doctor isn't as tightly knit as it used to be.' Michael Peters, Head of Doctors for Doctors Unit, BMA.

Paul Philip also made a similar observation:

'Today you don't have a GP, you're registered with a practice and quite often you don't see the same doctor on an ongoing basis; it's the same in hospitals, you go to hospital used to be there was Dr Snooks' team and you know you would see somebody working for Dr Snooks, but actually what you now see is the person on take and stuff like that so it's less personal I suppose is what I'm trying to get at, and I think that could possibly lead to more people to make a complaint because there's not the same amount of time to build rapport on a personal basis with a doctor.' Paul Philip, Chief Operating Officer, GMC.

Amongst our participants there was a considerable sense of nostalgia for a supposed 'golden-age' of medical care. The figure of 'Dr Finlay' looms large as shorthand for a version of care, especially primary care, where a patient would always be treated by the same GP, at a local surgery, and could rely upon that doctor knowing them personally and understanding their medical history. Recent research has found that seeing a preferred practitioner is important to patients and that 'this has become more problematic in recent years' (King's Fund 2011). This model of primary care also features in three of the few positive newspaper reports to feature in our sample, which tell of a hardworking Scottish GP who provided out of hours care willingly to her patients and who was 'forced out' of her practice due to false allegations (Aitken 2007; Cramb 2007; Harris 2008).

This nostalgia was not universal, however. Paul Hodgkin, Chief Executive of Patient Opinion, viewed the Dr Finlay model more critically:

‘...if you look in the fifties and sixties we started off here with Dr Finlay who was not very personal, he might know you from when you were a nipper but you certainly wouldn’t know him except as this big, big patronising man.’ Paul Hodgkin, Chief Executive, Patient Opinion.

If the nostalgia for such a model of medical practice is replicated amongst the general public, or if there is widespread negativity towards locum doctors or doctors trained abroad (as is apparent in media coverage as discussed in section 3.2.1), it may be a driving factor behind dissatisfaction with medical treatment which may in turn lead to complaints being made. The loss of this style of medical care may cause more people to complain about their doctors – either because they feel that their care has been poorer because of a lack of continuity, or because the lack of a long-term relationship between doctor and patient means that patients cannot contextualise one-off poor experiences. They are no longer able to chalk up a doctor’s shortcomings to ‘having a bad day’ if they have never met the clinician before.

3.3.3 Changes in the doctor-patient relationship

The depersonalisation of doctor-patient relationships has been driven by changes to provision, influenced by political and economic factors. Other changes, though, have been driven by patients themselves. Notably, patient empowerment was a key theme which arose from our interviews with stakeholders. Patients were felt to be more knowledgeable and better informed about their health than in the past, with several participants referring to the notion of patients bringing information into the consultation:

‘I mean I think the world has changed where patients in the main were very deferential towards their doctor, I think they’re much more assertive now, I think they’re much more knowledgeable, the health literacy that you see of the average patient is increasing with the introduction of the computer...’ Michael Peters, Head of Doctors for Doctors Unit, BMA.

‘...people can diagnose themselves now online and you can go into the doctor and tell them exactly what’s wrong with you and tell them what treatment you need.’ Sean King, Medical Pay and Workforce Team, NHS Employers.

‘...they are often better informed when they come, and they want better information from you so the days of do this and go away and come back in a week if you’re not better, they’re not really like that anymore, people want to know much more about

their illness, so that's been a significant change.' Gavin McBurnie, Interim Executive Director of Operations (Business Transformation), PHSO.

Moreover, patients were generally thought to be less deferential than in the past, and therefore more likely to question and to challenge doctors if they felt it necessary:

'...what's happening is that, patients aren't expert in the what of medicine but they're expert in the how of medicine so the patients are experts, they truly are the experts in compassion, they're the only ones who can judge whether they were treated compassionately with respect and dignity.' Paul Hodgkin, CEO, Patient Opinion.

'...patients have become more articulate, more assertive, and more understanding of their rights, then that will be another reason it seems to me why complaints are likely to increase.' Sol Mead, former Chair, Royal Medical Colleges Patient Liaison Group.

In addition, some interviewees mentioned that doctors had also changed or that they may need to change in response to changed patient behaviour, although there were different views about how changed doctor-patient relationships may play out for different generations of medics:

'...I think doctors are young people too, and actually their whole value set is very different to the value set of the past [...] I think you don't have the same attitudes from doctors; I think quite a lot of them are still egalitarian in what they're trying to do, but some of them are sort of, are bright boys and girls first rather than doctors...' Paul Philip, Chief Operating Officer, GMC.

'...some of the doctors who have been doctors for a while, probably find it more difficult to adjust to the circumstances where patients come in to meet them who have looked up on the website, say all right I think I've got this, or I see I can have all these treatments [...] so I mean I think some of them will understand, will find that more difficult than those younger doctors who are coming through, really do understand the change in relationship.' Sol Mead, former Chair, Royal Medical Colleges Patient Liaison Group.

The GMC's statistical data also highlights that problems in the doctor-patient relationship are at the heart of many of the complaints that it receives from members of the public. Allegation categories are assigned to cases once an enquiry passes through the triage stage of the FTP process to be investigated. It is important to note that each individual case may have more than one allegation assigned to it. The allegation category 'Relationships with Patients' is second only to 'Clinical Care', of nine total categories. Of these nine categories, some do not produce adequate numbers for meaningful analysis. These were 'Teaching

supervision', 'Health', 'Maintaining GMP' and 'Compliance with GMC Inv'. These are included in figure 24 in a combined 'Other' allegation category.¹⁶

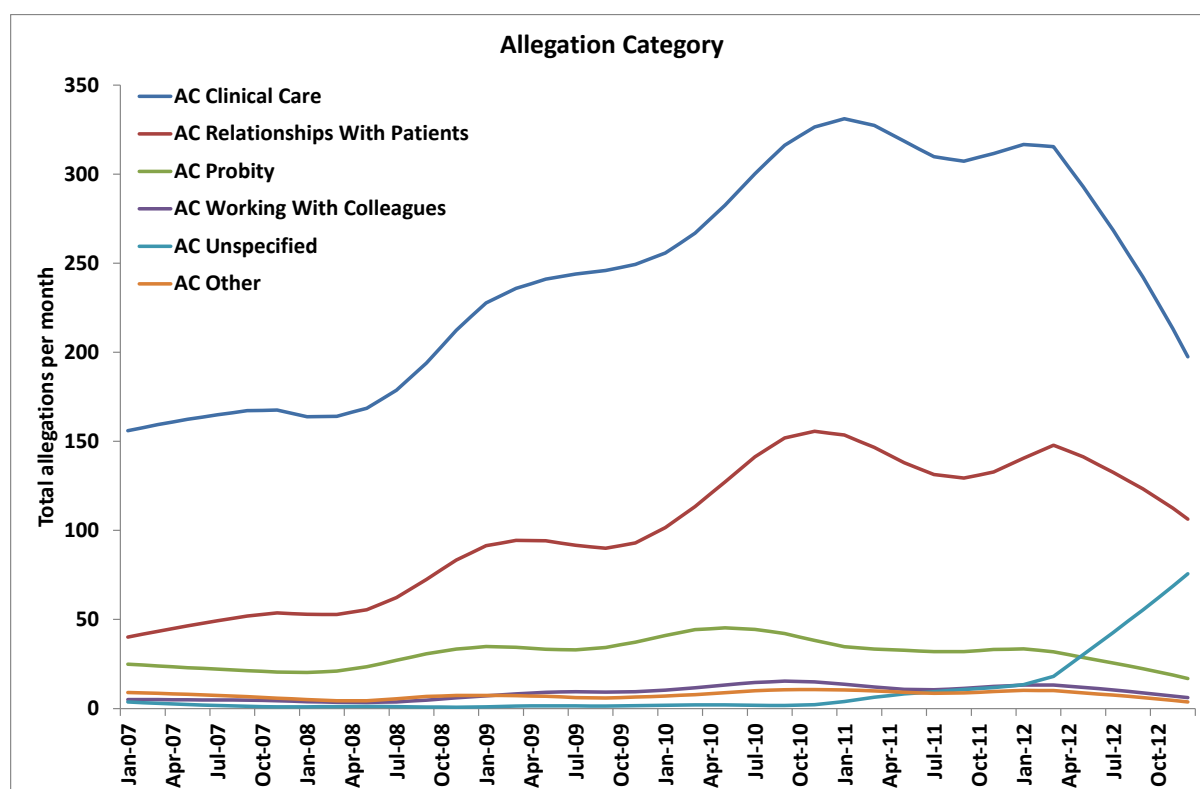


Figure 24: LOESS trend estimates showing the rates of FtP enquiries by allegation category, 2007-2012¹⁷

Furthermore, information collated by the GMC shows that of the complaints received from members of the public in 2012, ten percent were about communication with patients whilst a further thirty-five percent dealt with matters pertaining to both communication with patients and clinical care (GMC 2013f).

Communication between doctors and patients was highlighted as a key cause of complaints by several interviewees, and also features as a key sub-theme in many media stories:

'...that combination of communication problems and clinical problems is often something that we see in those complaints, yes. So by that I mean where, for example, a clinical procedure hasn't gone very well and the patient feels that it wasn't explained, that they weren't told what had happened or didn't know that a doctor was about to do a particular examination, those sorts of communication

¹⁶ Drops in data other than unspecified at the end of 2012 are due to the fact that categories are not added until after cases have been closed.

¹⁷ This data is total allegations in Case Data – those enquiries which have become cases for investigation.

issues often seem to be the subject of complaints as much as the clinical matter itself.'
Catherine Wills, Deputy Head of Advisory Services, MDU.

'...one of the sources of a complaint about a doctor will be that whilst that individual may be a good clinician, the attitude, the manner in which he or she will deliver certain messages, we've diagnosed you with this, these are your treatment options, in some cases should tell them what the risks are associated with those treatment options; now some people deliver that in a very friendly good manner, other people will do it in an abrupt, what I call unhelpful manner, and that will be a source of tension, a potential complaint about the doctor. Whilst the doctor's probably making the right decisions, giving the proper advice, the communication skills are not there, and if the communication skills are not there I think the patient will feel, often feels aggrieved you know.' Sol Mead, former Chair, Royal Medical Colleges Patient Liaison Group.

'...often a lot of the communication issues that we deal with are related to doctors' inability, or the fact that we haven't explained what's going to happen and that's often around some of the most difficult cases which are around end of life...' Gavin McBurnie, Interim Executive Director of Operations (Business Transformation), PHSO.

These comments clearly suggest that the distinction between clinical matters and those centred on communication can be blurred, and that poor communication – particularly when explaining clinical decisions – can compound patients' sense of dissatisfaction.

Again, this issue is not unique to the medical profession, as Mark Stobbs, Director of Legal Policy at the Law Society stated:

'I mean it seems to me to be crucial that a professional is able to talk intelligibly and sympathetically and empathetically with their client. It's a relationship of trust and if actually you can't understand or don't know what your doctor or lawyer is telling you, or find later on that there's a nasty surprise in there that he might have mentioned earlier then that seems to go to the heart of the professional relationship.' Mark Stobbs, Director of Legal Policy, Law Society.

This focus on the importance of doctor-patient communication and its prevalence as a cause for complaint has been identified by earlier research, and so is not a new problem (Mulcahy 2003: 86-89).

There was also a trend for interview participants, seven in all, to conceptualise the relationship between doctor and patient using consumerist terminology:

'...you treat them the same way you might treat you know, a mechanic or another you know trade person you know...' Sean King, Medical Pay and Workforce Team, NHS Employers.

'I think some people complain because they are consumers and they didn't get the service outcome that they wanted and that they feel that they are entitled to have received...' Stephanie McNamara, Head of Media, GMC.

However, Paul Hodgkin, Chief Executive of Patient Opinion, felt that it was important to distinguish between health issues, particular when things have gone wrong, and consumer transactions in some ways – due to the serious nature of health concerns and the extent of the potential negative impact on patients:

'...having a heart attack is not the same as having a Mercedes, you know having a mastectomy is not the same as having a holiday in the Maldives, one is a desired-driven consumer event and the other is something you deeply avoid...' Paul Hodgkin, CEO, Patient Opinion.

The 'patient-consumer' model has been enshrined in many initiatives within the health service since the early 1990s, particularly in policies focusing on patient choice and on making customer satisfaction a core aim of NHS local complaint resolution, and has been widely covered in academic literature (Lloyd-Bostock 1999: 110; Allsop 2004: 737; Baggott 2011; Allsop 2008; Mold 2010 & 2011).¹⁸ How far patients have truly and consistently adopted such a viewpoint is subject to debate (Lupton, 1997).

However, if patients do indeed now see their relationship with their doctor(s) as being one between a consumer or client and a service provider then they may expect access to 'customer service' responses if they experience dissatisfaction. It is also possible that members of the public more accustomed to complaining about other forms of 'service' may be more willing to complain about their doctors than was the case in the past.

3.3.4 Conclusion

Changes to the way in which patients interact with their doctors have emerged for a number of reasons including organisational changes, changes to patient attitudes and expectations, and doctors' reactions to these. Out-of-hours care and locum doctors have been subject to strong criticism in the media.

In particular, depersonalisation of the relationship between patients and their medical practitioners, especially in primary care settings, may have contributed to the rise in

¹⁸ An apparent dissatisfaction with the NHS complaints process is detailed 3.7.

complaints. Our interviews suggested that patients may be less happy with the type of consultation they received, and they may be more likely to complain about a doctor if they do not have a long-standing relationship with them.

3.4 Motivations of complainants

Although we have not spoken with individual complainants, we have asked our interview participants for their views on why people complain and have considered their responses in relation to existing literature on the subject. This has revealed that there are three key elements:

- Emotion
- Death and the grieving process
- Complaint-making as altruism

Of these, the latter two in particular may have particularly gathered strength in recent years as a result of wider social changes.

3.4.1 Emotion

When asked why people complain, and particularly why they complain about doctors, many of our interviewees referred to the strong emotions felt by those who believe that they have been poorly treated. In particular, complainants were perceived as being upset, angry or frustrated – five interviewees focused on these emotions in the drawing task they were set at the start of the interview.

Participants identified complainants as being unhappy or upset, angry and aggrieved. Participants generally felt that the majority of complainants raised serious matters, rather than trivial concerns. Notably, when talking about complainants coming to the GMC out of frustration, participants often identified that frustration as being a result of struggling to achieve redress or explanation via local complaint resolution mechanisms, suggesting that a poor, or drawn out, experience within the ‘system’ can compound the original hurt.

3.4.2 Death and the grieving process

Several interviewees saw complaint-making activity, in some cases, as being a means by which grieving relatives sought to avoid the reality of the death of a loved one:

‘...sometimes people are complaining in order to continue their battle against death, you know I can’t win there but I will win here, or whatever, I don’t understand what happened there so I’m going to understand what happened here.’ Paul Hodgkin, CEO, Patient Opinion.

‘...And it’s a mission yeah, and it becomes, and it is really tragic, I mean you can’t underestimate the devastating effects of thinking you know if something’s happened to your loved one and no-one has bothered to listen to you or explained to you or apologised to you...’ Stephanie McNamara, Head of Media, GMC.

‘...I think there’s a societal expectation that goes I think with a sort of materialist society about quality of life, longevity, difficult addressing mortality and the medical profession are there to get you out of that.’ Michael Peters, Head of Doctors for Doctors Unit, BMA.

This model of complaint-making activity places it as a displacement activity or a distraction. It also closely links to the suggestion (see section 3.6 on litigation) that people may expect to find someone to blame in the event that something goes wrong, whether or not there has truly been an error or poor practice.

3.4.3 Complaining as a civic duty

A notable trend in complaint-making is the construction of complaint-making as an altruistic act. In this model, the complainant is acting on behalf of others, seeking to prevent further poor practice by a doctor from affecting other patients in the future. This altruistic model has been identified as being cited as motivation in an increasing number of litigation claims made against public sector bodies with Furedi and Bristow claiming that seeking compensation has come to be presented not as an individualistic attempt to seek financial redress, but as a community-focused act, where the claimant is acting to prevent similar harm befalling other people (Furedi and Bristow 2012).

This trend follows the establishment of healthcare review sites, such as Patient Opinion founded in 2005, which allow service users to make public reviews of their experiences – both positive and negative – which can then be accessed by others. A review of contributions to Patient Opinion and comparable sites based in the United States and the Netherlands, highlighted the concept of ‘civic duty’ and helping others to make decisions about their care (Adams 2011: 1071-1072; 1075). Although the full impact and utility of such sites is yet to be seen (Lupton 2013), the value they have placed on patient feedback is being adopted elsewhere. This concept has also recently been embodied in the establishment of the ‘Friends and Family Test’, a measure of patient satisfaction being published for each NHS England hospital based upon patient feedback (NHS England 2013b).

The idea that acting ‘for the greater good’ is a motivation behind complaint-making behaviour (in health and other sectors) was also a key theme in the ‘patient-victim’ accounts featured in newspaper articles (Bentley 2010; Mostrous 2011), and was also alluded to by five interviewees, although there was disagreement about the weight that should be given to this concept:

‘...it’s very, very clear on Patient Opinion that people are doing it, not everybody, lots of people are telling their stories in order to make it better for the next lot of people ok, they think well I can’t get any different here but wouldn’t it be great if they did that and it never happened again like they did with my mum, and then that gives whatever happened with my mum some meaning.’ Paul Hodgkin, CEO, Patient Opinion.

‘I think a lot of people do complain because they don’t want what happened to them to happen to anybody else...’ Stephanie McNamara, Head of Media, GMC.

‘...the altruistic patients who said I had that operation and the scar just looked awful, I feel I should make a complaint to protect other people. [...] I think that’s the least; people generally speaking are selfish.’ Stuart Sanders, GP and RO.

‘...the more modern culture that says if you make a complaint that the doctor or nurse or whatever might learn from your complaint and aren’t you being very helpful to them by making a complaint [...] I don’t know if that culture really exists but I think it’s the modern culture which we all kind of want to subscribe to but we know it isn’t really there.’ Malcolm Alexander, Chair, NALM.

This model suggests that patients may feel that their complaint has a value and significance beyond their own personal experience and this may lead them to feel more empowered than in the past to speak out and take action if they feel that they have encountered a substandard practitioner. However, one interviewee also suggested the possibility that this type of behaviour suggests that the public no longer trusts institutions to act on their behalf and in the best interests of the public.

There is also evidence that some complaints are motivated by the pursuit of another goal, often with a political or ethical dimension. For example, the GMC has seen a number of complaints during the period from people wishing to object to a doctor having produced a report about their fitness to work, under a system of assessments linked to benefit payments carried out on behalf of the state by Atos. This campaign has also led to complaints being made to the NMC about some of their registrants who have been involved in this work:

'I suppose the one that we've had in the last year is the Atos campaign, so Atos where, particularly ever since the Paralympics last year, so they were the agency the government had employed to do the back to work interviews for welfare, and a lot of the disability bodies have done a campaign and we can tell a lot of the referrals are pretty similar and we can't prove it but they're quite pro forma, they're quite template-y...' Michael Styles, FTP Screening Manager, NMC.

The GMC has also received complaints which it has closed at the initial stage because they focused solely on issues relating to benefit claims and did not include any suggestion of malpractice or incompetence by a doctor, and saw an increase in such complaints during 2010 and 2011 (figure 25).

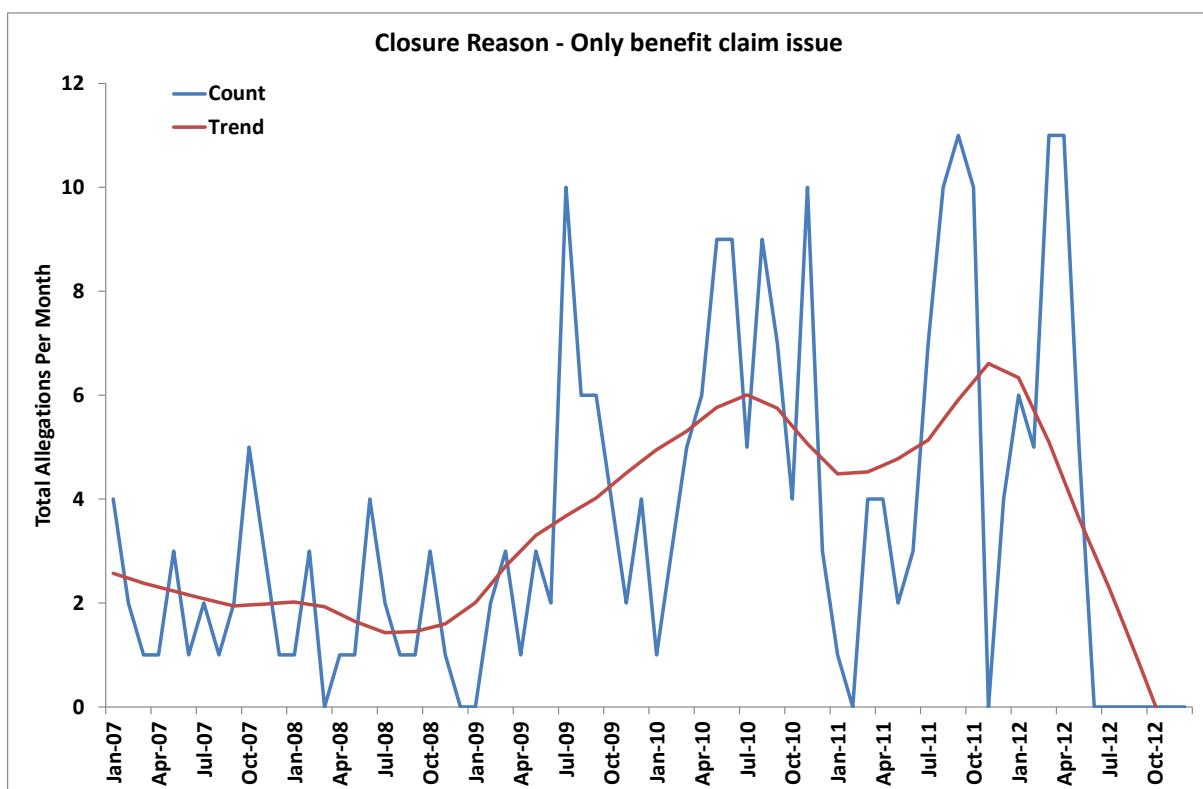


Figure 25: LOESS trend estimates and raw counts showing the 'only benefit claim' closure reason for FtP allegations per month, 2007-2012

Although the number of allegations to the GMC on this particular issue is relatively small, and bearing in mind that multiple allegations may be contained within one enquiry and therefore all closed for the same reason if applicable, it serves as an illustrative example of the idea that complaining to the GMC might be a 'secondary route' in the pursuit of a larger goal. In this case, the complainants' objections are likely to have centred on disagreement with the process of assessment, but in the absence of other mechanisms of appeal or

redress (or perhaps having exhausted these), they have then submitted a complaint to the GMC about the doctor's competence or professionalism.

This campaign echoes one which saw many complaints being made to the Advertising Standards Authority about the content in publicity materials produced by practitioners of complementary and alternative medicine:

'...we had a big issue with that, many hundreds of complaints being driven by the sceptical campaigners, and that continues, both with this one organisation I've had dealings with and others, they're not alone though because we get [...] anti-smoking lobbies...' Miles Lockwood, Director of Complaints and Investigations, ASA.

In that instance, the campaigners objected to the practices themselves, but used the ASA complaint process as another route to oppose them. This does not mean that complaints made to regulatory bodies in the course of 'campaigns' such as these do not have merit – they should be judged on their individual content. However, such a use of regulatory complaint-handling mechanisms is significant as it suggests that some people at least are prepared to use them to pursue their own political or ethical goals, in order to improve society for others or to challenge perceived unjust policies.

3.4.4: Conclusion

It is clear that people who make complaints often do so at times when they are very vulnerable and distressed. We did not find evidence that suggested people make complaints lightly or spuriously. Indeed, some of our interviewees felt that complex issues relating to the deaths of loved ones could be particularly difficult for people to navigate and could result in them bringing complaints in an attempt to seek explanation. However, we also found evidence that complaint-making can be driven by a desire to protect others from potential harm, or as an alternative route in the pursuit of a particular campaign.

3.5 Access and opportunity: the internet and social media

The internet has had a profound impact on most aspects of society since it became widely available in the 1990s. In recent years though there has been a further highly influential step-change due to the development of blogs, forums and social media platforms. These constituent elements of 'web 2.0', saw internet content shift from being almost solely provided by website creators to a model which has encouraged – and latterly, relied upon – contributions from the public and interaction between contributors.

Social media platforms such as Facebook, founded in 2004, and Twitter, founded in 2006, have become embedded in social behaviours in recent years. Alongside user review websites such as TripAdvisor, which was founded in 2000 but has expanded rapidly in recent years, and Patient Opinion in the UK healthcare sector, social media have encouraged people to speak or write publically about their experiences. The ability to comment on content, recount experiences, and to provide feedback are functions which are now built in to a broad range of websites. This means that people are now more accustomed to speaking out and that they perhaps feel that their feedback carries weight and is valued – Paul Hodgkin, CEO of Patient Opinion, believes that *'voice has been democratised.'*

As well as normalising 'speaking out' behaviour, of which complaint-making can be seen as an example, the expansion of online provision has also brought easier access to information about how and where to complain. The GMC provides details of its complaint procedures and an online complaint form on its own website. Information about the GMC is also carried on other websites though, including those of the Patients Association and AvMA for example. These sources of information would be easily found by anyone looking for information using an internet search engine. Furthermore, the growth of user-generated content on the internet means that official and traditional sources, such as large patient groups, are not the only sources available. Information on how and where to complain could be passed through Twitter or other social media sites.

The issue of complaints to the GMC about doctors working for Atos, discussed above in section 3.4.3, can also be used to illustrate how the internet can shape communications about complaints. A Google search for 'complaining to the GMC about Atos' returned

152,000 results, including blogs and forums where people discussed the idea of complaining to the GMC and shared links to the organisation's complaint page.¹⁹ The ability to share views and information in this way with a wide range of people, illustrates that people's avenues of activity are more diverse than ever.

Furthermore, Miles Lockwood, Director of Complaints and Investigations at the ASA also told us about a Google Chrome plug-in application that had been developed to enable people to make complaints to his organisation about website content more quickly (Robbins 2011). Developments such as this illustrate how members of the public are using the internet to facilitate easier complaint-making.

The internet has also changed the way in which people access media content, with more people accessing online news websites, including those provided by newspapers and broadcasters. Online newspaper articles often offer the opportunity for readers to comment on the content, or to share their own experiences. Readers can also easily share the link to the content with others, or discuss its significance on their blog or social media profile. The traditional 'career pattern' of a public event described by Molotch and Lester is constituted through three main agencies (Molotch and Lester, 1974):

- promoters, who identify news potential in an occurrence
- assemblers who take the material identified by the promoters and turn it into news for publication and/or broadcast
- consumers or readers/viewers of the news

The technologies and the institutions provide the 'structure' in and through which individuals may act independently or exercise 'agency' (Barker 2005). The traditional hierarchical top-down 'structure' of news production gave little scope for 'agency' on the part of the public. New media, and particularly social media, technologies, on the other hand, provide the opportunity for much greater public participation by enabling individuals to take on the roles of promoters and assemblers. The dialogic, where a continuous state of

¹⁹ See for example: <http://dwpexamination.org/forum/forum-help-and-support/atos-assessment-for-the-dwp-complaining-to-the-gmc/>
<http://www.bbc.co.uk/ouch/messageboards/F2322273?thread=7347834>
<http://www.urban75.net/forums/threads/atos-doctors-complain-to-the-gmc.287170/>

dialogue or exchange occurs, that is created through the rise of 'citizen generated' content presents a simultaneous and complex layering of lay, expert and political discourses. It is precisely this dialogical – 'We the Media' – principle that informs the online provision of the BBC (Allan 2006). The contemporary nature of news production and consumption can be visualised as a complicated 'web' of different voices in which there are simultaneous conversations rather than a definitive message.

As well as providing the public with an easy method of submitting a complaint, via an online form, the internet also offers people a variety of means of accessing and sharing information. This means that people may acquire information about the GMC and its complaint procedures from a wide range of sources, and that the information they access may not necessarily be complete or accurate. Furthermore, ad hoc networking between people with shared experiences or shared agendas are easily formed online, and through these networks people may encourage or facilitate each other's complaint-making behaviour. This is a development which has particularly taken hold only under the period under examination and its full impact may not yet be understood.

3.6 Complaints and litigation

The relationship between complaints about healthcare and litigation is one which warrants careful examination. It would be easy to assume that there would be a clear correlation between the two, however civil negligence claims are specifically aimed at winning monetary compensation whilst complaints procedures usually focus on investigating problems to ensure that patient safety is protected or that poor practice is eliminated.

Frank Furedi and Jennie Bristow argue in their recent report *The Social Cost of Litigation* that the UK has seen rising amounts of litigation, including 63,800 claims for medical negligence since 2001, and that this is having a negative impact not just financially but also socially as it has engendered a defensive response from the NHS Litigation Authority and Local Authorities who frequently settle claims before they get to court (Furedi 2012). Whether this increase in litigation has impacted upon the number of complaints made about healthcare is difficult to determine.

In 2007, Brazier suggested that ‘the litigation system had generated blame, distrust and dissatisfaction on the part of patients and defensiveness, concealment and low morale on the part of doctors’ whilst solicitors and claims management firms profited (Brazier, 2007: 226). The NHS Redress Act 2006 allowed patients in some instances to be offered compensation, in a package including apology, explanation and indication of corrective action, without having to go through civil proceedings (UK 2006; Brazier, 2007: 235-240). However, the relationship between complaint-making, and NHS redress and civil actions remains far from clear.

The House of Commons Health Committee examined NHS complaints and litigation together in 2011 and suggested in its report that strong complaints systems could help to limit the costs of litigation, presumably by providing satisfaction to complainants so that they would not feel compelled to pursue legal action (House of Commons Health Committee 2011a).

There is nothing in our data to suggest a direct relationship between complaint-making and litigation, certainly not in the majority of cases. When asked about litigation and its influence, some interviewees did suggest that it was possible that those seeking to pursue a

claim for compensation sometimes made a complaint to a regulatory body as a type of ‘fact-finding’ mission:

‘...it’s absolutely clear that lawyers will direct people to complain in order to get information. [...] Which is fair enough, and then they’ll say go and complain, see what you can get, see what happens, and then come back to us and we’ll see if we can see if it’s worthwhile going forward with your case...’ Paul Hodgkin, CEO, Patient Opinion.

‘I think any well advised client would try and do that as a way of assisting their case. It must help if a professional body’s found your lawyer guilty of misconduct or poor service or something like that. So I think there is a link there and I think it’s a policy question really as to whether the professional bodies as complaints authorities want to decide this before the courts do or afterwards.’ Mark Stobbs, Director of Legal Policy, Law Society.

However, others felt that the link was less direct than this in most cases:

‘I think the litigation stuff is in the background, I think it’s a societal thing, I don’t think there’s direct correlation, I think there have been a minority of complaints, a few where people are using us for a forum shopping exercise to try and get information [...] so I’ve heard that said, but it just doesn’t ring true to me, and if it is I’m sure it’s tiny numbers. So I think it’s more of a background factor, more of a societal attitudes factor...’ Paul Philip, Chief Operating Officer, GMC.

‘I mean to go against the big defence bodies is, for a patient is very you know, and it’s a big undertaking and again most sensible people would not necessarily want to put themselves through that but you’ll have a core of people I guess who want their day in court. So my sort of impression is that there isn’t a strong link but there is a link obviously...’ Michael Peters, Head of Doctors for Doctors Unit, BMA.

Furthermore, there was a general sense that complainants understood or would be informed that the GMC’s procedures themselves would not result in financial redress, and that complainants were motivated by other factors, such as the desire for an apology or explanation, or for a doctor to be punished. This view fits with the findings of earlier research on complainants’ desired outcomes (Mulcahy 2003: 94-5).

As newspaper coverage of clinical negligence often focuses on very serious cases, there are sometimes references to compensation awards. Our analysis identified 36 articles, from a sample of 301, which referred to compensation awards or legal actions seeking such awards. The reports may not clearly delineate between the roles of the GMC and the litigation process involving the NHS LA and the civil courts, so potential complainants may be under the impression that compensation is available.

Beyond traditional media, there is evidence that law firms use new media to engage with potential clients with issues relating to medical matters. Law firms specialising in medical negligence claims use a range of media (often through a dedicated media centre or office in the case of larger firms) to present an apparently personal, concerned and common sense view on specific events.

Pannone Solicitors, based in Manchester, are typical in having a medical negligence section on their website which includes links to some 50 organisations, ranging from independent charities to regulators, and which includes a direct link to the GMC homepage. The page also features the 'medical negligence blog' which contains content from solicitors in the practice. The contributions, several of which appear each week, provide 'independent' comment on a specific 'event'. The subject matters of the blog posts include issues raised by a TV documentary, newspaper articles (with reports from the Daily Mail being most prominent), government and other reports, as well as proposed or enacted legislation. The blogs usually include links to the material being commented upon, and readers are able to leave their own comments on the blog page itself, as well as being offered the option to share the blog via a number of social media platforms including Twitter, Facebook, Google+ and LinkedIn.

The production of content such as this shows that medical negligence solicitors are keen to promote their own view of specific healthcare situations, and that they are contributing to conversations and debate about relevant issues. For the law firms, such blogs represent an opportunity to demonstrate their expertise, to raise their profile and attract business. Furthermore, this behaviour provides further opportunities for the public to access, share and discuss medical matters, in a context specifically informed by the solicitors' contributions. It is also notable that a Google search for 'How to complain about a doctor' returns sponsored links to two legal firms above the GMC's own website, suggesting that such firms at least hope to receive web traffic from potential complainants.²⁰

²⁰ Search conducted 05/08/2013. The two websites were: www.neil-hudgell.co.uk/negligence and www.irwinmitchell.com/Medical

The nature of a 'compensation culture', and whether such a thing exists at all, is open to debate (Harpwood, 2007: 79-105). However, a strong focus on compensation in recent years may have contributed to the emergence of a general culture in which, when faced with a negative experience, people may believe that there should be someone held responsible, that someone or something must be at fault, and that there should be some form of redress available. This may have been supported by the plethora of TV advertising campaigns encouraging people involved in accidents to pursue personal injury claim firms, for example, as well as the high online profile of law firms, as discussed above (Brazier, 2007: 226).

Finally, in future it may be useful to reconsider these matters once the impact of changes to legal aid provision introduced by the Legal Aid, Sentencing and Punishment of Offenders Act 2012 is seen (UK 2012). This Act means that from 1st April 2013 only those who have been injured during pregnancy, labour, or the first eight weeks of life, will be eligible for Legal Aid funding to pursue a clinical negligence claim. This does not mean that people will be unable to take legal action in other types of case but simply that it may become more costly to do so. In further changes brought in through this Act, conditional fee agreements will be altered so that successful claimants pay the solicitor's 'success fee' from their compensation award, along other fees. That these changes have been made shows that the issue of litigation involving health services and the cost of such claims to the NHS has been a matter of concern to the government. Whether these changes will impact on the numbers of legal claims or on the number of complaints is unlikely to become apparent for a number of years.

3.7 Confused complainants? The wider healthcare complaint-handling system.

As the regulatory body for the medical profession, the GMC operates within a wider system of complaint handling bodies which exist to provide resolution to complaints made by patients or their relatives. Evidently, people may sometimes wish to complain about more than one individual, or about both a doctor's practice and the hospital or practice within which treatment occurred. It is entirely possible that a complainant may not know whether their dissatisfactory experience could be the fault of a systems failure or of poor practice by an individual within the system. A recurring theme during the interviews was the complexity of the wider system of complaint-handling which exists in the healthcare sector in the UK and the confusion that this complexity may cause for complainants. This system includes the GMC and eight other regulators with responsibility for healthcare professions, but it also encompasses organisations with responsibility for ensuring that the 'systems' in place are also functioning well, such as the Care Quality Commission (CQC) in England, and the health services ombudsmen.

Concerns about the complexity of this system are certainly not new, having been discussed in *Good Doctors, Safer Patients*, a 2006 report by the Chief Medical Officer which identified a need to 'ensure a stronger interface between complaints about clinical services and complaints about doctors (DH 2006). Since then, there have been changes to the NHS complaint-handling mechanism, but our analysis shows that confusion about the divisions within the system remains.

The division of complaint-handling mechanisms into 'professional disciplinary' and 'systemic' responsibilities may be necessary as a result of legislation and healthcare structures, but it engenders questions about whether the public knows and understands the differences between the various bodies and how a complainant finds their way to the organisation which is best equipped to deal with their complaint.

3.7.1 Confused complainants

NHS complaints resolution is split between the service providers, and at the next level between Ombudsmen in each of the four nations of the United Kingdom. The CQC can

handle some public complaints about mental health services in England, and the healthcare professions are regulated by a total of nine regulatory bodies, most covering the whole of the UK, although pharmacists in Northern Ireland are regulated by a separate body.

Changes to this system have taken place during the period under examination with the most significant being to the NHS complaint resolution system. Before 2009, the NHS complaints system had consisted of three stages: in the first instance, patients or their families would have to put their complaint to the NHS service provider involved; if the complainant was dissatisfied with the response received, they could request an independent review of the matter, reviews which were at first conducted by locally appointed panels and later by the Healthcare Commission; finally, if the complainant remained unhappy after the second-stage review, they could escalate their complaint to the ombudsmen.

In 2009, the independent local review (or the second stage of the process) was abolished and complainants dissatisfied with the response from the NHS service involved were to take their complaints directly to the PHSO. The number of health complaints received by the PHSO increased from 6,780 in 2009 to 14,429 in 2010 following this change (PHSO 2011).

The changes were intended to shorten what had been a lengthy process, in order to achieve a faster resolution to complaints. However, there has been speculation that these changes have had wider implications as limitations to the circumstances in which the PHSO could act – it could only intervene in cases where it would be able to achieve a ‘worthwhile outcome’ – meant that it only accepted a small number of cases for formal investigation. In 2011-12 the PHSO received some 16,000 complaints, of which around 4,000 were deemed to be within the scope of its remit, and of those formal investigations were carried out in only 400 or so cases (PHSO 2012). Gavin McBurnie, Interim Executive Director of Operations (Business Transformation) at the PHSO, explained that the ombudsman’s organisation is changing its practices so that it will now investigate more complaints, even if it seems that no worthwhile outcome is achievable as long the complaints meet basic legal criteria governing the PHSO’s remit: that the complainant is a ‘suitable complainant’; local resolution processes have been exhausted; and the complaint is properly made. Furthermore, McBurnie also acknowledged that the length of time taken to resolve complaints could put others off complaining to the PHSO but stated that:

‘...a lot of complainants don’t come anywhere near us when they should come near us because they’ve suffered a significant injustice that should be put right. So we think we’d like to see a lot more complaints, which does give a logistical issue of how we handle them all, but [...] we’d like to have the problem.’ Gavin McBurnie, Interim Executive Director of Operations (Business Transformation), PSHO.

There may therefore have been a perception amongst complainants, and amongst patient advocacy and advice groups, that there is little chance of achieving redress via the PHSO. The small number of cases formally investigated by the PHSO was raised as a cause for concern, for example, by representatives of the Patients’ Association and Action Against Medical Accidents (AvMA) in oral evidence given to the House of Commons Health Select Committee during its examination of the NHS complaints procedures (House of Commons Health Committee 2011b).

Moreover, Malcolm Alexander, Chair of NALM, suggested that recent changes to PALS provision in many areas may also have had an effect on complaints to other bodies. However, whether this has led members of the public to seek redress from other agencies, such as the professional regulators like the GMC, remains to be seen. However, it may be that the longevity and apparent stability of the professional regulators means that they offer an outlet to complainants who are confused or frustrated by other bodies.

When asked about the efficacy of the current complaint handling mechanisms across the healthcare sector, many of our interviewees believed that the wider system lacked clarity:

‘...I think people complain to the GMC because they have been unhappy with something that’s happened locally, they have gone and tried to get either an answer or an apology or something, and by going through that local process where they feel they get no answers and they get no apology their views harden about the system and about the individuals in that system...’ Stephanie McNamara, Head of Media, GMC.

‘...I’m not sure where it’s dealt with in terms of Trust level or commissioning groups now etc. and if I’m not clear, and I’m a patient as well as a doctor, then the patients aren’t going to be clear, but the one thing they do hear about is the GMC, so I think it’s about in a way taking a step backwards and actually saying do we need to go back and actually have something a bit more robust locally so that it doesn’t get elevated to the GMC.’ Michael Peters, Head of Doctors for Doctors Unit, BMA.

‘...there are examples where patients have been told ‘yeah we’re dealing with it’, and the patients constantly have to chase the people dealing with the complaint to see what’s happening, oh we’re dealing with it, well that’s not good enough in my view, you have to have a proper structured approach that if you don’t give me an answer

for that I move up to the next stage...’ Sol Mead, former Chair, Royal Medical Colleges Patient Liaison Group.

‘...my experience is that by the time they come to us they are so fed up with the complaints system they don’t feel that they’ve been treated seriously, they feel that there’s been cover-ups, that they don’t want that from us, what they want is some degree of closure, or some degree of punishment for the doctor, and we’re not set-up to deliver that at all.’ Paul Philip, Chief Operating Officer, GMC.

These comments are in tune with the findings of the recent Clywd-Hart review of complaints systems in NHS hospitals, which found that such systems could be confusing and long-winded for complainants, and highlighted that this has been a long-standing problem (Clywd & Hart 2013).

Analysis of the GMC’s complaints data also points to the possibility that members of the public are increasingly bringing complaints about multiple individuals or making multiple allegations.

As figure 26 shows, LOESS trend estimates show that both total allegation and unique enquiry rates have increased, though the unique enquiries rate shows a slower increase than the total allegation rate. As the total allegation rate includes each row of data taken from the database as a separate enquiry, this indicates that enquiries include more allegations and/or doctors as time progresses. The timescale for the major divergence between the two lines coincides with that of the changes to the NHS complaint-handling system.

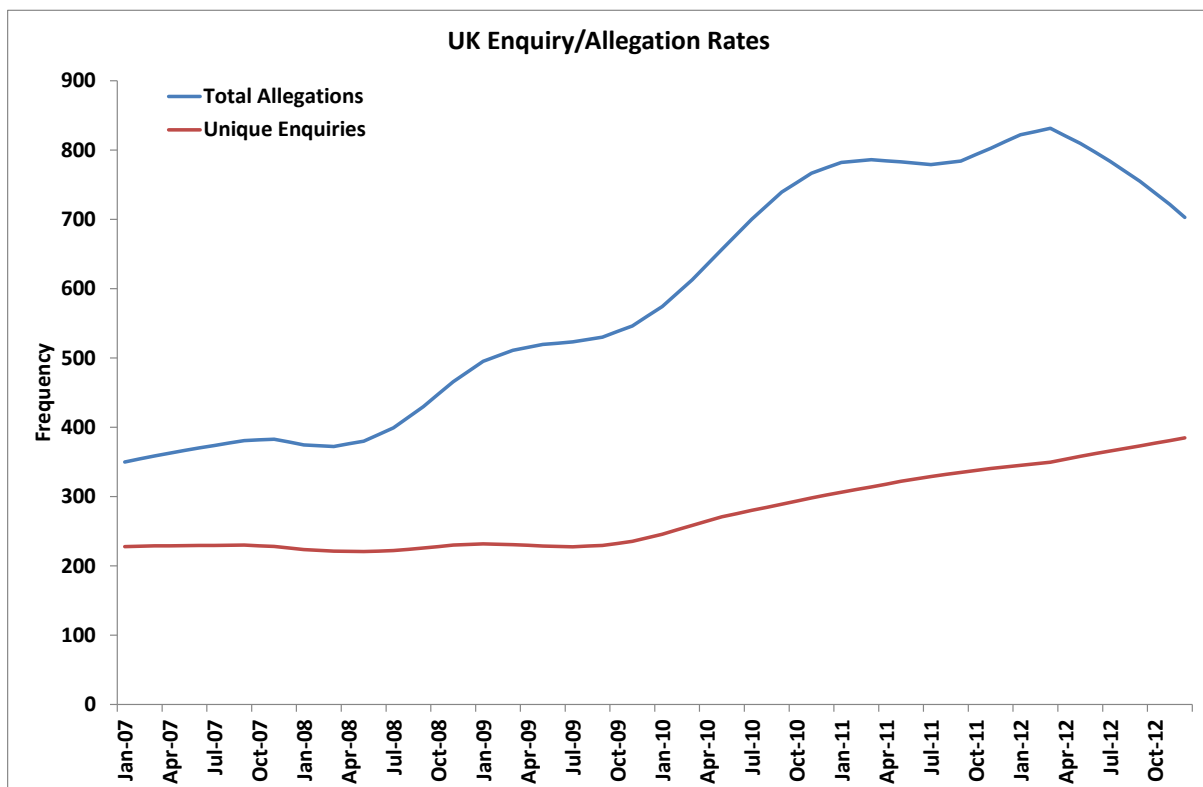


Figure 26: LOESS trend estimates showing the 'total allegation' and 'unique enquiry' rates of FtP enquiries in the UK, 2007-2012

Furthermore, examination of the closure reasons assigned by the GMC to enquiries closed at the triage stage of the FtP procedure may also support this hypothesis. There were a total of 29 classifications for Closure Reason, with many of these categories containing very few cases. Of these 29, only 8 recorded a LOESS trend figure of more than 15 cases in a month. As with previous data, the remaining reasons have been summarised in an 'Other' category (figure 27).

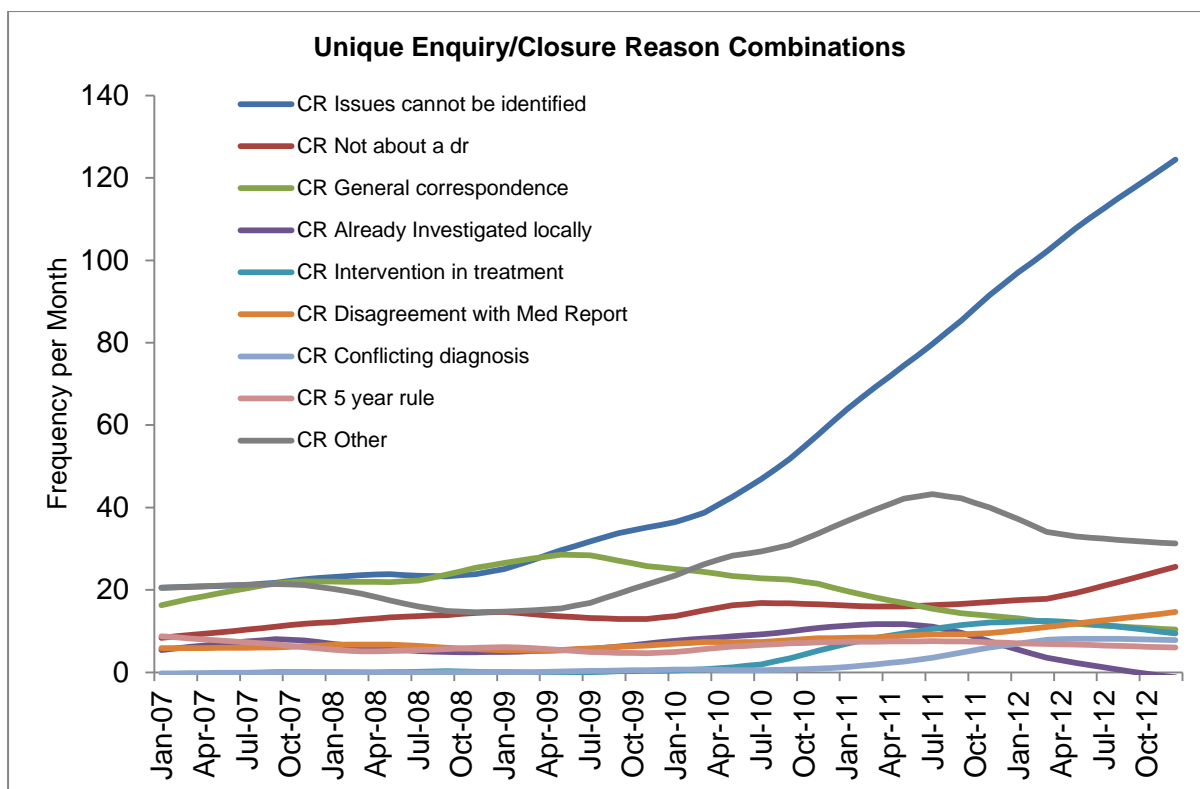


Figure 27: LOESS trend estimates showing the closure reasons for FtP enquiries in the UK, 2007-2012

Most of the categories of closure reason show a steady level of complaints per month across all six years. *CR Already Investigated locally* drops away after 2011 as it ceased to be used as a closure reason. However the main reason that cases are closed, *Issues cannot be identified*, has dramatically increased. Relatively stable from 2007 to the end of 2008, there has been a steady increase in complaints closed for this reason over the next three years with the rate marginally slowing for 2012. This category is used where no issue that would warrant a GMC investigation can be identified within the complaint.²¹ With a limited number of closure reasons available on the database, the best fit must be applied which means that this data must be treated with caution. However, the increase in complaints which were closed because no issue falling within the GMC's remit could be identified remains notable.

These trends in the statistical data may be indicative of people making complaints to the GMC about systemic issues or generally poor healthcare experiences, rather than complaints which are focused on individual practitioners.

²¹ Information from GMC research liaison.

The NMC has witnessed similar trends, with their representative Michael Styles saying that complainants are increasingly seeking to complain about multiple practitioners, including some who are not registered by the NMC:

‘...we do get referrals from members of the public where they will refer everyone in the ward, and without many details and we would need to look into it and it turns out half of them are healthcare assistants who we don’t regulate so we just have to close them and they don’t really understand why we can’t do anything about them.’ Michael Styles, FTP Screening Manager, NMC.

It seems clear then that there is an issue of confusion around the wider complaint-handling mechanisms which operate in the healthcare sector. In addition, there were also suggestions from three interviewees that patients may feel hesitant about complaining locally as they may fear being treated differently if they need on-going care from the doctor or hospital they have complained about, a suggestion in line with evidence given to the House of Commons Health Select Committee in 2011 by an ICAS representative (House of Commons Health Committee 2011b: 44). The GMC, may, therefore, appeal because of its independence from NHS services.

As seen in section 3.1, it is likely that the GMC has achieved a degree of name recognition amongst the general public, but that people do not fully understand its FtP remit. The GMC’s FtP procedures are designed only to handle cases that may potentially lead to action being taken against a doctor’s registration. However, currently it seems that a good deal of the responsibility for navigating a complex network of complaint handling mechanisms lies with members of the public seeking to make a complaint. This may result in the GMC receiving complaints which are outside its remit which may explain why more cases are being closed at triage, and particularly may speak to why more are falling into the ‘Issues cannot be identified’ category. If then people are seeking to bring other complaints to the organisation, about generally dissatisfying experiences of care, for example, or lower level ‘customer service’ type complaints, it is necessary to consider why this may be and whether there are approaches which may address these issues.

3.7.2 Potential interventions

During our research, two possible approaches have emerged as worthy of consideration. Firstly, organisations regulating two different professions have adopted similar strategies in

seeking to separate out ‘customer service’ complaints from professional disciplinary affairs. In 2006, the General Dental Council launched the Dental Complaints Service to handle complaints about private dental treatment which were not within the scope of its FtP procedures.²² The DCS offers resolution options similar to those which the health services ombudsmen provide to NHS patients, such as achieving apology, explanation or fee refunds.

Clearly there is a wider usage of private dental care than medical care, however there may be some value in such an option for private medical patients where there is no overall system for complaint handling. If NHS funded medical patients are not receiving satisfactory complaint-handling from the local resolution and ombudsmen services, as some suggest, then there may be pressure for the GMC to take more action – however, this would require alteration or extension of the organisation’s activities and remit.

The regulation of lawyers was the subject of considerable criticism in a report by Sir David Clementi (Clementi, 2004). As a result, complaint-handling was split into a customer service arm, the Legal Ombudsman (LeO), whilst professional disciplinary functions remained within the remit of existing professional bodies though these were required to create independent arms to oversee disciplinary matters. There are now eight approved regulators for legal professionals, for example solicitors are regulated by the Solicitors Regulatory Authority (SRA) which is the regulatory arm of the Law Society, which are overseen by the Legal Services Board. The division between customer service matters and professional discipline therefore mirrors that in place across much of the healthcare sector. However, the division between what is a customer service complaint, and what is a more serious disciplinary matter, is not always clear – there will always be overlaps and grey areas.

A second potential intervention to ensure that healthcare complaints, whether customer-service, professional disciplinary or systemic, find their way to the correct complaint-resolution mechanism was discussed by three interviewees, all involved in regulation. They noted that the creation of a single portal for complaints was under discussion by regulators. This would involve complaints being assessed and then passed to the correct body for investigation, meaning that the onus for directing the complaint through a complex system,

²² <http://www.gdc-uk.org/sites/dcs/Pages/default.aspx>

particularly where aspects of a complaint may be pertinent to more than one organisation, would shift away from the complainant. This model is not a new concept having been under discussion for some years (Brazier, 2007: 223).

Such an approach would seem to sit within a trend towards more proactive and engaged regulation. The Francis Report highlighted the need for healthcare regulators to try to identify poor practise by looking for patterns in complaints and also by sharing information with each other more effectively, particularly in recommendations numbers 35, 222, 223 and 234 (Francis 2013). The Berwick report for NHS England also recommends that 'regulatory regimes should be simple and clear' (Berwick 2013: 5). Gavin McBurnie, Interim Executive Director of Operations (Business Transformation) at the PHSO, suggested that there was a need for better co-operation between the various complaint-handling bodies:

'So if you were to take Mid Staffs, we had some complaints, we didn't have that many actually because at that point we were a level three body so most got screened out by the Healthcare Commission, so we'd just get complaints and the GMC will have had complaints and the NMC will have had complaints about this although there's a bit of overlap, there's also a large gulf between us as well [...] And it's how do we make these connections much more effectively so that if there is any systemic problem going on then the system recognises it.' Gavin McBurnie, Interim Executive Director of Operations (Business Transformation), PHSO.

A single portal for healthcare complaints could work to support this process by providing data across the sector and prior to the split between systemic and professional concerns is enacted, enabling a better response to complaints, a better experience for complainants and better analysis of service provision and professional practice across the sector.

The GMC has responded to the Francis recommendations by recognising the need for better mechanisms for addressing generic concerns and has stated that it will discuss the issue with the Department of Health and the CQC (GMC 2013e). Moreover, it stated that it has already extended its activities in an effort to be 'more outward facing and engaged' through the establishment of two liaison networks, the Employer Liaison Advisers and Regional Liaison Advisers (GMC 2013e). Part of the RLAs work will be to liaise with 'local staff from systems regulators, sharing intelligence and making sure our activities are co-ordinated' (GMC 2013e). There will also be the network of Responsible Officers who will oversee the revalidation process for doctors in their locality. This move towards a 'localised' model of

regulation was referred to by Paul Philip, Chief Operations Officer at the GMC, as having the potential to reduce the number of complaints entering the central system by ensuring that problems with doctors are identified and addressed earlier locally:

'So you've to reengineer the processes to make them as efficient as possible, but you've also got to think about whether or not dealing with this activity is genuinely the right way to act in the public interest, or whether or not now in the context of revalidation there are other ways of dealing with it, in particular revalidation regulations put a legal obligation on medical directors as responsible officers, not all medical directors but most of them are, to take responsibility for the fitness to practise of doctors. All the public enquiries of yesteryear say that people who knew what was happening were other doctors, so pushing it locally and basically making sure that local systems of clinical governance are robust has to be what the game's about, that is what revalidation's about, it's about two things, it about improving local clinical governance and encouraging reflective practice of doctors.' Paul Philip, Chief Operating Officer, GMC.

The GMC clearly does not bear sole responsibility for improving the regulation of healthcare or for meeting the Francis recommendations. The difficulties, for example, of using the GMC's database to identify risk have been identified elsewhere (Lloyd-Bostock 2008 and 2010). However, representatives from other organisations have also stated that a more proactive model of regulation is emerging and that there is a desire to improve co-operation. Michael Styles, FTP Screening Manager at the NMC stated that his organisation has sought to better share information with the other regulators since the Francis Report and to become more active in looking for trends in complaints that might point to worries about a particular service.

The trend for more active regulation in healthcare also encompasses the establishment of on-going oversight systems, such as the revalidation scheme introduced by the GMC and equivalent programmes in other professions, which are mentioned repeatedly in the Professional Standards Authority's *The Performance Review Standards: Standards of Good Regulation* (PSA 2010).

Beyond healthcare, Miles Lockwood, Director of Complaints and Investigations at the ASA also told us that that organisation was likely to pursue more active methods of regulation suggesting that this is part of a wider socio-political *zeitgeist*. The regulatory landscape seems to be undergoing notable changes currently, and navigating these depends upon a

clear understanding of the purpose of regulation and the constituency that it is intended to benefit.

3.7.3 Conclusion

The wider system is confusing and frustrating for patients, especially since the onus of the 'division of labour' over deciding where to make a complaint is on the public. Navigating the system may lead to further frustration for complainants, and some may also prefer to take their complaint to an independent body like the GMC rather than using local resolution mechanisms.

Our findings suggest that more active regulation is a current trend which may offer some solutions, with better co-operation between different regulators offering the potential to improve situations where complainants approach an inappropriate organisation.

Furthermore, changes in the GMC's own activities may also have an impact in future.

3.8 Standards of Care

We could not investigate an increasing number of complaints without asking if such a trend were simply a response to a decline in standards of medical care. However, analysis of the actual quality of care and changes to it in recent years was beyond the parameters of this research. Lack of access to the content of complaints or research with complainants also limits our insight in this area, although the large amount of cases assigned to the 'clinical care' allegation category, and the growth of this category during the period under examination, suggest that levels of dissatisfaction with care have increased (see figure 24 showing allegation category trends in section 3.3, p.72). Although the number of consultations has also increased (see section 3.3.1) and may therefore partially explain this trend, this has been outpaced by the rise in complaints.

There were varied views on this issue amongst interview participants regarding whether budget constraints imposed on the NHS by the coalition government, and the pressure to meet the 'Nicholson challenge', in which the Chief Executive of the NHS, David Nicholson, set out requirements for the NHS to achieve £15-20 billion in efficiency savings between 2011 and 2015, may have had a negative impact upon the quality of care provided to patients (DH 2009: 47).

'...I think with the cuts in a lot of trusts and the numbers of nurses have been cut, we have had an increase in referrals from trusts, struggling trusts do refer to us more...'
Michael Styles, FTP Screening Manager, NMC.

'...the assumption is that they must, things must be bad because there's more of it on TV and you know there seems to be bigger scandals and things happening with more frequency, but whether that's because you know, there's more of a light being shone in some of those corners than before...' Sean King, Medical Pay and Workforce Team, NHS Employers.

'...I mean we talk to doctors, as I've been doing, and they will tell you that in certain areas they're under extreme pressure, and I hear many examples, good examples of extreme pressure, for all sorts of reasons, and any work, any employee, any worker under pressure is likely to make mistakes or try and cut corners...' Sol Mead, former Chair, Royal Medical Colleges Patient Liaison Group.

'I honestly don't have a shred of evidence to suggest that's the case. Again anecdotally I would say it's more an increase in reporting rather than a reduction in care...' Paul Philip, Chief Operating Officer, GMC.

As discussed above, out of hours provision and the role of foreign doctors, particularly when employed as locums, are topics which have been subject to extensive critical media attention. There has also been a strong focus on the quality of care provided to elderly patients, which has run alongside the sustained attention given to the aftermath of the failures at Mid-Staffordshire Foundation Trust between 2005 and 2008. Furthermore, changes to the style in which medical care is provided (as discussed in section 3.3) may impact upon patients' perceptions of its quality, whether correctly or not. Whether there has indeed been any decrease in the standards of care experienced is not the subject of this research, and is a much wider question, but our interview data suggests that the topic and its impact on complaint rates merits further investigation.

4. Conclusion

Our research has established that the rise in fitness to practise complaints from members of the public between 2007 and 2012 resulted from wider social change.

The trend was broadly similar across the regions and SHAs of the UK during this period and so cannot be assigned to specific localised issues. Other regulators have also seen increases in the number of complaints they have received, again indicating wider issues, but, within the healthcare sector, the GMC receives a higher rate when judged against its registrant base.

A combination of long-term shifts, short term developments and on-going issues has created the context in which the rise in complaints occurred.

Long-term changes in the relationship between the public and the medical profession and in the nature of individuals' interactions with their own doctors have altered the way in which people view doctors. The FtP allegation category relating to 'relationships with patients' has risen significantly perhaps indicating that patients are now more likely to complain if they are dissatisfied with their individual doctor for reasons not relating to clinical care, or encompassing both clinical care and other factors as well. In particular, patients have become more empowered and less deferent, as well as being more informed. They have higher expectations and the relationship between doctor and patient is increasingly being shaped by a more consumerist ideology.

Alongside these changes, short-term developments have made finding information about how to complain and the act of complaining itself easier. While traditional media do not appear to have had at least a statistically measurable impact on FtP enquiries; there is no doubt that the growth of the internet has had an enormous impact upon how information is now produced, disseminated and used. People can now access information from a variety of sources, which may lead them to the GMC but which are not necessarily full or accurate in portraying its work. In addition, the emergence of social media may mean that many people are now more accustomed to publically discussing and reviewing their experiences.

The continued complexity of the wider system through which complaints about healthcare issues are managed may cause some patients to bring complaints to the GMC which should properly go elsewhere. The GMC may be better known to the public than other bodies because of its longevity and stability, although they may not understand its functions or remit, in a sector which has seen notable changes and it may also appeal to those who prefer to complain to an independent body rather than local resolution processes. Although regulators are seeking to become more proactive in working together to combat these issues, the burden of responsibility for navigating the system has been placed on the complainant.

Furthermore, there may have been a decline in the standard of care provided during this period due to budgetary restraints, or there may simply be a perception that this is the case.

Against this socio-political backdrop, the GMC has sought to develop a more active and localised model of regulation. However, careful consideration should be given to how the organisation engages with the general public. It appears currently that it has achieved a certain level of name-recognition but that its role and remit are not well understood.

How the GMC relates to and interacts with the public is a critical issue with regards to fitness to practise complaints. The GMC acts to protect the public through the maintenance of professional standards which places 'the public' in an 'arms-length' position in relation to the organisation. However, the fitness to practise system, and the actions of complainants in making use of it, place the GMC in a direct relationship with the public. Mismatched expectations of this relationship may result in the public anticipating that the GMC will act in circumstances where it is unable to do so, raising the likelihood of complaints which fall outside its remit being made. Reflecting on the nature of this relationship would benefit both the GMC and complainants.

5. References

- Aitken, M. 2007. 'Please can we have our hard working village doctor back?', *Mail on Sunday*, 12/08/2007.
- Allan, S. 2006. *Online News* London: Open University Press.
- Allsop, J., Jones, K., and Baggott, R. 2004. 'Health consumer groups in the UK: a new social movement?' *Sociology of Health & Illness*, 26(6): 737-756.
- Allsop, J., and Jones, K. 2008. 'Withering the Citizen, Managing the Consumer: Complaints in Healthcare Settings.' *Social Policy and Society*, 7(02): 233-243.
- Archer, J., Regan de Bere, S., Nunn, S., Clark, J., and Corrigan, O. 2012. *Revalidation: in Policy*, <http://www1.plymouth.ac.uk/peninsula/research/camera/revalidation/Documents/Stage-One-Report.pdf>
- ASA. 2011. *Annual Report 2011*. London: Advertising Standards Authority.
- Aston, J. 2012. 'MMR jab doctor appeals GMC ruling.' *The Independent*, 13/02/2012.
- Attewill, F. 2007. 'GMC hears surgeon used texts to pester patient for a date.' *Guardian*, 3/01/2007.
- Baggott, R., Allsop, J., and Jones, K. 2005. *Speaking for Patients and Carers: Health Consumer Groups and the Policy Process*. Basingstoke, Palgrave Macmillan.
- BARB. 2013. *Broadcasters Audience Research Board* website. <http://www.barb.co.uk/>
- Barker, C. 2005. *Cultural Studies: Theory and Practice*. London: Sage.
- BBC. 2007. 'Panorama Press Release.' http://www.bbc.co.uk/pressoffice/pressreleases/stories/2007/02_february/07/panorama.shtml
- Bentley, P. 2010. 'GP keeps job after missing fatal cancer'. *Daily Mail*, 12/08/2010.
- Bentley, P. 2012. 'The Sex Offender Doctors Allowed to Keep Working' *Daily Mail*, 25/09/2012
- Berwick, D. 2013. *A Promise to learn – a commitment to act: Improving the safety of patients in England*. London: Department of Health.
- Bowman, S. and Willis, C. 2003. 'We Media: How Audiences are Shaping the Future of News and Information.' The Media Center at the American Press Institute. <http://www.hypergene.net/wemedia/weblog.php>

Bradby, H., Gabe, J., and Bury, M. 1995. 'Sexy docs' and 'busty blondes': press coverage of professional misconduct cases brought before the General Medical Council.' *Sociology of Health and Illness*, 17(4): 458-476.

Brazier, M. 2007. *Medicine, Patients and the Law*, 4th edition. London: Penguin Books.

Case, P. 2011. 'The good, the bad and the dishonest doctor: the General Medical Council and the 'redemption model' of fitness to practise.' *Legal Studies*, 31(4): 591-614.

Chamberlain, J. M. 2013. *The Sociology of Medical Regulation*. Heidelberg/New York/London: Springer Dordrecht.

Chatfield, C. 2004. *The analysis of time series: an introduction*. 6th Ed. Boca Raton: CRC Press.

Clementi, D. 2004. *Review of the regulatory framework for legal services in England and Wales: Final Report*. London: Department for Constitutional Affairs.

<http://webarchive.nationalarchives.gov.uk/+http://www.legal-services-review.org.uk/content/report/report-chap.pdf>

Cleveland, W.S., Grosse, E., and Shyu, W.M. 1992. 'Local regression models' in Chambers, J.M., and Hastie, T.J. (eds) *Statistical Models in S*, London: Wadsworth & Brooks/Cole.

Clywd, A., and Hart, T. 2013. *A Review of NHS Hospitals Complaints System: Putting Patients Back in the Picture*. London: Williams Lea.

Cohen vs GMC. 2008. LS Law Medical 246, EWHC 581 (Admin).

<http://www.bailii.org/ew/cases/EWHC/Admin/2008/581.html>

Cramb, A. 2007. 'Highlanders fight to bring back 'old-fashioned' GP', *The Daily Telegraph*, 11/08/2007.

DH. 2006. *Good Doctors, Safer Patients: a report by the Chief Medical Officer*. London: Department of Health.

DH, 2009. *The Year: NHS Chief Executive's Annual Report*. London: Department of Health.

Edwards, D. 1991. 'Categories are for Talking: On the Cognitive and Discursive Bases of Categorization' *Theory & Psychology*, 1.4, 515-542.

Elkins, L. 2009. 'Should you trust a stand-in surgeon?' *Daily Mail*, 17/11/2009.

Engeström, Y. 1999. 'Activity theory and individual and social transformation' in *Perspectives on Activity Theory*, Engeström, Y., Miettinen, R., and Punamäki, R.L. (eds). Cambridge: Cambridge University Press.

Feinmann, J. 2012. 'Why are we so soft on dodgy doctors?' *Daily Mail*, 7/02/2012.

- Ford, C. 2011. 'Doctor Struck Off For Faking Prescriptions', *The Journal (Newcastle)*, 9/04/2011.
- Francis, R. 2013. *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Volume 2: Analysis of evidence and lessons learned (part 2)*. London: Stationery Office.
- FSO. 2012. *Annual Review 2011-12*. London: Financial Services Ombudsman.
- Furedi, F., and Bristow, J. 2012. *The Social Cost of Litigation*. London: Centre for Policy Studies.
- Garfinkel, H. 2002. *Ethnomethodology's Program Working Out Durkheim's Aphorism*, (ed. Anne Rawls). Lanham: Rowman & Littlefield.
- GDC. 2007. *Annual Report*. London: General Dental Council.
- GDC. 2008. *Annual Report*. London: General Dental Council.
- GDC. 2009. *Annual Report*. London: General Dental Council.
- GDC. 2010. *Annual Report*. London: General Dental Council.
- GDC. 2011. *Annual Report: additional figures*. London: General Dental Council.
- GDC. 2013. *Dental Complaints Service homepage*. <http://www.gdc-uk.org/sites/dcs/Pages/default.aspx>
- GfK (Growth from Knowledge) NOP Social Research. 2011. *Research into Fitness to Practise referrals*. [http://www.gmc-uk.org/Research into Fitness to Practise referrals 2011.pdf](http://www.gmc-uk.org/Research%20into%20Fitness%20to%20Practise%20referrals%202011.pdf) 44498587.pdf
- Gill, V., Bridges, S., and McNaughton Nicholls, C. 2012. *The standards expected of doctors: patient and public attitudes*. National Centre for Social Research. [http://www.gmc-uk.org/GMC standards expected of doctors final report v2.pdf](http://www.gmc-uk.org/GMC_standards_expected_of_doctors_final_report_v2.pdf) 51766111.pdf
- GMC. 2004. *General Medical Council (Fitness to Practise) Rules Order of Council 2004*. [http://www.gmc-uk.org/consolidated version of FTP Rules.pdf](http://www.gmc-uk.org/consolidated_version_of_FTP_Rules.pdf) 26875225.pdf
- GMC. 2006. *Good Medical Practice*. London, General Medical Council. http://www.gmc-uk.org/static/documents/content/GMP_0910.pdf
- GMC. 2009. *Guidance to the GMC's Fitness to Practise Rules 2004*. [http://www.gmc-uk.org/Guidance to the FtP Rules 2 .pdf](http://www.gmc-uk.org/Guidance%20to%20the%20FtP%20Rules%202004.pdf) 35398575.pdf
- GMC. 2010. *2009 Annual Statistics: Fitness to Practise*. London: General Medical Council.

GMC. 2011. *2010 Annual Statistics: Fitness to Practise*. London: General Medical Council.
http://www.gmc-uk.org/2010_Annual_Statistics.pdf 45103627.pdf

GMC. 2012a. *Making decisions on cases at the end of investigation stage: Guidance for the Investigation Committee and Case Examiners*. [http://www.gmc-uk.org/Guidance for case examiners and the Investigation Committee.pdf](http://www.gmc-uk.org/Guidance_for_case_examiners_and_the_Investigation_Committee.pdf) 27248903.pdf

GMC. 2012b. *The State of Medical Education and Practice in the UK 2012*. London: General Medical Council. [http://www.gmc-uk.org/The state of medical education and practice in the UK 2012_0912.pdf](http://www.gmc-uk.org/The_state_of_medical_education_and_practice_in_the_UK_2012_0912.pdf) 49843330.pdf

GMC. 2012c. *2011 Annual Statistics: Fitness to Practise*. London: General Medical Council.
http://www.gmc-uk.org/GMC_Annual_Statistics_2011_2.pdf 50323977.pdf

GMC. 2013a. *Good Medical Practice*. http://www.gmc-uk.org/GMP_2013.pdf 51447599.pdf

GMC. 2013b. *How to complain about a doctor in England*. London: General Medical Council.
[http://www.gmc-uk.org/How to complain about a doctor in England_0713.pdf](http://www.gmc-uk.org/How_to_complain_about_a_doctor_in_England_0713.pdf) 48911926.pdf

GMC. 2013c. *Patient's Help*. http://www.gmc-uk.org/concerns/making_a_complaint/3841.asp

GMC. 2013d. *What to expect from your doctor: a guide for patients*. London: General Medical Council. [http://www.gmc-uk.org/What to expect from your doctor a guide for patients_English_0413.pdf](http://www.gmc-uk.org/What_to_expect_from_your_doctor_a_guide_for_patients_English_0413.pdf) 51776352.pdf

GMC. 2013e. *Our response to the report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry*. <http://www.gmc-uk.org/about/21705.asp#profess>

GMC. 2013f. *State of Medical Education and Practice in the UK 2013*, London: General Medical Council.

GMC. 2013g. *2012 Annual Statistics: Fitness to Practise*. London: General Medical Council.
http://www.gmc-uk.org/2012_Annual_Statistics.pdf 53844772.pdf

GOsC. 2007. *Annual Report and Accounts, 2006-7*. London: General Osteopathic Council.

GOsC. 2008. *Annual Report and Accounts, 2007-8*. London: General Osteopathic Council.

GOsC. 2009. *Annual Report and Accounts, 2008-9*. London: General Osteopathic Council.

- GOsC. 2010. *Annual Report and Accounts, 2009-10*. London: General Osteopathic Council.
- GOsC. 2011. *Annual Report and Accounts, 2010-11*. London: General Osteopathic Council.
- GOsC. 2012. *Annual Report and Accounts, 2011-12*. London: General Osteopathic Council.
- Greenslade, R. 2007. 'The good news about bad news – it sells' *Guardian*
<http://www.guardian.co.uk/media/greenslade/2007/sep/04/thegoodnewsaboutbadnews>
- Hall, S., Critcher, C., Jefferson, T., Clarke, J., and Roberts, B. 1978. *Policing the Crisis: Mugging, the State, and Law and Order*. London: MacMillan.
- Harpwood, V. 2007. *Medicine, Malpractice and Misapprehensions*. Abingdon: Routledge-Cavendish.
- Harris, G. 2008. 'This doctor's patients loved her for tending to them at all hours. Her colleagues told the GMC she was demented', *Sunday Times*, 10/02/2008.
- Hermida, A. 2010. 'Twittering the News: The emergence of ambient journalism.' *Journalism Practice*, 4.3, 297-308.
- Horn, J. 2009. 'Sex pest doctor struck off register.' *Kent Messenger*, 27/03/2009.
- HPC. 2007. *Fitness to Practise Annual Report, 2006-07*. London: Health Professions Council.
- HPC. 2008. *Fitness to Practise Annual Report, 2007-08*. London: Health Professions Council.
- HPC. 2009. *Fitness to Practise Annual Report, 2008-09*. London: Health Professions Council.
- HPC. 2010. *Fitness to Practise Annual Report, 2009-10*. London: Health Professions Council.
- HPC. 2011. *Fitness to Practise Annual Report, 2010-11*. London: Health Professions Council.
- HCPC. 2012. *Fitness to Practise – Key information 2012*. London: Health and Care Professions Council.
- House of Commons Health Committee. 2011a. *Complaints and Litigation: Volume I*. London: Stationery Office
- House of Commons Health Committee. 2011b. *Complaints and Litigation: Volume II*. London: Stationery Office.
- Humphrey, C., Hughes, J., and Locke, R. 2007. *External audit of decisions in the investigation stage of the GMC's fitness to practise cases*. London: King's College London.
- IpsosMORI. 2013. *Trust in Professions Survey*. <http://www.ipsos-mori.com/researchpublications/researcharchive/15/Trust-in-Professions.aspx?view=wide>

Jardine, C. 2010. 'Dangerous Maverick or medical martyr?; Despite a damning verdict from the General Medical Council, Andrew Wakefield is unrepentant about his role in the MMR furore', *The Daily Telegraph*, 29/01/2010.

Johnston, L., and Halle, M. 2007. 'Now shamed baby doctor faces prison.' *Sunday Express*, 9/12/2007.

Karph, A. 1987. *Doctoring the Media: The reporting of health and medicine*. London: Routledge.

Lattimer, V. et al. 2010. *The impact of changing workforce patterns in emergency and urgent out-of-hours care on patient experience, staff practice and health system performance*. London: Stationery Office. http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1519-97_V01.pdf

Leach, B. and Donnelly, L. 2012. 'Revealed: 3 in 4 danger doctors are from abroad; Alarm at level of training given to foreign doctors', *The Sunday Telegraph*. 30th December 2012.

Lister, M., Dovey, J., Giddings, S., Grant, I., and Kelly, K. 2003. *New Media: A critical introduction*. London: Routledge.

Lloyd-Bostock, S. 1999. 'Calling doctors and hospitals to account: complaining and claiming as social processes' in *Medical Mishaps: Pieces of the Puzzle*, M. M. Rosenthal, Mulcahy, L., and Lloyd-Bostock, S. (eds). Buckingham: Open University Press.

Lloyd-Bostock, S. M., and Hutter, B.M. 2008. 'Reforming regulation of the medical profession: The risks of risk-based approaches.' *Health, Risk & Society*, 10(1): 69-83.

Lloyd-Bostock, S. 2010. 'The creation of risk-related information: The UK General Medical Council's electronic database.' *Journal of Health Organization and Management* 24(6): 584-596.

Lupton, D. 1997. 'Consumerism, reflexivity and the medical encounter.' *Social Science & Medicine*, 45.3, 373-381.

Lupton, D. 2013. *The Commodification of Patient Opinion: the Digital Patient Experience Economy in the Age of Big Data*. Sydney Health & Society Group Working Paper No. 3. Sydney: Sydney Health & Society Group.

Lynn, N., Lea, S. 2003. 'A Phantom Menace and the New Apartheid: The Social Construction of Asylum-Seekers in the United Kingdom'. *Discourse & Society* Vol 14(4): 425-452.

Martin, D. 2010. 'Foreign GPs still won't face language testing', *Daily Mail*, 12/03/2010.

McHoul, A. 1982. *Telling How Texts Talk. Essays on Reading and Ethnomethodology*. London: Routledge & Kegan Paul.

MCI. 2011. *Medical Council: Annual Report and Financial Statements*. Dublin: Medical Council of Ireland.

MacRae, F. 2007. 'Shame of the foreign doctors', *Daily Mail*, 11/08/2007.

Macrae, F. 2011. 'Cleared to work, the doctors who can't spot cancer'. *Daily Mail*, 3/10/2011.

MacRae, F. and Levy, A. 2012. 'Three-quarters of doctors who are struck off in Britain are trained abroad', *Mail Online*. 31st December 2012.

Meikle, J. 2012. 'Tomlinson pathologist found unfit to practise.' *Guardian*, 22/08/2012.

Mold, A. 2010. 'Patient Groups and the Construction of the Patient-Consumer in Britain: An Historical Overview.' *Journal of Social Policy*, 39(04): 505-521.

Mold, A. 2011. 'Making the patient-consumer in Margaret Thatcher's Britain.' *The Historical Journal*, 54 (02): 509-528.

Molotch, H. and Lester, M.(1974) 'News as Purposive Behaviour: On the strategic use of routine events, accidents and scandals' in Tumber, H. (ed) *News: A Reader*. Oxford: Oxford University Press, 1999.

Mostrous, A. 2011. 'Years of loneliness for a widow whose husband died after routine surgery.' *The Times*. 3/11/2011.

MPTS. 2012. *Medical Practitioners Tribunal Service* <http://www.mpts-uk.org/about/news/1760.asp>

Mulcahy, L. 2003. *Disputing Doctors: The socio-legal dynamics of complaints about medical care*. Maidenhead: Open University Press.

Naish, J. 2012. 'Sentenced to death for being old.' *Daily Mail*, 7/04/2012.

NHS England. 2013a. *High quality care for all, now and for future generations: Transforming urgent and emergency care services in England*. <http://www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf>

NHS England. 2013b. *Friends and Family Test*. <http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/>

NHS HSCIC. 2012. *Hospital Episode Statistics: Admitted Patient Care, 2011-12: Summary Report*. <https://catalogue.ic.nhs.uk/publications/hospital/inpatients/hosp-epis-stat-admi-pati-care-eng-2011-2012/hosp-epis-stat-admi-head-figs-11-12-rep.pdf>

NMC. 2007. *Annual Fitness to Practise Report, 2006-2007*. London: Nursing and Midwifery Council.

NMC. 2008. *Annual Fitness to Practise Report, 2007-2008*. London: Nursing and Midwifery Council.

NMC. 2009. *Annual Fitness to Practise Report, 2008-2009*. London: Nursing and Midwifery Council.

NMC. 2010. *Annual Fitness to Practise Report, 2009-2010*. London: Nursing and Midwifery Council.

NMC. 2011. *Annual Fitness to Practise Report, 2010-2011*. London: Nursing and Midwifery Council.

NMC. 2012. *Annual Fitness to Practise Report, 2011-2012*. London: Nursing and Midwifery Council.

ONM. 2011. *Conseil National de l'Ordre: Au Service des médecins, dans l'intérêt des patients – Rapport d'activités 2010-2011*. Paris : Ordre National des Médecins.

Peters, J., McManus, I.C., and Hutchinson, A. 2001. 'Good Medical Practice: comparing the views of doctors and the general population.' *Medical Education*, 35 (supp. 1): 52-59.

PHSO. 2010. *Listening and Learning: the Ombudsman's review of complaint handling by the NHS in England, 2009-10*. London: Stationery Office.

PHSO. 2011. *Listening and Learning: the Ombudsman's review of complaint handling by the NHS in England, 2010-11*. London: Stationery Office.

PHSO. 2012. *Listening and Learning: the Ombudsman's review of complaint handling by the NHS in England, 2011-12*. London: Stationery Office.

Potter, J. and Wetherell, M. 1987. *Discourse and Social Psychology Beyond Attitudes and Behaviour*. London: Sage.

PSA. 2010. *The Performance Review Standards: Standards of Good Regulation*. London: Professional Standards Authority for Health and Social Care.
[http://www.professionalstandards.org.uk/docs/scrutiny-quality/120720-the-performance-review-standards-\(updated\)-psa-version.pdf?sfvrsn=0](http://www.professionalstandards.org.uk/docs/scrutiny-quality/120720-the-performance-review-standards-(updated)-psa-version.pdf?sfvrsn=0)

- PSOW. 2011. *Annual Report, 2010-11*. Cardiff: Public Services Ombudsman for Wales.
- PSOW. 2012. *Annual Report, 2011-2012*. Cardiff: Public Services Ombudsman for Wales.
- Preston, P. (2011). 'Comment: Holding MPs to account.' *Guardian*, 24/10/2011.
- Pyrah, L. 2011. 'Doctor struck off over fraud', *The Northern Echo*, 8/10/2011.
- QResearch and NHS HSCIC. 2009. *Trends in Consultation Rates in General Practice 1995/1996 to 2008/2009: Analysis of the QResearch database*.
<https://catalogue.ic.nhs.uk/publications/primary-care/general-practice/tren-cons-rate-gene-prac-95-09/tren-cons-rate-gene-prac-95-09-95-09-rep.pdf>
- R Development Core Team. 2008. *R: A language and environment for statistical computing*. Vienna, Austria: R Foundation for Statistical Computing. <http://www.R-project.org>
- Richards, S. 2013. 'Making News'. *BBC Radio 4*, 9/04/2013.
- Robbins, M. 2011. 'FishBarrel: New browser plugin lets you bust quacks in seconds.' *Guardian*, 22/04/2011. <http://www.theguardian.com/science/the-lay-scientist/2011/apr/22/2>
- Robinson, M. 2012. "A danger to patients': Twice suspended doctor who prescribed wrong drugs and did unauthorised operations back at work.' *Daily Mail*, 11/04/2012.
- Rosenthal, M.M., Mulcahy, L., and Lloyd-Bostock, S. 1999. *Medical Mishaps: Pieces of the Puzzle*, Buckingham: Open University Press.
- Saldana, J. 2013. *The Coding Manual for Qualitative Researchers*. London: Sage.
- SWA News. 2010. 'Baby death doctor to practise again', *South Wales Argus*. 17/07/2010.
- Taylor, S. 2001. 'Evaluating and Applying Discourse Analytic Research' in M. Wetherell, S. Taylor, S.J. Yates (eds.) *Discourse as Data: A Guide for Analysis*. London: Sage.
- The King's Fund. 2011. *Improving the quality of care in general practice*. London: The King's Fund. http://www.kingsfund.org.uk/sites/files/kf/improving-quality-of-care-general-practice-independent-inquiry-report-kings-fund-march-2011_0.pdf
- United Kingdom. 2008. *NHS Redress Act 2006*.
http://www.legislation.gov.uk/ukpga/2006/44/pdfs/ukpga_20060044_en.pdf
- United Kingdom. 2008. *Health and Social Care Act*.
<http://www.legislation.gov.uk/ukpga/2008/14/contents>

United Kingdom. 2012. *Legal Aid, Sentencing and Punishment of Offenders Act*
<http://www.legislation.gov.uk/ukpga/2012/10/contents>

Verkiak. R. 2012. 'Children's author awarded £250,000 after botched laser eye surgery left her with blurred vision.' *Daily Mail*. 7/07/2012.

Wainwright, M, 2008. 'GMC hearing: Persaud suspended from practice for three months over plagiarism: Psychiatrist reprimanded for dishonest conduct.' *Guardian*, 21/06/2008.

Waring, J., Dixon-Woods, M., and Yeung, K. 2010. 'Modernising medical regulation: where are we now?' *Journal of Health Organization and Management*, 24(6): 540-555.

Watson, R. 1997. 'Ethnomethodology and Textual Analysis' In D. Silverman (ed.) *Qualitative Research Theory, Method and Practice*. London: Sage.

6. List of annexes

Annexe A – page 114: Interviews – ethics clearance; consent form and information sheet for participants; interview coding scheme.

Annexe B – page 121: Media searches and analysis.

Annexe C – page 137: Data manipulation and analysis, including forecast modelling.

Annexe A: Interviews

Ethics approval letter



28 January 2013

CONFIDENTIAL

Dr Julian Archer
Director of the Collaboration for the Advancement of Medical Education Research
& Assessment (CAMERA)
Plymouth University Peninsula Schools of Medicine & Dentistry
C408 Portland Square
Plymouth University
Drake Circus
Plymouth PL4 8AA

Dear Julian

Reference Number: 12/13-91

Application Title: *Understanding the rise in Fitness to Practise complaints from the public*

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

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

Please note that should any MAJOR changes to your research design occur which effect the ethics of procedures involved you must inform the Committee. Please contact Claire Butcher on (01752) 585337 or by email claire.butcher@plymouth.ac.uk

Yours sincerely

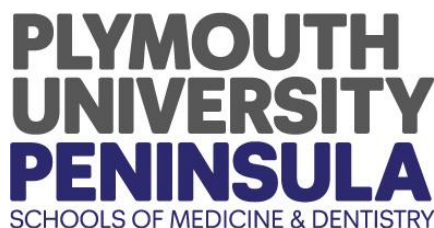
A handwritten signature in black ink, appearing to read 'M Sheppard'.

Professor Michael Sheppard, PhD, AcSS
Chair, Research Ethics Committee -
Faculty of Health, Education & Society and
Peninsula Schools of Medicine & Dentistry

Faculty of Health, Education and Society
Plymouth University
Drake Circus
Plymouth PL4 8AA

T +44 (0)1752 585337
F +44 (0)1752 585328
E claire.butcher@plymouth.ac.uk
W www.plymouth.ac.uk

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



Understanding the rise in Fitness to Practise complaints from the public

Information for participants

[v3 and 25th January 2013]

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

What is the aim of the project?

Since 2007 the General Medical Council (GMC) has seen a significant increase in complaints from the public submitted to their Fitness to Practise (FTP) procedures. However despite this increase there has not been a sustained rise in these complaints developing, within the GMC beyond an initial assessment. The objectives of this research, commissioned by the GMC, are to:

- understand these increasing volumes of complaints
- identify the complex range of factors that exert an influence and shape public use of the system
- explore crucial broader cultural contexts
- address the need for a clearer understanding of any connections in order for the GMC to be able to develop interventions that will enable it to deliver a better service.

What type of participants are needed?

We have contacted you personally along with others as we are interested in speaking to people who represent stakeholders involved in FTP. We are looking to recruit participants from a broad spectrum including: professional regulators, responsible officers, the Ombudsman, The

Patients Association and other patient interest groups, patients advocacy groups, patient feedback groups and solicitors groups in order to gain a deeper understanding of the way the public is engaging in FTP processes, to explore their attitudes, their perceptions and experiences.

What will participants be asked to do?

Should you agree to take part in this project, you will be asked to complete and return the accompanying consent form. One of the research team will then contact you to arrange a convenient time and place for them to interview you either face to face or on the telephone.

Time commitment

Approximately 1 hour

Can participants change their mind and withdraw from the project?

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind. You are not required to give a reason for your decision to withdraw.

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

This research involves an open-questioning technique where the precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. In the event that a line of questioning does evolve in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from participation in the research at any time and without any disadvantage to yourself of any kind. Interviewees may also be asked to 'draw' how they understand the process as another way of capturing data.

Individual interviews will be recorded and transcribed. Digital audio tapes will be sent to the transcriber using an encrypted memory stick, who is bound by a confidentiality agreement. Your interview transcript will be combined with those of the other participants and the dataset will be analysed as a whole. Any 'Drawings' produced in the interview will be treated in the same way as other data for analysis.

Participants will be provided with a copy of the transcript of their interview with a member of the research team on request in order to check for accuracy and request omissions but not to alter the content. Hard copies of data will be kept in a secure cabinet and locked at all times. Electronic data is stored on a shared hard drive on University servers these are encrypted and password protected.

The data collected will be used as primary research material for a research report *Understanding the rise in Fitness to Practise complaints from the public* to be submitted to the GMC.

Results of this project may also be published in peer review journal articles. In each case any quotes used will be attributed, and the associated organisation will also be named

Why me?

You have been approached as we are interested in speaking to people who represent stakeholders involved in FTP.

What if participants have any questions?

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

Dr Julian Archer	or	Dr Sam Regan de Bere
Director of the Collaboration for the Advancement of Medical Education Research & Assessment (CAMERA)		Lead for Medical Humanities
Tel No: 01752 586750		CAMERA
julian.archer@pms.ac.uk		Tel No: 01752 586777
		S.Regandebere@plymouth.ac.uk

Complaints

If you have any complaints about the way in which this study has been carried out please contact the principle investigator Dr Julian Archer in the first instance, this may be followed by a complaint to the administrator of the Faculty Human Ethics Committee.

.....

(printed name of participant)

.....

(signature of participant)

.....

(date)

.....

(printed name of researcher)

.....

(signature of researcher)

.....

(date)

This project has been reviewed and approved by the University of Plymouth Faculty of Health,
Education & Society Research Ethics Committee.

Understanding the rise in Fitness to Practise complaints from the public

Consent form for participants

[v3 and 25/01/2013]

I have read the Information Sheet Version3 Date 25/01/2013 concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that;

1. My participation in the project is entirely voluntary.	Y / N
2. I am free to withdraw from the project at any time without any disadvantage and without having to give a reason for my decision to withdraw	Y / N
3. Audio-tapes will be retained in secure storage.	Y / N
4. The interview will use an open-question technique where the precise nature of the questions which will be asked have not been determined in advance Interviewees may also be asked to 'draw' as part of the interview	Y / N
5. The results of the project may be published and I understand that any quotes used will be attributed to me, and my organisation will also be named	Y / N
6. I understand that a trainee researcher may be present during the interview for training purposes and I am / am not (please delete as appropriate) happy for them to be present	Y / N

















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

**This project has been reviewed and approved by the University of Plymouth
Faculty of Health, Education & Society Research Ethics Committee**

Interview Coding Scheme

- Shown here is the coding scheme used to analyse the interview data. Codes (called nodes in the Nvivo9 programme) were developed deductively using prior knowledge from the literature review and inductively from the data during analysis.
- A 'source' refers to an interview transcript.
- A 'reference' is a section of text assigned to that code during analysis.
- Totals for parent nodes include the aggregated totals of their child nodes.

Name (parent node)	Name (child node)	Sources	References
● Cause of complaints		13	88
	● Communication	6	23
● Complaint process		12	89
	● Single portal	3	7
● Death		9	19
● Doctor-patient relationship		11	77
● Doctors		10	102
	● Locum	2	12
● Emotions		12	95
	● Anger	7	22
	● Blame	3	3
	● Compassion	1	4
	● Frustration	5	10
	● Guilt	2	3
	● Loyalty	1	2
	● Nostalgia	4	10
	● Stress	2	6
	● Upset or unhappy	6	11
● GMC		13	169
● Identity		12	42
● Legalities		12	56
● Media		13	129
	● Information	10	23
● Motivations		11	47
	● Civic duty	5	12
● Network or campaigns		4	10
● Old age		4	6

	Other organisations		13	219
		ASA	1	23
		BMA	8	16
		Law Society	2	12
		MDU	1	11
		NMC	4	17
		PALS	1	2
		Patient Opinion	1	20
		Patients Association	2	3
		PHSO	5	28
	Patients and the public		12	135
	Social trends		7	21
		Consumerism	7	12
	Standards of Care		3	8
	System failures		9	46
	VISUALS		11	20

Annexe B – Media analysis

Our media research focused on identifying meaningful, relevant samples of data to which a variety of further research techniques were applied including content analysis, thematic analysis, and discursive analysis. The results of these analyses were then triangulated with the statistical and interview data and are presented in the findings sections of the main body of this report.

This annexe contains further information about the search and sampling strategies employed in identifying media data, and some further information on wider findings which, whilst not directly relevant to the research questions answered in this report, may still be of interest with regards to the context within which media representations of fitness to practise and the GMC are located.

Newspaper analysis

Searches

We used the Lexis Nexis database, and sources searched included UK national and regional newspapers, broadsheets and tabloids (both print and online editions). We also conducted searches of broadcast media, including news broadcasts, as well as other factual and non-factual programming, using the Television and Radio Index for Learning and Teaching (TRILT) database, and www.itnsource.com for independent programming.

Ten separate sets of search terms were entered into the Lexis Nexis database, with results returned across the whole period (1st January 2007 – 31st December 2012) and, in some cases, also month by month, resulting in a total of 24 individual searches.

All searches were conducted with the same basic parameters:

Index terms = medical and healthcare

Subject = all subjects

Country/region = United Kingdom

Lexis Nexis also allows other parameters to be adjusted as appropriate. Variable parameters were: whether the search included all UK newspapers available on the database, UK national newspapers only, or UK regional newspapers only; and, whether the search results should include duplicate articles or should exclude duplicates that showed high similarity to another article. For this research, these options were set according to the search term, with more limited parameters being set for more tightly-focused searches, where a more tightly

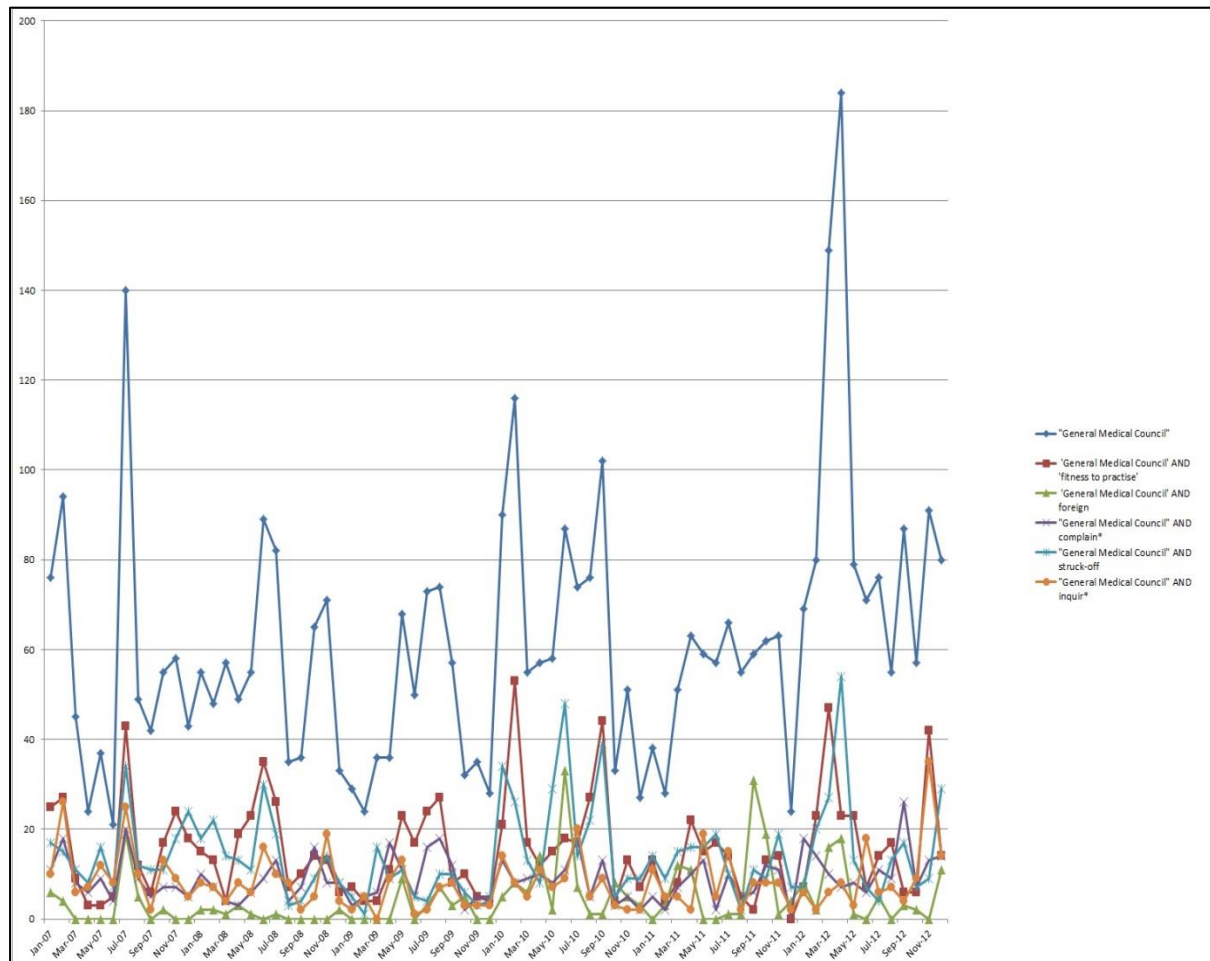
defined focus on a particular subset of articles was intended. The search results are presented in the graph below, which also shows the total number of articles returned across the whole period between 1st January 2007 and 31st December 2012, with details of variable parameters:

Search terms	Rationale	Search parameters	Date range	Results
"General Medical Council" AND "fitness to practise"	Basic search, to give overview of newspaper coverage of the GMC and its fitness to practise processes.	UK newspapers searched Duplicates not excluded	01/01/2007-31/12/2012	1177
'General Medical Council' AND foreign	Reading some articles returned by the first search suggested a strong focus on foreign doctors.	UK newspapers searched Duplicates not excluded	01/01/2007-31/12/2012	394
"General Medical Council"	Very broad search, conducted to show how much coverage there is of the GMC overall.	UK newspapers searched Search both with duplicates not excluded and with high similarity duplicates excluded.	01/01/2007-31/12/2012	4298 (4430 without duplicates removed)
"General Medical Council" AND complain*	To identify articles referring to the GMC and including the word complain or any similarly stemmed words.	High similarity duplicates removed	01/01/2007-31/12/2012	683 (729 without duplicates removed)
"General Medical Council" AND complain*	As above	Searched only UK national newspapers Search both with duplicates not excluded and with high similarity duplicates excluded.	01/01/2007-31/12/2012	331 (379 without duplicates removed)
"General Medical Council" AND complain*	As above	Searched only UK regional newspapers Search both with duplicates not excluded and with high similarity duplicates excluded.	01/01/2007-31/12/2012	357 (375 without duplicates removed)
"General Medical Council" AND struck-off	Looking at some of the articles returned by earlier searches highlighted this as a key term in the reporting of fitness to practise processes.	Searched all UK newspaper, with and without high similarity duplicates removed Searched UK national newspapers. Searched UK regional newspapers.	01/01/2007-31/12/2012	1236 (duplicates not removed) 1161 (duplicates removed) 455 (520 without duplicates removed) 737 (815 without duplicates removed)

				removed)
"General Medical Council" AND inquir*	This search was done to identify articles containing about the GMC and inquiries (or similarly stemmed words).	Searched all UK newspaper, with and without high similarity duplicates removed Searched UK national newspapers. Searched UK regional newspapers.	01/01/2007-31/12/2012	508 (duplicates not removed) 491 (duplicates removed) 217 (235 without duplicates removed) 268 (283 without duplicates removed)
"Nursing and Midwifery Council" AND complain*	This search was carried out to provide a point of comparison.	Searched all UK newspaper, with and without high similarity duplicates removed Searched UK national newspapers. Searched UK regional newspapers.	01/01/2007-31/12/2012	236 (duplicates not removed) 209 (duplicates removed) 76 (96 without duplicates removed) 123 (132 without duplicates removed)
"General Dental Council" AND complain*	This search was carried out to provide a point of comparison.	Searched all UK newspaper, with and without high similarity duplicates removed Searched UK national newspapers. Searched UK regional newspapers.	01/01/2007-31/12/2012	138 (duplicates not removed) 122 (duplicates removed) 42 (49 with duplicates not removed) 77 (85 with duplicates not removed)
GMC AND NHS AND "doctor struck off"	Search carried out using 'struck-off' which had been identified from earlier searches as a key phrase.	All UK newspapers, no duplicates removed.	01/01/2007-31/03/2013	78
'good doctors'	Search carried out to test notion that most stories about doctors in practice were negative.	All UK newspapers, no duplicates removed.	01/01/2007-31/03/2013	1330

In addition to the results being recorded as a single total across the whole period, several searches were carried out on a month by month basis in order to allow the amount of media

coverage to be mapped against the numbers of complaints being received by the GMC. Month by month searches all covered all UK newspapers.



The results of the basic, broadest search using the search term “General Medical Council” were recorded on a month by month basis with no duplicates removed, in order to give a complete picture of how many articles were published which referred to the GMC. The results for the search using the term “General Medical Council” AND “fitness to practise” are also recorded on a month by month basis with no duplicates removed with the exception of the result returned for March 2012, when the total of 99 articles included a large number of identical articles about a law firm specialising in FtP cases. As this seemed to be an unusual result and possibly a database error, this month’s result was altered to exclude high similarity articles and therefore was recorded as 47 articles.

As the remaining searches were intended to identify articles which were focused on more specific aspects of newspaper coverage of the GMC, and were intended to return results which would both be tracked against GMC complaints data but which would also provide a relevant sample of articles for further qualitative analysis, it was necessary to make further decisions about inclusion and exclusion criteria in order to ensure that these searches were useful as possible.

Although it is possible to exclude high similarity duplicates, for example, using the tools available in the Lexis Nexis database, sometimes these duplicates can be interesting - for instance, when an article is published both in an online version and a print edition of a newspaper, or when an article is published in a morning print edition and then expanded or had the headline changed before being used again in a later edition. Using the Lexis Nexis exclusion tool, when set to exclude high similarity duplicates, seemed to exclude articles that were basically identical but also seemed to leave some very similar articles in the results. Therefore, when recording articles in the month by month results, articles that were from the same edition and had the same or a very similar word count and headline were excluded. However, versions of the same story, published by the same newspaper or newspaper group were included if they were published in a different edition (e.g. online and print, or national print and Scottish print), or if they were re-published with a notably different word count (+/- 25 words) or a different headline. We also excluded articles that were not relevant to the subject being searched for, however it is important to note that 'relevance' is broadly defined here, in order to avoid artificially narrowing the article selection available for a full qualitative analysis. For example, when searching using the terms "General Medical Council" and "foreign", we excluded a number of articles from June 2008 about Raj Persaud being suspended from for three months after being found to have plagiarised 'foreign' articles whereas articles referring to foreign doctors practising in the UK were included whether or not they were focused on fitness to practise matters.



Sampling and Nvivo coding





After careful consideration of the Lexis Nexis search results, articles resulting from the search for "General Medical Council" AND complain* in UK national newspapers were identified as providing a good basis for the sample to be analysed using Nvivo software. This was the search which returned results most relevant to the scope of this project, and yet which still offered a broad sample of material to consider. From the 331 articles returned by Lexis Nexis, and after applying the further exclusion criteria detailed above, a total of 301 newspaper articles were added to an Nvivo project. The articles were classified according to a number of attributes (date of publication, newspaper and edition) which enabled us to interrogate across or within various subsets of the data.

The newspaper articles were coded using Nvivo9 qualitative data analysis software. Codes were created deductively from prior knowledge based on the literature review, and inductively during the analysis (Saldana, 2013). Two separate coding schemes were developed: the first – the more extensive - was thematic; the second was topic based, to allow articles on the same subject matters (mostly high-profile FtP cases) to be easily grouped together.

Thematic coding:

	Name	Sources	References
	Care of the Elderly	27	41
	Cause of complaint	103	291
	Clinical	53	77
	Dishonesty	19	29
	Fraud	5	14
	Improper relationship	2	13
	Other cause	16	17
	Sexual impropriety	32	113
	Vexatious	4	4
	Celebrity	17	45
	Communication	21	29
	Confusion	0	0
	Death	92	200
	Doctor-patient relationship	9	11
	Doctors	221	845
	Age	30	31
	Consultants	50	99
	Expert witnesses	11	44
	GPs	92	248
	GPs for all doctors	5	5
	Juniors doctors	8	12
	Locum	32	58
	Nationality	58	109
	Other	40	48
	Private practice	24	49
	FOI	1	1
	Gender	22	35
	GMC	299	929
	Finlay Scott	1	2
	GMC action or outcome of complaint	155	408
	Graeme Catto	2	2
	MPTS	2	7
	Niall Dickson	42	55
	Peter Rubin	3	3
	Legalities	98	286
	Compensation	36	73
	Maternity care	19	23

 Medical profession	54	87
 Motivations	12	16














 Anger	4	4
 Apology	0	0
 Explanation	2	3
 Greater good	7	8

 NHS	70	136
 Other regulators	56	128
 Patient care or safety	29	49
 Patient-victims and families	111	330

 Impact on complainant	28	60
---	----	----

 Rhetorical devices	60	99
--	----	----

Topic coding:

	Name	Sources	References
	Baby P	10	11
	Bonhoeffer	3	3
	Headline	295	296
	Mid Staffs or Francis Report	6	11
	OOH	23	36
	Patel	28	28
	Paterson	1	1
	Patient Advice or Advocacy	33	72
	Shipman	14	26
	Southall	8	8
	Taranissi	11	11
	Ubani	25	33
	Wakefield	10	10

Discursive analysis of media reporting

Mobile computing is reshaping the relationship between the public and the media. What is clear is that the control over news content which the established media outlets once had is gone. The internet now permits anyone and everyone (with the requisite machinery and access) to create, report, and publish news to a global audience.

The challenge for newspapers has been to respond to this competition. The plethora of online news outlets and the ability of almost anyone with a mobile phone or tablet to record 'newsworthy' events mean that the competition to 'break news' is intense. Online audiences not only demand a constant and easily accessible diet of news they expect it immediately – preferably 'as-it-happens'. The news consumers of today are media savvy;

they are both active and interactive in how they consume and construct ‘news’ (Richards 2013).

While the dynamics of cyberspace have fundamentally altered the way in which news is created and consumed, there are some elements of the journalists’ *craft*; the discursive and rhetorical aspects of ‘good’ news copy, that remain as pertinent to hypertext as they are to newsprint. Consequently, this analysis concentrates on the discursive and rhetorical machinery that newspaper journalists employ when they produce news reports about medical doctors.

The advantages of a discourse analysis

It is important to remember that a news report, like all written or spoken discourse, ‘creates what it refers to’ (Taylor 2001: 8). As happens in our everyday social or business lives, we *do* things with our talk or our written texts. We categorise, blame, deny, justify, persuade, accuse, refute, argue, excuse etc (Edwards 1991). We can do this because language and discourse is not a neutral or a purely representative medium (Harris 1981). Descriptions of things can always be constructed differently. Empirically, the form of discourse analysis used in this report is concerned with the ‘function, construction, and variation’ of discourse as it is used in the chosen texts (Potter & Wetherell 1987).

Journalistic writing practices

The rhetorical and discursive features that make for a ‘good’ news story appear to have survived the move to cyberspace. Clearly, the online news medium produces a newspaper that is tangibly different in ‘format’ to the newsprint version in that it cannot be read from cover to cover.

Digital technology now allows newspaper editors and reporters greater creative and visual scope. Indeed, news consumers expect a dynamic visual experience. Online news reports are no longer confined to text and still photographs; they have video footage embedded within their online articles and these features are usually complimented by a host of other hyperlinks to social networking sites and search engines to facilitate interaction. This interconnectedness means the transmission and dissemination of information across the internet has a characteristically viral quality.

But, even allowing for these differences in format, it seems that the construction of the written text still utilises a traditional journalistic construction: that is, the use of a news ‘headline’ followed by a ‘summary news lead’ – a summarising opening paragraph that is then unpacked in subsequent paragraphs. This ‘inverted pyramid’ structure has been a staple of traditional newsprint journalism for many decades and is designed to encourage the reader to read on.

Headlines are more than just succinct introductory prefaces or titles: they are ‘seen but unnoticed’ (Garfinkel, 2002) performative components designed to attract the reader’s

attention and to prime or ‘predispose’ the reader “towards a particular way of reading the following story” (Watson, 1997: 85).

In addition to these rhetorical devices a ‘good’ news story must also include some specific narrative elements: drama, sex, surprise, human tragedy, and celebrity. Stories with a subject matter that is extra-ordinary, dark, unsavoury or bizarre, will also find favour with news editors and readers.

News production is rhetorical in its construction and self-serving in its use. It is neither objective nor dispassionate and always involves some form of categorising. News production may be summarised as a process that defines, ‘for the majority of the population *what* significant events are taking place, but, also they offer powerful interpretations of *how* to understand these events’ (Hall et al., 1978: 57 original emphasis).

Bad Doctors: Four narrative genres

As discussed in the main body of this report, our discursive analysis of newspaper articles focused on the medical profession identified four core narrative genres.

- Criminal doctors
- Foreign doctors
- ‘Maverick’ doctors
- The patient-victim’s perception of doctors

Newspaper representations of medical doctors present an intriguing paradox for the medical professionals and media analysts. As a profession, doctors continue to be held in high esteem by the public; yet newspapers insist on reporting only those doctors who do wrong or abuse their professional position. It may be that the public’s regard for doctors is what encourages journalists to concentrate their attention on the small number of practitioners who breach that high standard. To chart the fall from grace of the saintly or well-respected individual is, rhetorically speaking, always more dramatic and newsworthy than that of the rogue. The journalists’ aim is always, of course, to sell newspapers and attract new readers with interesting news copy.

To fulfil that aim, journalists continue to rely upon a long-held maxim of their craft: namely, that the public are fascinated by ‘bad’ news. So long as this operational axiom remains valid, journalists and news editors will continue to report news in the way they do. Doctors and regulators can rightly attempt to correct misinformation and be proactive in working more closely with journalists to encourage them to move away from overwhelming negative portrayals; but the extent of change is likely to be small and gradual. However, the influence of social media on newspapers and broadcast media is not yet fully understood. It may be that as these areas evolve and are better understood, the opportunities for change become heightened.

Broadcast Media analysis

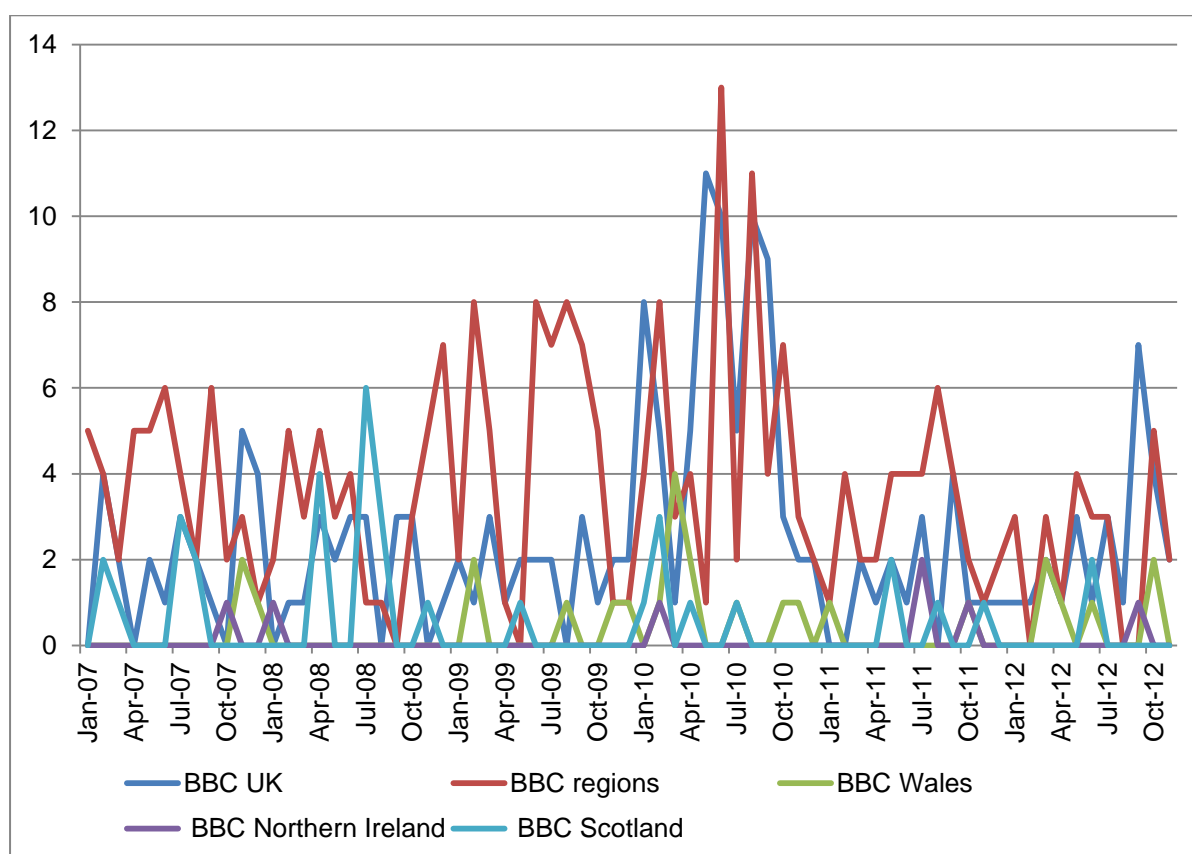
Broadcast media searches

News (online): 'General Medical Council' was the only search term used as the BBC, ITV and Channel 4 news websites did not facilitate more advanced Boolean searches. Search dates throughout were from 1 Jan 2007 00:00 to 4 Nov 2012 00:00.

Search of BBC News archive online www.bbc.co.uk/news using 'General Medical Council' returned a total 590 results:

News (519)	TV & Radio Programmes (26)
TV & Radio Sites (10)	Blogs (10)
Elsewhere on the web (25)	

We concentrated on the results for 'News' and filtered the group down to 505. This included all regional programmes and BBC Health. The BBC News entries were divided into regions in order to show regional 'spikes.'

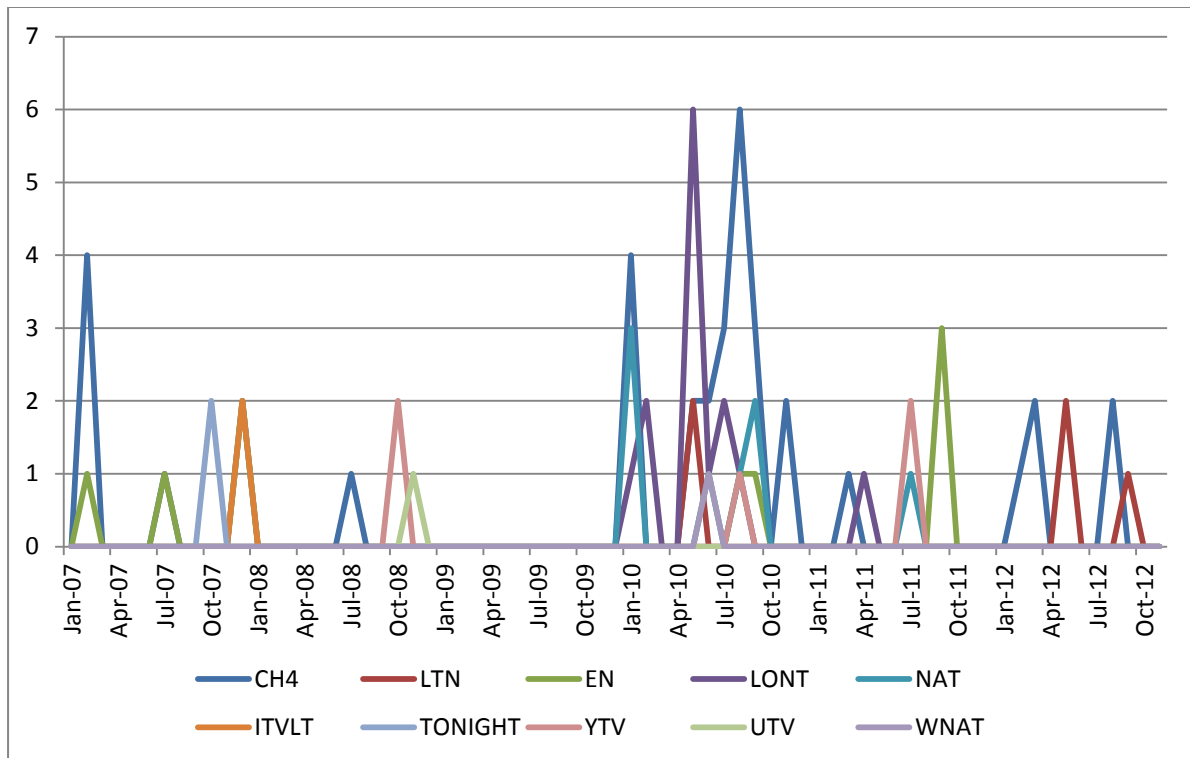


The independent news archive held online at www.itnsource.com was also searched using the same search term. The search which included ITN partners, ITV and Ulster Television returned 131 results:

Total results	131		
Filtered results	83		
ITV Lunchtime News (LTN)	5	TONIGHT	2

England (EN)	9	Ulster Television (UTV)	1
London Tonight (LONT)	14	ITV late News (ITVLT)	2
Weekend National News (WANT)	1	Yorkshire Television (YTV)	5
National (NAT)	8	Chanel 4 News (C4N)	36

When visualised as a graph the 'spike' between April and October 2010 alerts us to the time frame of most activity during the period:



Broadcast media using Television and Radio Index for Learning (TRILT)

Repeating the search terms used for print media was not practical since TRILT broadcast searches rely solely on the text contained within the title and synopsis of the programme rather than actual content; causing the scope of the search to be restricted. Related terms were agreed by the research team with the following results:

General Medical Council search = 3

Doctor OR Doctors AND foreign = 205 results filtered to 3

Doctor OR Doctors AND medical = 333 filtered to 45

Doctor OR Doctors AND complain OR complaint = 0

Hospital AND complain OR complaint = 799 filtered to 20

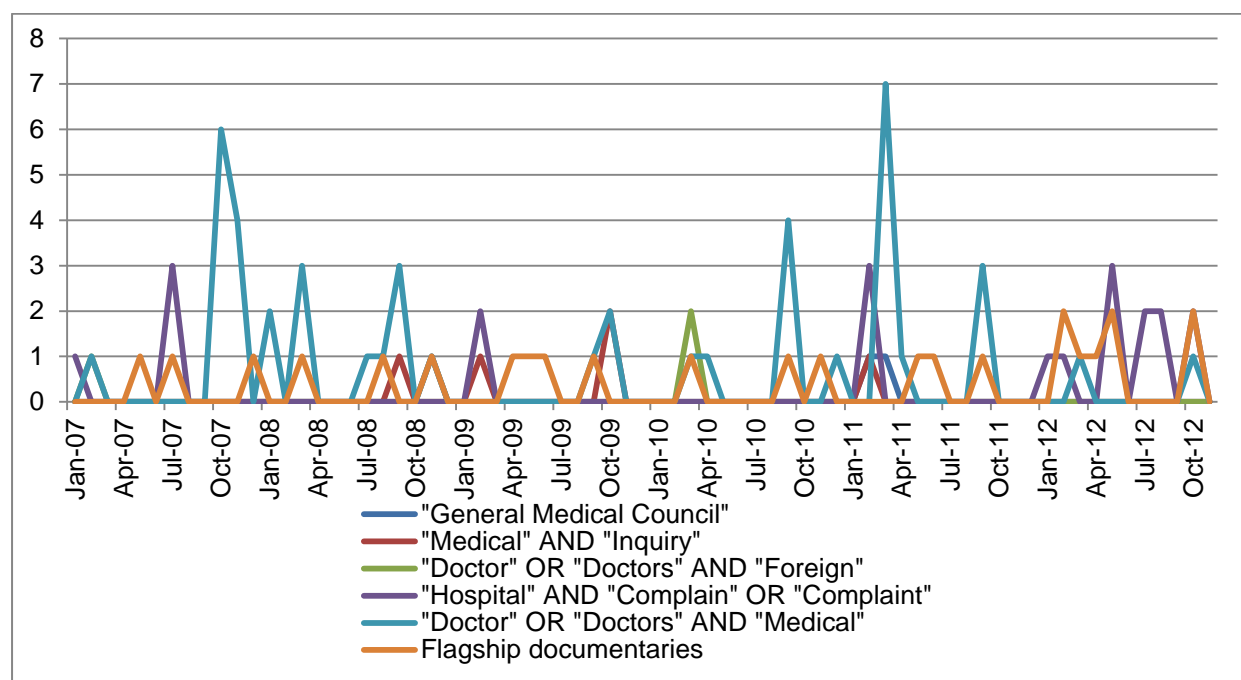
Medical AND inquiry = 9 filtered to 5

Search dates from 1 Jan 2007 00:00 to 4 Nov 2012 00:00 in all fields

The initial search results were filtered to exclude non-relevant programmes, for example an Alfred Hitchcock remake was excluded. Also excluded were programmes with a non-UK

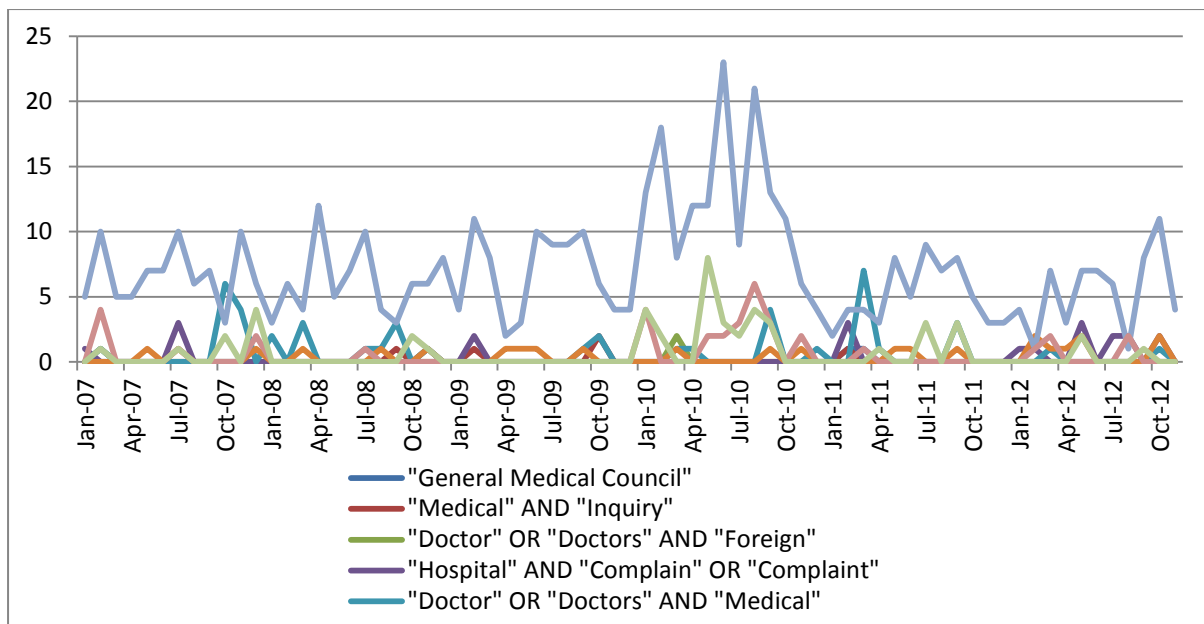
focus, i.e. the American series *ER*, and programmes about medical conditions, i.e. Channel 4's *Embarrassing Bodies*. The filtered results (76) were either programmes about policy or those where the 'work' of medical doctors featured. Repeats of the programmes were also included as these would attract additional audiences.

A further specific search of archive of flagship documentaries Panorama (BBC1), Dispatches (Ch4), and Cutting Edge (Ch4) produced an additional 24 (no repeats) programmes. These investigative journalism programmes have a human interest angle and tend to focus on patient care and the NHS but they have been included because they continue to be available online and, as 'prime time' programmes when originally broadcast, would have attracted considerable viewer numbers.²³ The results of the TRILT searches combined with the 'flagship documentaries' were translated into a graph:



The graph below combines the TV news and TRILT results. It should be noted that here the values for BBC and ITV News are an amalgamation of national and regional programmes.

²³ http://www.bbc.co.uk/pressoffice/pressreleases/stories/2007/02_february/07/panorama.shtml



Broadcast and online media analysis

Viewing figures testify to the UK audience's continuing appetite for both fictional and factual representations of medicine across a range of sources; primarily newspapers, TV and radio. *Holby City* and *Casualty* (BBC1) for example regularly attract audiences of between 5 and 6 million viewers (BARB).

We found 4 broad genres of programming with a UK focus:

- News and comment – these were primarily news on the main channels and radio broadcasts mainly on Radio 4. BBC Parliament also covers Health Select Committees and debates in Parliament.
- Documentaries – including 'Fly on the wall' (*Junior Doctors: your life in their hands*), modern freak shows (*Embarrassing bodies*) and flagship current events programmes (*Panorama*, *Dispatches*).
- Long running Drama/Soaps – *Holby City*, *Casualty*, *Doctors*, *Doc Martin*.
- Comedy – *Doctor in the House* (Radio 4).

TV News

ITV and BBC both provide national and regional news. We expected to find that news items of local interest received follow-up national coverage if they were either 'serious' enough i.e. the Birmingham surgeon Dr Ian Paterson, or had an 'angle' and could be linked to a well-known figure. However we did not find evidence of this causal regional/national relationship, we found instead that regional stories with a national interest were reported simultaneously. The relationship between media forms is intertextual in that they regularly monitor and rework their rival's news copy (Richards 2013).

For example, between January 2007 and November 2012 the 3 main UK news channels featured 48 'stories' on the paediatrician David Southall.²⁴ There is significant overlap of content and 'angle' across both independent and BBC news content and the use of the same 'sound bites' from lawyers for the families involved, spokespeople from the GMC and the Department of Health. Also included are direct quotations from both the GMC panel and the criminal court proceedings. In 2009 the BBC broadcast a Panorama documentary entitled *A Very Dangerous Doctor* (08.06.2009) exploring the complex chain of events since 2000.²⁵ In 2011 Channel 4's Cutting Edge broadcast a programme about David Southall, also called *A Very Dangerous Doctor* (12.05.2011), which took two years to make and again explored the controversy around Southall and the mothers he accused of abusing their children.

This 'event' is long running, complex and highly emotive. It sits at the nexus of a number of related discourses including medical professionalism, child protection and parental, particularly maternal, nurture: as such it provides a number of potential ways to 'assemble' the story. However, the use of a limited number of frames to describe such a complex issue limits public perceptions by closing down the potential number of ways of interpreting the story – 'in this closing off of possibilities lies the power of newswork and all accounting activity' (Molotch and Lester, 1974).

Flagship documentaries

Information is provided for the benefit of viewers at the end of the 'flagship documentaries' about available help and support if either they or someone they know has been affected by the issues raised in the programme: this information is simultaneously available on the channel/programme website. News features (print, TV, radio and online) too, often provide information about help and support and direct viewers to the individual channel website for further information. For 'on demand viewers' a Help and Support section accompanies the programme synopsis even if the full programme is no longer available. 'Can you trust your doctor?' *Dispatches* (03.10.2011), Channel 4, is a fairly typical example of the increasingly complex ways in which information is exchanged across media platforms. The dedicated programme website offers viewers the opportunity to 'Share Your Story' (excluding individual Dr's or NHS staff names) if they have 'experienced a misdiagnosis or have concerns about your treatment from a doctor.'²⁶ They are also asked: 'If you have a story about your GP that you'd like to share with the Channel 4 Dispatches team for any follow-up programmes, please contact us in confidence at dispatches@channel4.co.uk.' In addition viewers may also comment on the 'contributed feature' by Aneez Esmail, Professor of General Practice at the University of Manchester and a key contributor to the Dispatches

²⁴ He had been in the news since 2000 when Dr Southall's intervention in the case of Sally Clark, the mother convicted in 1999 of killing her two infant sons in 1996 and 1998.

²⁵ <http://www.bbc.co.uk/programmes/b00l6ds5>

²⁶ <http://www.channel4.com/programmes/dispatches/episode-guide/series-103/episode-1>

programme. Contributions from viewers stay online for some time after the full programme is no longer available; as do the 'Related links: how to complain about your GP' which include hyperlinks to various patient groups, NHS complaints and the GMC. The public are also instructed how to make a specific complaint about the GP surgery featured in the programme.

The scope of news and current events programming is extended through online technologies both in terms of supplementary content produced by the programme makers and content produced by the audience.

Long running medical drama/soaps

The collegiate nature of medical practice is a theme reinforced in popular medical drama/soap programmes. *Casualty* and *Holby City* have both featured storylines in which complaints provide a vehicle for character development, promote the idea that doctors 'stick together' or use a specific incident to make a more general point.

For example in *Holby City* when a white, middle aged patient demands a second opinion, and the consultant agrees with the registrar she says 'you people all stick together ... doctors, you all stick together.'²⁷ The consultant refutes her generalisation about doctors but this exchange makes the implicit racial sub-text to this exchange explicit. When the patient makes a complaint about the registrar for accusing her of racism he is told by the consultant 'this woman now has your career in her hands.'

In early 2012 the popular medical soap opera *Casualty* (BBC1) included a narrative thread over three episodes about a complaint made by a patient to the GMC as discussed in the main body of this report.

Blogging²⁸

Aside from blogs produced by professional journalists as part of the online news package, individuals with access to the internet can produce independent blogs or contribute through 'open blogs' like *Dr Blogs* part of the Hospital Doctor website that focuses on secondary care.²⁹ News content becomes recycled through blogs. www.hospitaldoctor.co.uk reproduces news and comment from across the web, including BBC Health, individual blogs (including its own), online newspapers and medical journals like Pulse.

Blogging has been described as a form of 'citizen based journalism' that sits in opposition to the traditional 'top-down' model of news production (Bowman and Willis, 2003).³⁰

Technorati distinguish between individual and corporate bloggers although in practice the

²⁷ BBC1 *Holby City* Series 13 episode 17 of 52 'Anger Management' Broadcast 08.02.2011.

²⁸ In 2006 blog-tracking site Technorati said that 175000 new blogs appear per day worldwide http://news.cnet.com/2100-1025_3-6102935.html

²⁹ <http://www.hospitaldr.co.uk/blogs/dr-blogs>

distinction may not be that obvious.³¹ For example, larger law firms who have an interest in medical negligence claims use a range of media (often through a dedicated media centre or office) to present an apparently personal, concerned and common sense view on specific events by individuals, as discussed in the main report.

Twitter is a type of 'micro-blog' and has been adopted by newsrooms "as an essential mechanism to distribute breaking news quickly and concisely, or as a tool to solicit story ideas, sources and facts" (Hermida, 2010: 299).

³¹ <http://technorati.com/social-media/article/state-of-the-blogsphere-2011-introduction/>

Annexe C: Data manipulation and analysis

This section describes further how the statistical database provided by the GMC was prepared and analysed. The results of the full analysis are not presented in here but are available on request.

Data manipulation:

Data were provided across a series of spread sheets for the time period covering Jan 2007 through to Dec 2012. These were split by year and further split by 'Case Open' or 'Triage Closure Data'.

To complete the analysis of timelines, spread sheets were combined into a single data set. The database contained several characters such as forward slashes that prevent efficient analysis, so where appropriate these have been removed or swapped. All data was filtered using 'Enquiry Source Type' so that only enquiries sourced from 'Public (Individual)' would be analysed.

Frequency timelines were created for all of our media searches, alongside daily and monthly timelines for the following fields within the Fitness to Practise data.

Total allegation rate – This counted each row in the data set. As each enquiry may contain a number of allegations against different doctors, this provides a baseline for Fitness to Practise allegations.

This data was further split to provide rates for:

Case Data

Triage Closure Data

Level 2 Regions (Northern Ireland, England, Channel Islands, Wales, Scotland, Unspecified)

Level 1 Names (Unspecified, London Strategic Health Authority, North West Strategic Health Authority, East of England Strategic Health Authority, West Midlands Strategic Health Authority, South East Coast Strategic Health Authority, NHS Scotland, Yorkshire and The Humber Strategic Health Authority, East Midlands Strategic Health Authority, South West

Strategic Health Authority, South Central Strategic Health Authority, Health Solutions Wales, North East Strategic Health Authority, Health and Social Care Northern Ireland)

Allegation Category (Clinical Care, Relationships With Patients, Probity, Compliance with GMC Inv, Health, Working With Colleagues, Unspecified, Teaching / Supervision, Maintaining GMP)

Case Closure Reason (Concluded Assistant Registrar, Failed PIT, CR Case Created, Concluded at CE Decision, Consent Withdrawn, Voluntary Erasure, Presidents Review, Concluded at Hearing, Restoration Recommended, Doctor Died, Not Applicable, Concluded at IC, Limited Registration expired, No review hearing, R28 Closure, Admin Erasure, Rule 12 Review, FTP Action Expired, Invalid Referral)

Presidents Review, Limited Registration required, FTP action expired and Invalid Referral were excluded as they had no cases generated from a public (individual) enquiry

Closure Reason (Unspecified, NCM unrelated to prof cap, Issues cannot be identified, Disagreement with Med Report, Failed local complaint proc, Re level/quality of service, Only benefit claim issues, General correspondence, Not about a dr, 5 year rule, Practice/dept dispute, Dr's failure to take up post, Dr's profession is incidental, Anon complaint: no danger, Minor motoring offence, <6 months delay for report, Copy correspondence, Fees for private treatment, Removal from GP list, Already Investigated locally, Enquirer seeking apology only, Dr's immigration status, Intervention in treatment, Side effects of treatment, Demanding drugs/treatment, Conflicting diagnosis, Exercising legal/human rights, Implementing public policy, Failure to visit, Patient still ill, Vexatious complaint, Licensing issue res by Reg)

As with the Case Closure Reason, not all Closure Reasons had been generated by Public (Individual) enquiries. The excluded fields were 'Dr's failure to take up post', 'Minor motoring offence', and 'Vexatious complaint'.

Unique Enquiry Rate – This counted each enquiry as a single point of data. While an enquiry may contain a number of allegations concerning a number of doctors, the underlying enquiry rate reveals the number of times a members of the public have complained to the GMC.

It was further split to provide timeline data for:

Case Data

Triage Closure Data

Level 2 Regions (Northern Ireland, England, Channel Islands, Wales, Scotland, Unspecified)

Level 1 Names (Unspecified, London Strategic Health Authority, North West Strategic Health Authority, East of England Strategic Health Authority, West Midlands Strategic Health Authority, South East Coast Strategic Health Authority, NHS Scotland, Yorkshire and The Humber Strategic Health Authority, East Midlands Strategic Health Authority, South West Strategic Health Authority, South Central Strategic Health Authority, Health Solutions Wales, North East Strategic Health Authority, Health and Social Care Northern Ireland)

These data allow us to examine the timelines at the levels of interest:

UK level

Total allegation rate – Each row of data considered as separate case

Unique enquiry rate – Each enquiry number considered as a separate case

Unique enquiries in Case Data – Spread sheets that contain all opened cases

Triage Closure Data – Spread Sheets that contain all closed cases

Allegation Category – The allegation being made, exclusively in Case Data

Case Closure Reason – The reason a case was closed, exclusively in Case Data

Closure Reason – The reason a case was closed, typically in Triage Closure data

National level

Total Enquiry Rate – Each row of data considered as separate case

Unique enquiry rate – Each enquiry number considered as a separate case

Regional level

Total Enquiry Rate – Each row of data considered as separate case

Unique enquiry rate – Each enquiry number considered as a separate case

Unique Enquiry/Reference Number Rate – This counted each unique combination of enquiry and reference number. A single enquiry may therefore yield a number of data points where several doctors, each with a unique reference number, are identified as part of a single enquiry.

This data was further split to provide rates for:

Level 2 Regions (Northern Ireland, England, Channel Islands, Wales, Scotland, Unspecified)

Level 1 Names (Unspecified, London Strategic Health Authority, North West Strategic Health Authority, East of England Strategic Health Authority, West Midlands Strategic Health Authority, South East Coast Strategic Health Authority, NHS Scotland, Yorkshire and The Humber Strategic Health Authority, East Midlands Strategic Health Authority, South West Strategic Health Authority, South Central Strategic Health Authority, Health Solutions Wales, North East Strategic Health Authority, Health and Social Care Northern Ireland)

Case Data (complete data, and split by L1 Name and L2 Region)

Triage Closure Data (complete data, and split by L1 Name and L2 Region)

Scaling of the data:

Timelines were scaled using the postcode population data provided by the State of Medical Education and Practice (SoMEP) research group. Where data were scaled, we had to exclude Level 2 Region Channel Islands as no population information was provided for this group, and all unspecified Level 1 Names and Level 2 Regions.

To scale data we allocated each postal code population to a region (e.g. England) and strategic health authority. To match the data SoMEP had provided, we examined how many cases there were each month per 100,000 people. This was undertaken by dividing 100,000 by the population of the area of interest, and then multiplying it by the count for each month in the timeline.

Initial investigation:

For each of the time series of interest, we performed a range of analyses and prepared a handful of plots. These included:

- A plot of the timeline based on the time series data

- A check for seasonality and random variations in the data, and the creation of a log transformed data series for analysis should the data require it. As seasonal and random fluctuations in the data were consistent over time, these have not been used.
- A decomposed time series, which separates each time series into its trend, seasonal and irregular components.
- A smoothed moving average which used three scores to estimate each data point in the time series.

The analysis was repeated with LOESS (locally-weighted scatterplot smoothing) which uses local regression to smooth the data. LOESS provides a slightly more sophisticated method of examining the trends in the data by fitting a local regression model using no parametric techniques to produce a smooth model.

Correlations to explore the relationship between media activity and FtP activity over time

We performed a number of correlations between media search term results and various enquiry rates. These focussed on monthly correlations as it minimises the risk of influences from seasonal trends such as a dip in the enquiry rates during festive periods, or lag where the influence of one variable can only be seen in the other after a delay. Where a high profile case appears in the media, it may be a day or two later when enquiries relating to it appear in the FtP database but by using monthly data we can remove most of the influence of this effect, should it exist.

Method

Each pair of data has been analysed using Pearson's Product-Moment Correlation Coefficient as a measure of linear dependence between the two variables in question. For each correlation we have carried out some bootstrapping to provide 95% confidence intervals on the coefficient. No correction has been made for multiple testing because the coefficient demonstrates the effect size with bootstrapped confidence intervals, regardless of whether the correlation has been flagged as significant or not.

Media Searches:-

"General Medical Council", 'General Medical Council' AND 'fitness to practise', 'General Medical Council' AND foreign, "General Medical Council" AND complain, "General Medical Council" AND struck-off, "General Medical Council" AND inquir*

Timelines:- Only data listed as Public (Individual) is included

General - Total allegations (every line of the database), Unique Enquiries, Unique Reference, Case Data, Triage Case Closed, Unique Case Data, Unique Triage Case Closed.

Level 2 Region – NI, Wales, Scotland, England, Channel Islands, Unspecified

Correlations are carried out using total allegations (every row), unique enquiries, and unique enquiry/reference number combinations

Population based proportional data is also included, though unspecified and Channel Islands data is excluded from this part of the analysis

Level 1 Name – North West Strategic Health Authority, West Midlands Strategic Health Authority, South West Strategic Health Authority, London Strategic Health Authority, South East Coast Strategic Health Authority, East Midlands Strategic Health Authority, North East Strategic Health Authority, Yorkshire and The Humber Strategic Health Authority, Health Solutions Wales, NHS Scotland, South Central Strategic Health Authority, East of England Strategic Health Authority, Health and Social Care in Northern Ireland

Correlations are carried out using total allegation (every row), unique enquiries, and unique enquiry/reference number combinations

Population based proportional data is also included, though unspecified data is excluded from this part of the analysis.

Media and FtP activity correlation results in summary

Search Term - "General Medical Council"

The rate at which the search term "General Medical Council" appeared in the media produced a number of significant correlations.

There was a significant correlation between the search term and the total allegation rate. ($r=0.295$, 95% CI [0.031,0.497], $n=72$, $p=0.012$).

Further significant correlations have been found with Unique Enquiries ($r=0.368$, 95% CI [0.159,0.526], $n=72$, $p=0.001$), Unique Reference Numbers ($r=0.329$, 95% CI [0.111,0.496], $n=72$, $p=0.005$), and Unique Enquiry/Reference number combinations ($r=0.279$, 95% CI [0.041,0.472], $n=72$, $p=0.018$).

Examining the data set further reveals that there is not a significant correlation between the media search and all Case Data ($r=0.214$, 95% CI [-0.064,0.431], $n=72$, $p=0.071$), but there is for Triage Case Closed data ($r=0.374$, 95% CI [0.151,0.548], $n=72$, $p=0.001$). Using the enquiry number to examine the unique enquiry rate reveals significant correlations with unique Case Data ($r=0.254$, 95% CI [0.061,0.419], $n=72$, $p=0.031$) and unique Triage Case Closed ($r=0.352$, 95% CI [0.142,0.52], $n=72$, $p=0.002$).

For the total allegations on level 2 Regions, only England shows a significant correlation with the media search ($r=0.306$, 95% CI [0.023,0.527], $n=72$, $p=0.009$), but when examining the unique cases we see significant correlations with England ($r=0.357$, 95% CI [0.117,0.551], $n=72$, $p=0.002$), Scotland ($r=0.288$, 95% CI [0.103,0.457], $n=72$, $p=0.014$), and Unspecified cases ($r=0.31$, 95% CI [0.156,0.457], $n=72$, $p=0.008$). When the data is adjusted by the proportion of the population within each of the areas, we see England again as the only L2 Region returning a significant correlation for total allegations ($r=0.306$, 95% CI [0.032,0.506], $n=72$, $p=0.009$), and for unique enquiries we see both England ($r=0.357$, 95% CI [0.129,0.545], $n=72$, $p=0.002$) and Scotland ($r=0.288$, 95% CI [0.101,0.452], $n=72$, $p=0.014$) showing significant relationships. Unspecified data is excluded from this part of the analysis.

For Level 1 Names, the correlations total allegations showed a significant relationship with West Midlands Strategic Health Authority ($r=0.321$, 95% CI [0.107,0.526], $n=72$, $p=0.006$), London Strategic Health Authority ($r=0.241$, 95% CI [-0.037,0.459], $n=72$, $p=0.041$), and East of England Strategic Health Authority ($r=0.41$, 95% CI [0.033,0.68], $n=72$, $p=0.0003$).

Examining the unique enquiry rate for each of the L1 Names reveals further significant correlations with Unspecified ($r=0.309$, 95% CI [0.146,0.453], $n=72$, $p=0.008$), West Midlands Strategic Health Authority ($r=0.301$, 95% CI [0.101,0.469], $n=72$, $p=0.01$), London Strategic Health Authority ($r=0.311$, 95% CI [0.077,0.517], $n=72$, $p=0.008$), South East Coast Strategic Health Authority ($r=0.307$, 95% CI [0.034,0.522], $n=72$, $p=0.009$), East Midlands Strategic Health Authority ($r=0.293$, 95% CI [0.097,0.472], $n=72$, $p=0.012$), Yorkshire and The Humber Strategic Health Authority ($r=0.307$, 95% CI [0.173,0.45], $n=72$, $p=0.009$), NHS Scotland ($r=0.288$, 95% CI [0.102,0.462], $n=72$, $p=0.014$) though this is the same finding as for L2 Region as it includes the same data/area of the UK, and East of England Strategic Health Authority ($r=0.388$, 95% CI [0.097,0.624], $n=72$, $p=0.001$).

Adjusting the data for the population within each region shows the media search was significantly correlated with total allegations for West Midlands Strategic Health Authority ($r=0.321$, 95% CI [0.07,0.53], $n=72$, $p=0.006$), London Strategic Health Authority ($r=0.241$, 95% CI [-0.058,0.464], $n=72$, $p=0.041$) and East of England Strategic Health Authority ($r=0.41$, 95% CI [0.008,0.681], $n=72$, $p=0$). Unique enquiries were significantly correlated with West Midlands Strategic Health Authority ($r=0.301$, 95% CI [0.098,0.489], $n=72$, $p=0.01$), London Strategic Health Authority ($r=0.311$, 95% CI [0.07,0.508], $n=72$, $p=0.008$), South East Coast Strategic Health Authority ($r=0.307$, 95% CI [0.04,0.543], $n=72$, $p=0.009$), East Midlands Strategic Health Authority ($r=0.293$, 95% CI [0.099,0.503], $n=72$, $p=0.012$), Yorkshire and The Humber Strategic Health Authority ($r=0.307$, 95% CI [0.172,0.449], $n=72$, $p=0.009$), NHS Scotland ($r=0.288$, 95% CI [0.093,0.463], $n=72$, $p=0.014$) and East of England Strategic Health Authority ($r=0.388$, 95% CI [0.092,0.623], $n=72$, $p=0.001$).

When looking at the relationships with Allegation Category, there were no significant correlations with the highest value of r set at .228. The majority of Closure Reasons also showed no relationship with the media search though there were significant relationships with Issues cannot be identified ($r=0.37$, 95% CI [0.112,0.561], $n=72$, $p=0.001$), Only benefit

claim issues ($r=0.366$, 95% CI [0.088,0.57], $n=72$, $p=0.002$), Side effects of treatment ($r=0.233$, 95% CI [0.072,0.386], $n=72$, $p=0.049$), Conflicting diagnosis ($r=0.308$, 95% CI [0.091,0.513], $n=72$, $p=0.009$), Intervention in treatment ($r=0.303$, 95% CI [-0.009,0.52], $n=72$, $p=0.01$), Disagreement with Med Report ($r=0.329$, 95% CI [0.074,0.526], $n=72$, $p=0.005$), Patient still ill ($r=0.276$, 95% CI [0.047,0.499], $n=72$, $p=0.019$), and Dr profession is incidental ($r=0.251$, 95% CI [0.032,0.458], $n=72$, $p=0.034$). The majority of Case Closure Reasons also showed no significant relationship, with the exception of Not Applicable ($r=0.238$, 95% CI [0.099,0.393], $n=72$, $p=0.044$), Concluded at CE Decision ($r=0.281$, 95% CI [-0.08,0.521], $n=72$, $p=0.017$), CR Case Created ($r=-0.239$, 95% CI [-0.395,-0.068], $n=72$, $p=0.043$) and Failed PIT ($r=-0.236$, 95% CI [-0.524,0.095], $n=72$, $p=0.046$). It is interesting to note that these last two relationships were negative, and were the only negative relationships flagged as significant for this media search

For unique enquiry/reference combinations, there were many more significant correlations with the media search. While the Case Data did not correlate, there was a significant correlation with Triage Case Closed data ($r=0.28$, 95%CI [0.039,0.472], $n=72$, $p=0.017$).

For Level 2 regions, there were significant correlations for Northern Ireland ($r=0.289$, 95%CI [0.023,0.496], $n=72$, $p=0.014$), England ($r=0.285$, 95%CI [0.049,0.476], $n=72$, $p=0.015$), Channel Islands ($r=0.32$, 95%CI [0.13,0.488], $n=72$, $p=0.006$), Wales ($r=0.305$, 95%CI [0.025,0.516], $n=72$, $p=0.009$), and Scotland ($r=0.333$, 95%CI [0.114,0.515], $n=72$, $p=0.004$) but not Unspecified data. Examining just the Case Data reveals significant correlations for England ($r=0.269$, 95%CI [0.055,0.441], $n=72$, $p=0.023$), Channel Islands ($r=0.32$, 95%CI [0.135,0.486], $n=72$, $p=0.006$), and Scotland ($r=0.246$, 95%CI [0.127,0.37], $n=72$, $p=0.037$).

For Triage Case Closed data we see significant correlations for Northern Ireland ($r=0.348$, 95%CI [0.074,0.557], $n=72$, $p=0.003$), England ($r=0.281$, 95%CI [0.038,0.469], $n=72$, $p=0.017$), Wales ($r=0.318$, 95%CI [0.077,0.501], $n=72$, $p=0.007$), Scotland ($r=0.28$, 95%CI [0.045,0.47], $n=72$, $p=0.017$) and Unspecified ($r=0.242$, 95%CI [0.011,0.433], $n=72$, $p=0.041$).

Examining Level 2 regions adjusted for population within each region reveals a similar pattern of significances. The media search significantly correlated with unique enquiry/reference combinations for Northern Ireland ($r=0.289$, 95%CI [0.016,0.48], $n=72$, $p=0.014$), England ($r=0.285$, 95%CI [0.032,0.461], $n=72$, $p=0.015$), Wales ($r=0.305$, 95%CI

[0.014,0.496], $n=72$, $p=0.009$) and Scotland ($r=0.333$, 95%CI [0.098,0.498], $n=72$, $p=0.004$). When filtered into Case Data only, there are significant correlations with England ($r=0.269$, 95%CI [0.064,0.445], $n=72$, $p=0.023$) and Scotland ($r=0.246$, 95%CI [0.116,0.367], $n=72$, $p=0.037$). When filtered into Triage Case Closed data only, there are significant correlations with Northern Ireland ($r=0.348$, 95%CI [0.054,0.566], $n=72$, $p=0.003$), England ($r=0.281$, 95%CI [0.046,0.48], $n=72$, $p=0.017$), Wales ($r=0.318$, 95%CI [0.082,0.506], $n=72$, $p=0.007$) and Scotland ($r=0.28$, 95%CI [0.038,0.476], $n=72$, $p=0.017$).

For Level 1 Regions there were significant relationships between the media search and unique enquiry/reference combinations for North West Strategic Health Authority ($r=0.245$, 95%CI [-0.012,0.447], $n=72$, $p=0.038$), West Midlands Strategic Health Authority ($r=0.322$, 95%CI [0.069,0.517], $n=72$, $p=0.006$), South West Strategic Health Authority ($r=0.311$, 95%CI [0.117,0.469], $n=72$, $p=0.008$), London Strategic Health Authority ($r=0.305$, 95%CI [0.056,0.503], $n=72$, $p=0.009$), East Midlands Strategic Health Authority ($r=0.289$, 95%CI [0.057,0.469], $n=72$, $p=0.014$), North East Strategic Health Authority ($r=0.345$, 95%CI [0.11,0.539], $n=72$, $p=0.003$), Yorkshire and The Humber Strategic Health Authority ($r=0.255$, 95%CI [-0.006,0.453], $n=72$, $p=0.031$), Health Solution Wales ($r=0.294$, 95%CI [0.005,0.514], $n=72$, $p=0.012$), NHS Scotland ($r=0.333$, 95%CI [0.114,0.515], $n=72$, $p=0.004$), East of England Strategic Health Authority ($r=0.27$, 95%CI [0.054,0.454], $n=72$, $p=0.022$), and Health and Social Care Northern Ireland ($r=0.289$, 95%CI [0.023,0.496], $n=72$, $p=0.014$). With just Case Data, only London Strategic Health Authority ($r=0.252$, 95%CI [0.054,0.418], $n=72$, $p=0.033$), North East Strategic Health Authority ($r=0.286$, 95%CI [0.115,0.441], $n=72$, $p=0.015$), NHS Scotland ($r=0.246$, 95%CI [0.127,0.37], $n=72$, $p=0.037$) and East of England Strategic Health Authority ($r=0.335$, 95%CI [0.11,0.517], $n=72$, $p=0.004$) were significantly correlated. When examining Triage Case Closed data we see significant correlations for Unspecified ($r=0.243$, 95%CI [0.012,0.434], $n=72$, $p=0.039$), North West Strategic Health Authority ($r=0.273$, 95%CI [0.037,0.46], $n=72$, $p=0.02$), West Midlands Strategic Health Authority ($r=0.294$, 95%CI [0.042,0.481], $n=72$, $p=0.012$), South West Strategic Health Authority ($r=0.304$, 95%CI [0.062,0.488], $n=72$, $p=0.009$), London Strategic Health Authority ($r=0.283$, 95%CI [0.031,0.481], $n=72$, $p=0.016$), East Midlands Strategic Health Authority ($r=0.33$, 95%CI [0.094,0.519], $n=72$, $p=0.005$), North East Strategic Health Authority ($r=0.338$, 95%CI [0.084,0.529], $n=72$, $p=0.004$), Yorkshire and The Humber Strategic Health Authority

($r=0.275$, 95%CI [0.016,0.472], $n=72$, $p=0.019$), Health Solutions Wales ($r=0.312$, 95%CI [0.067,0.502], $n=72$, $p=0.008$), NHS Scotland ($r=0.28$, 95%CI [0.045,0.47], $n=72$, $p=0.017$), South Central Strategic Health Authority ($r=0.259$, 95%CI [0.024,0.451], $n=72$, $p=0.028$) and Health and Social Care in Northern Ireland ($r=0.348$, 95%CI [0.074,0.557], $n=72$, $p=0.003$)

When adjusted for population size we see significant relationships between the media search and unique enquiry/reference combinations for North West Strategic Health Authority ($r=0.245$, 95%CI [-0.02,0.432], $n=72$, $p=0.038$), West Midlands Strategic Health Authority ($r=0.322$, 95%CI [0.073,0.501], $n=72$, $p=0.006$), South West Strategic Health Authority ($r=0.311$, 95%CI [0.092,0.455], $n=72$, $p=0.008$), London Strategic Health Authority ($r=0.305$, 95%CI [0.033,0.486], $n=72$, $p=0.009$), East Midlands Strategic Health Authority ($r=0.289$, 95%CI [0.045,0.456], $n=72$, $p=0.014$), North East Strategic Health Authority ($r=0.345$, 95%CI [0.091,0.521], $n=72$, $p=0.003$), Yorkshire and The Humber Strategic Health Authority ($r=0.255$, 95%CI [-0.001,0.443], $n=72$, $p=0.031$), Health Solutions Wales ($r=0.294$, 95%CI [-0.002,0.494], $n=72$, $p=0.012$), NHS Scotland ($r=0.333$, 95%CI [0.098,0.498], $n=72$, $p=0.004$), East of England Strategic Health Authority ($r=0.27$, 95%CI [0.035,0.437], $n=72$, $p=0.022$) and Health and Social Care in Northern Ireland ($r=0.289$, 95%CI [0.016,0.48], $n=72$, $p=0.014$). When split into Case Data and Triage Case Closed data we see significant relationships with Case Data for London Strategic Health Authority ($r=0.252$, 95%CI [0.055,0.423], $n=72$, $p=0.033$), North East Strategic Health Authority ($r=0.286$, 95%CI [0.116,0.439], $n=72$, $p=0.015$), NHS Scotland ($r=0.246$, 95%CI [0.116,0.367], $n=72$, $p=0.037$), and East of England Strategic Health Authority ($r=0.335$, 95%CI [0.121,0.505], $n=72$, $p=0.004$). For Triage Case Closed data there were significant relationships with North West Strategic Health Authority ($r=0.273$, 95%CI [0.048,0.471], $n=72$, $p=0.02$), West Midlands Strategic Health Authority ($r=0.294$, 95%CI [0.045,0.487], $n=72$, $p=0.012$), South West Strategic Health Authority ($r=0.304$, 95%CI [0.07,0.499], $n=72$, $p=0.009$), London Strategic Health Authority ($r=0.283$, 95%CI [0.041,0.487], $n=72$, $p=0.016$), East Midlands Strategic Health Authority ($r=0.33$, 95%CI [0.093,0.522], $n=72$, $p=0.005$), North East Strategic Health Authority ($r=0.338$, 95%CI [0.081,0.546], $n=72$, $p=0.004$), Yorkshire and The Humber Strategic Health Authority ($r=0.275$, 95%CI [0.023,0.488], $n=72$, $p=0.019$), Health Solutions Wales ($r=0.312$, 95%CI [0.072,0.504], $n=72$, $p=0.008$), NHS Scotland ($r=0.28$, 95%CI [0.038,0.476], $n=72$, $p=0.017$), South Central Strategic Health Authority ($r=0.259$, 95%CI

[0.025,0.456], $n=72$, $p=0.028$) and Health and Social Care in Northern Ireland ($r=0.348$, 95%CI [0.054,0.566], $n=72$, $p=0.003$).

Search Term - 'General Medical Council' AND 'fitness to practise'

When the term 'fitness to practise' was added to the media search for 'General Medical Council', only two of the 134 comparisons to timeline data taken from the FtP database produced significant results. These were both taken from the Closure Reason timelines which show a significant relationship between the media search and Dr Profession is Incidental ($r=0.259$, 95% CI [0.006,0.449], $n=72$, $p=0.028$), and Failure to Visit ($r=-0.272$, 95% CI [-0.416,-0.079], $n=72$, $p=0.021$). The latter of these correlations is negative.

There were no significant correlations for any of the general, unique or population proportioned data for the UK, Level 1 Names, Level 2 Regions, Allegation Categories, or Case Closure Reasons.

There were also no significant relationships between unique enquiry/reference number and the media search , or for any of the Case Data or Triage Case Closed data for any count and proportioned data across geographical regions

Search Term - 'General Medical Council' AND foreign

By combining the GMC search term with the word 'foreign' we see a number of significant correlations scattered through the data.

There is a significant relationship with total allegations ($r=0.282$, 95% CI [0.074,0.458], $n=72$, $p=0.017$), unique enquiries ($r=0.295$, 95% CI [0.11,0.474], $n=72$, $p=0.012$) and unique reference numbers ($r=0.312$, 95% CI [0.11,0.488], $n=72$, $p=0.008$). Total allegations seen in case data, and unique case data numbers do not show a significant relationship with the media search, but Triage Case Closed data is significantly correlated for both total allegations ($r=0.341$, 95% CI [0.137,0.549], $n=72$, $p=0.003$) and unique enquiry numbers ($r=0.322$, 95% CI [0.126,0.524], $n=72$, $p=0.006$).

For the complete L2 data, only England ($r=0.286$, 95% CI [0.088,0.469], $n=72$, $p=0.015$) and Unspecified ($r=0.259$, 95% CI [0.006,0.487], $n=72$, $p=0.028$) are significant. This is repeated for unique records for both England ($r=0.286$, 95% CI [0.089,0.472], $n=72$, $p=0.015$) and Unspecified ($r=0.32$, 95% CI [0.093,0.479], $n=72$, $p=0.006$). While unspecified data is not analysed as part of the proportional data based on population, England remains the only L2 field that is significant for total allegations ($r=0.286$, 95% CI [0.091,0.466], $n=72$, $p=0.015$), and unique entries ($r=0.286$, 95% CI [0.079,0.473], $n=72$, $p=0.015$).

There were further significant correlations between the media search and total allegation for L1 names for Unspecified ($r=0.254$, 95% CI [0.006,0.465], $n=72$, $p=0.031$), West Midlands Strategic Health Authority ($r=0.438$, 95% CI [0.235,0.625], $n=72$, $p=0.0001$), South West Strategic Health Authority ($r=0.263$, 95% CI [0.072,0.452], $n=72$, $p=0.026$), South East Coast Strategic Health Authority ($r=0.273$, 95% CI [0.054,0.527], $n=72$, $p=0.02$), Yorkshire and The Humber Strategic Health Authority ($r=0.313$, 95% CI [0.047,0.569], $n=72$, $p=0.007$), and East of England Strategic Health Authority ($r=0.288$, 95% CI [0.069,0.513], $n=72$, $p=0.014$). When we only consider unique enquiries, five of these correlations remain. These are Unspecified ($r=0.316$, 95% CI [0.098,0.474], $n=72$, $p=0.007$), West Midlands Strategic Health Authority ($r=0.371$, 95% CI [0.21,0.535], $n=72$, $p=0.001$), South West Strategic Health Authority ($r=0.252$, 95% CI [0.064,0.422], $n=72$, $p=0.033$), South East Coast Strategic Health Authority ($r=0.335$, 95% CI [0.063,0.563], $n=72$, $p=0.004$), and East of England Strategic Health Authority ($r=0.241$, 95% CI [0.047,0.459], $n=72$, $p=0.041$).

When data is proportioned by the population in each area, we see a significant correlation between the media search and the total allegations for West Midlands Strategic Health Authority ($r=0.438$, 95% CI [0.218,0.616], $n=72$, $p=0.0001$), South West Strategic Health Authority ($r=0.263$, 95% CI [0.066,0.456], $n=72$, $p=0.026$), South East Coast Strategic Health Authority ($r=0.273$, 95% CI [0.048,0.514], $n=72$, $p=0.02$), Yorkshire and The Humber Strategic Health Authority ($r=0.313$, 95% CI [0.039,0.587], $n=72$, $p=0.007$), and East of England Strategic Health Authority ($r=0.288$, 95% CI [0.067,0.51], $n=72$, $p=0.014$). When considering unique enquiries we find significant relationships with the West Midlands Strategic Health Authority ($r=0.371$, 95% CI [0.21,0.536], $n=72$, $p=0.001$), South West Strategic Health Authority ($r=0.252$, 95% CI [0.047,0.428], $n=72$, $p=0.033$), South East Coast Strategic Health

Authority ($r=0.335$, 95% CI [0.069,0.571], $n=72$, $p=0.004$), and East of England Strategic Health Authority ($r=0.241$, 95% CI [0.063,0.44], $n=72$, $p=0.041$).

There were no significant relationships with allegation categories, but for Closure reason there were significant relationships with Issues cannot be identified ($r=0.301$, 95% CI [0.054,0.54], $n=72$, $p=0.01$), Not about a dr ($r=0.311$, 95% CI [0.034,0.513], $n=72$, $p=0.008$), Only benefit claim issues ($r=0.528$, 95% CI [0.274,0.695], $n=72$, $p=0.000002$), Intervention in treatment ($r=0.294$, 95% CI [0.041,0.531], $n=72$, $p=0.012$), Removal from GP list ($r=0.337$, 95% CI [-0.093,0.67], $n=72$, $p=0.004$), Licensing issue res by Reg ($r=0.259$, 95% CI [0.187,0.514], $n=72$, $p=0.028$), and Implementing public policy ($r=0.474$, 95% CI [-0.109,0.768], $n=72$, $p=0.00003$). The only Case Closure Reason with a significant correlation was Concluded at CE Decision ($r=0.258$, 95% CI [0.03,0.471], $n=72$, $p=0.029$).

When data was filtered by unique enquiry/reference number combinations there was a significant relationship between the media search and the complete data set ($r=0.268$, 95%CI [0.078,0.464], $n=72$, $p=0.023$), Case Data ($r=0.248$, 95%CI [0.086,0.4], $n=72$, $p=0.036$), and Triage Case Closed ($r=0.261$, 95%CI [0.059,0.471], $n=72$, $p=0.027$). For Level 2 Regions there were significant relationships with England ($r=0.259$, 95%CI [0.061,0.462], $n=72$, $p=0.028$) and Unspecified data ($r=0.319$, 95%CI [0.141,0.482], $n=72$, $p=0.006$). For Level 1 Names there were relationships with Unspecified ($r=0.319$, 95%CI [0.141,0.481], $n=72$, $p=0.006$), North West Strategic Health Authority ($r=0.251$, 95%CI [0.019,0.487], $n=72$, $p=0.033$), West Midlands Strategic Health Authority ($r=0.25$, 95%CI [0.071,0.435], $n=72$, $p=0.034$), London Strategic Health Authority ($r=0.264$, 95%CI [0.06,0.465], $n=72$, $p=0.025$), South East Coast Strategic Health Authority ($r=0.336$, 95%CI [0.133,0.534], $n=72$, $p=0.004$), East Midlands Strategic Health Authority ($r=0.259$, 95%CI [0.04,0.475], $n=72$, $p=0.028$), Yorkshire and The Humber Strategic Health Authority ($r=0.237$, 95%CI [0.033,0.448], $n=72$, $p=0.045$), and East of England Strategic Health Authority ($r=0.239$, 95%CI [0.062,0.431], $n=72$, $p=0.043$). Population proportioned data showed significant relationships between England at L2 ($r=0.259$, 95%CI [0.052,0.466], $n=72$, $p=0.028$), and at L1 for North West Strategic Health Authority ($r=0.251$, 95%CI [0.019,0.487], $n=72$, $p=0.033$), West Midlands Strategic Health Authority ($r=0.25$, 95%CI [0.07,0.44], $n=72$, $p=0.034$), London Strategic Health Authority ($r=0.264$, 95%CI [0.055,0.472], $n=72$, $p=0.025$), South East Coast Strategic

Health Authority ($r=0.336$, 95%CI [0.124,0.532], $n=72$, $p=0.004$), East Midlands Strategic Health Authority ($r=0.259$, 95%CI [0.035,0.472], $n=72$, $p=0.028$), Yorkshire and The Humber Strategic Health Authority ($r=0.237$, 95%CI [0.031,0.454], $n=72$, $p=0.045$) and East of England Strategic Health Authority ($r=0.239$, 95%CI [0.056,0.438], $n=72$, $p=0.043$).

When split into Case and Triage data there are further significant correlations with the media search and Case Data for England at L2 ($r=0.263$, 95%CI [0.114,0.413], $n=72$, $p=0.025$), and at Level 1 for West Midlands Strategic Health Authority ($r=0.312$, 95%CI [0.134,0.502], $n=72$, $p=0.008$), South East Coast Strategic Health Authority ($r=0.363$, 95%CI [0.16,0.548], $n=72$, $p=0.002$), East Midlands Strategic Health Authority ($r=0.308$, 95%CI [0.083,0.524], $n=72$, $p=0.009$), and East of England Strategic Health Authority ($r=0.237$, 95%CI [0.069,0.419], $n=72$, $p=0.045$). Triage Case Closed data was significant for England ($r=0.251$, 95%CI [0.028,0.486], $n=72$, $p=0.033$) and Unspecified data ($r=0.307$, 95%CI [0.12,0.478], $n=72$, $p=0.009$) at Level 2, and at Level 1 for Unspecified ($r=0.308$, 95%CI [0.12,0.478], $n=72$, $p=0.009$), North West Strategic Health Authority ($r=0.247$, 95%CI [0.017,0.483], $n=72$, $p=0.037$), London Strategic Health Authority ($r=0.266$, 95%CI [0.034,0.509], $n=72$, $p=0.024$), South East Coast Strategic Health Authority ($r=0.325$, 95%CI [0.108,0.54], $n=72$, $p=0.005$), North East Strategic Health Authority ($r=0.246$, 95%CI [0.041,0.475], $n=72$, $p=0.037$) and Yorkshire and The Humber Strategic Health Authority ($r=0.279$, 95%CI [0.058,0.513], $n=72$, $p=0.018$).

When proportioned by population, there were significant correlations with Case Data for L2 data for England ($r=0.263$, 95%CI [0.09,0.406], $n=72$, $p=0.025$), and L1 data for West Midlands Strategic Health Authority ($r=0.312$, 95%CI [0.116,0.476], $n=72$, $p=0.008$), South East Coast Strategic Health Authority ($r=0.363$, 95%CI [0.142,0.545], $n=72$, $p=0.002$), East Midlands Strategic Health Authority ($r=0.308$, 95%CI [0.09,0.517], $n=72$, $p=0.009$) and East of England Strategic Health Authority ($r=0.237$, 95%CI [0.053,0.415], $n=72$, $p=0.045$). There were further significant correlations for Triage Case Closed data at L2 for England ($r=0.251$, 95%CI [0.032,0.465], $n=72$, $p=0.033$), North West Strategic Health Authority ($r=0.247$, 95%CI [0.022,0.467], $n=72$, $p=0.037$), London Strategic Health Authority ($r=0.266$, 95%CI [0.038,0.48], $n=72$, $p=0.024$), South East Coast Strategic Health Authority ($r=0.325$, 95%CI [0.106,0.53], $n=72$, $p=0.005$), North East Strategic Health Authority ($r=0.246$, 95%CI

[0.035,0.446], n=72, p=0.037) and Yorkshire and The Humber Strategic Health Authority (r=0.279, 95%CI [0.048,0.498], n=72, p=0.018)

Search Term - "General Medical Council" AND complain

This combination of media search terms did not produce many significant relationships with our various timelines. There were no relationships evident with the general timelines, L2 regions or L1 names with the exception of unique enquiries for North East Strategic Health Authority (r=0.282, 95% CI [-0.071,0.56], n=72, p=0.017) and Yorkshire and The Humber Strategic Health Authority (r=0.294, 95% CI [0,0.54], n=72, p=0.012). When considering the unique enquiries and proportion of population in each SHA, both North East Strategic Health Authority (r=0.282, 95% CI [-0.045,0.554], n=72, p=0.017) and Yorkshire and The Humber Strategic Health Authority (r=0.294, 95% CI [-0.019,0.554], n=72, p=0.012) remain as the only significant correlations.

For Allegation Category, only unspecified allegations showed significance (r=0.247, 95% CI [-0.023,0.515], n=72, p=0.037). For Case Closure Reason, only Not Applicable (r=0.26, 95% CI [-0.033,0.499], n=72, p=0.027) and No Review Hearing (r=0.33, 95% CI [0.027,0.517], n=72, p=0.005) were significant, and for Closure Reason only Conflicting diagnosis (r=0.314, 95% CI [-0.007,0.573], n=72, p=0.007), Removal from GP list (r=-0.245, 95% CI [-0.4,-0.095], n=72, p=0.038) and Failure to visit (r=-0.323, 95% CI [-0.468,-0.19], n=72, p=0.006) were significant. Both Removal from GP List and Failure to Visit were negatively correlated.

There were no significant correlations with any of the fields examined for unique enquiry/reference number combinations.

Search Term - "General Medical Council" AND struck-off

There were 13 significant correlations between the FtP timeline data and this media search. These were with total allegation rate for L1 East of England Strategic Health Authority (r=0.239, 95% CI [-0.137,0.529], n=72, p=0.044), the population based proportional data for the same SHA (r=0.239, 95% CI [-0.157,0.542], n=72, p=0.044), the Only Benefits Claim Issue closure reason (r=0.266, 95% CI [-0.076,0.518], n=72, p=0.024), the Dr Profession is Incidental closure reason (r=0.247, 95% CI [0.105,0.404], n=72, p=0.036), and the Implementing Public Policy closure reason (r=0.415, 95% CI [-0.118,0.683], n=72, p=0.0003).

The last 8 significant correlations used unique enquiry/reference number combinations and highlighted relationships between NHS Scotland, both at Level 2 Name and Level 1 Region as they use the same data set, and for count ($r=0.25$, 95%CI [0.08,0.426], $n=72$, $p=0.034$) and population proportioned data ($r=0.25$, 95%CI [0.081,0.414], $n=72$, $p=0.034$). Level 1 Regions of West Midland Strategic Health Authority ($r=0.293$, 95%CI [0.048,0.487], $n=72$, $p=0.013$) and London Strategic Health Authority ($r=0.28$, 95%CI [0.044,0.464], $n=72$, $p=0.017$) were also significant along with their population proportioned counterparts which showed ($r=0.293$, 95%CI [0.045,0.5], $n=72$, $p=0.013$) for West Midlands and ($r=0.28$, 95%CI [0.062,0.468], $n=72$, $p=0.017$) for London SHA.

Search Term - "General Medical Council" AND inquir*

There were a total of 17 significant correlations between this media search and the FtP data. The first of these was with the total allegation rate which showed a significant negative correlation ($r=-0.234$, 95% CI [-0.414,-0.034], $n=72$, $p=0.048$). The L1 South Central Strategic Health Authority showed a significant effect for unique enquiries ($r=0.274$, 95% CI [-0.033,0.539], $n=72$, $p=0.02$) which was repeated when data was adjusted for the population ($r=0.274$, 95% CI [-0.051,0.536], $n=72$, $p=0.02$).

The other significant correlations were between the media search and Clinical Care allegation category ($r=-0.317$, 95% CI [-0.511,-0.072], $n=72$, $p=0.007$) which showed a negative relationship, Unspecified allegation category ($r=0.392$, 95% CI [-0.1,0.705], $n=72$, $p=0.001$), Disagreement with Med Report closure reason ($r=0.309$, 95% CI [0.048,0.511], $n=72$, $p=0.008$), and the Case Closure Reasons of Concluded Assistant Registrar ($r=-0.232$, 95% CI [-0.433,0.024], $n=72$, $p=0.05$), Concluded at CE Decision ($r=-0.263$, 95% CI [-0.452,0.003], $n=72$, $p=0.026$), Not Applicable ($r=0.263$, 95% CI [-0.206,0.599], $n=72$, $p=0.025$), No review hearing ($r=0.403$, 95% CI [-0.008,0.676], $n=72$, $p=0$), and Rule 12 Review ($r=0.243$, 95% CI [-0.095,0.547], $n=72$, $p=0.04$). Both Concluded Assistant Registrar and Concluded at CE Decision showed a negative relationship.

The final significant correlations came from the unique enquiry/reference number combination Case Data for Scotland at Level 1 Name and Level 2 Region (both with $r=0.288$, 95%CI [0.033,0.517], $n=72$, $p=0.014$) and for the population proportioned data for both levels ($r=0.288$, 95%CI [0.017,0.501], $n=72$, $p=0.014$), and the Case Data for South West

Strategic Health Authority for both count ($r=0.376$, 95%CI [0.136,0.567], $n=72$, $p=0.001$) and population proportioned data ($r=0.376$, 95%CI [0.109,0.556], $n=72$, $p=0.001$)

Forecast modelling: Forecasts for 2013

Presented below are the results of forecast modelling derived from analysis of the GMC statistical data. However, in conversation with GMC representatives we have been informed that the complaint rate in the early months of 2013 has dropped. As these forecasts are based on past data with an upward trajectory, they may already be out of sync with actual current trends. The forecasts may in some cases also have been affected by the drops in recorded data during 2012 which result from the GMC not recording full details until after cases are completed.

Data

We examined the UK monthly data from 2007 to 2012 inclusive for the numbers of (a) complainant submissions (potentially containing multiple allegations) recorded, (b) total allegations made. Over the six years of data examined there has been a growing tendency for complainant submissions to contain complaints about multiple doctors, as shown by the diverging time series plots in Figure 1.

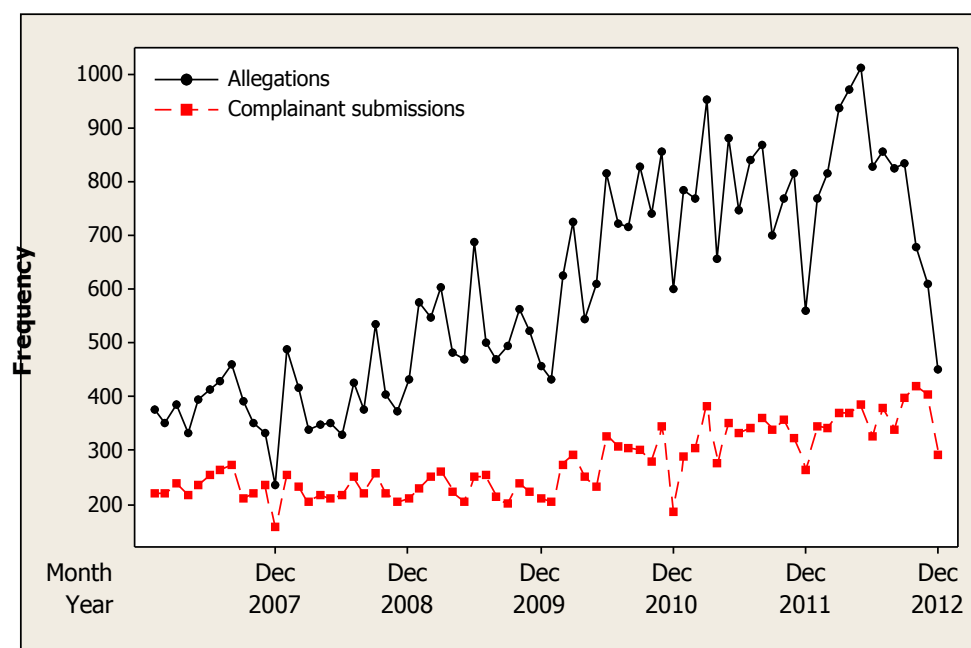


Figure 28: Time series plots (Jan 2007 to Dec 2012) of the number of complainant submissions and the total number of allegations made against individual doctors.

Forecasts for submissions and complaints

Using the historical data we made forecasts, using the multiplicative Holt-Winters model, for the numbers of these two variables predicted in 2013. This well-known forecasting model is recommended as being a “generally reliable, easy to understand method for seasonal data” (Chatfield 2004).

Figure 2 shows the observed time series for the number of complainant submissions (or unique enquiries), together with the fitted values from the Holt-Winters model and the 2013 predictions and 95% prediction limits from that model. The model explains 82% of the variation in the data and predicts a total of 4,834 submissions in 2013, compared with 4,372 observed in 2012.

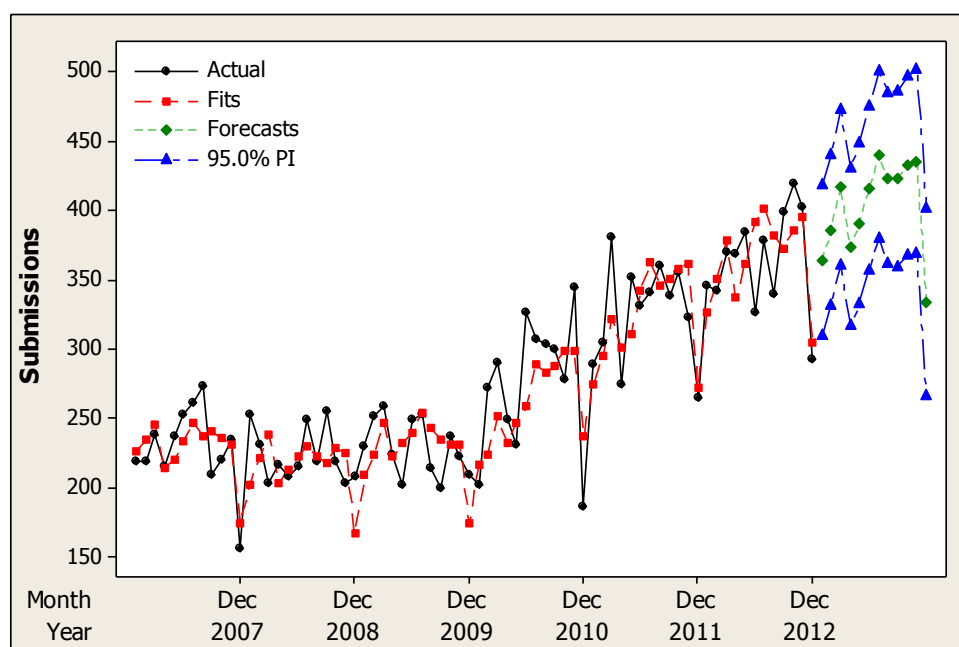


Figure 29: Holt-Winters time series model for the total number of complainant submissions (unique enquiries) received.

Figure 3 shows the observed time series for the total number of complaints made, together with the fitted values, the 2013 predictions and 95% prediction limits. The model explains 83% of the variation in the data and predicts a total of 7,682 complaints in 2013, compared with 9,595 in 2012.

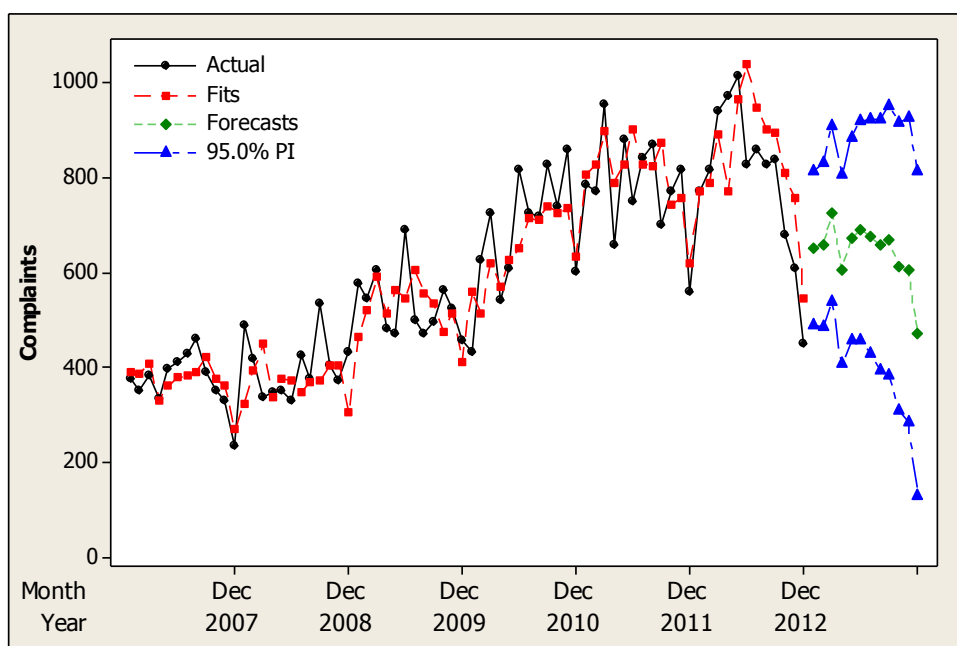


Figure 30: Holt-Winters time series model for the total number of allegations made.

New complainees

We also investigated the proportion of complaints relating to new complainees: doctors about whom there were no earlier complaints in the 2007-12 records. Through lack of prior data this proportion was high in 2007 but seems to have settled in the 45-50% range during the three latest years (Figure 4)

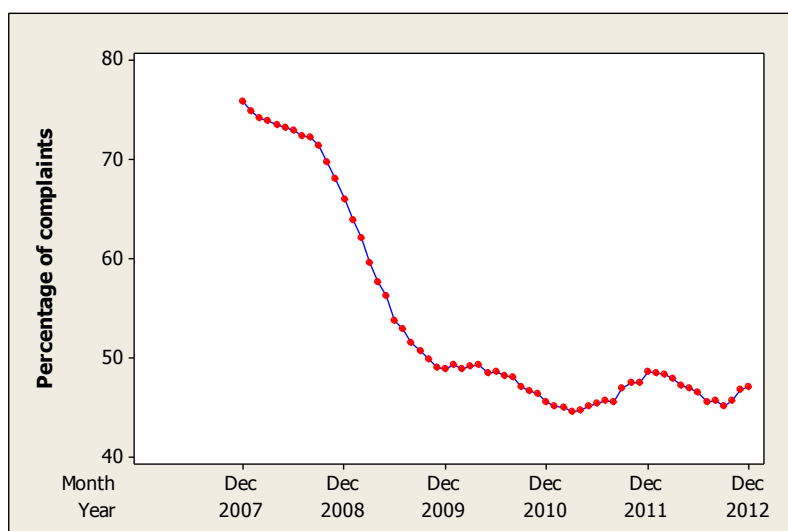


Figure 31: Percentage of complaints in previous 12 months which involved new complainees.

Figure 5 shows the observed time series for the total number of enquiries made, together with the fitted values, the 2013 predictions and 95% prediction limits. The model explains

83% of the variation in the data and predicts a total of 5,804 enquiries in 2013, compared with 5,857 in 2012.

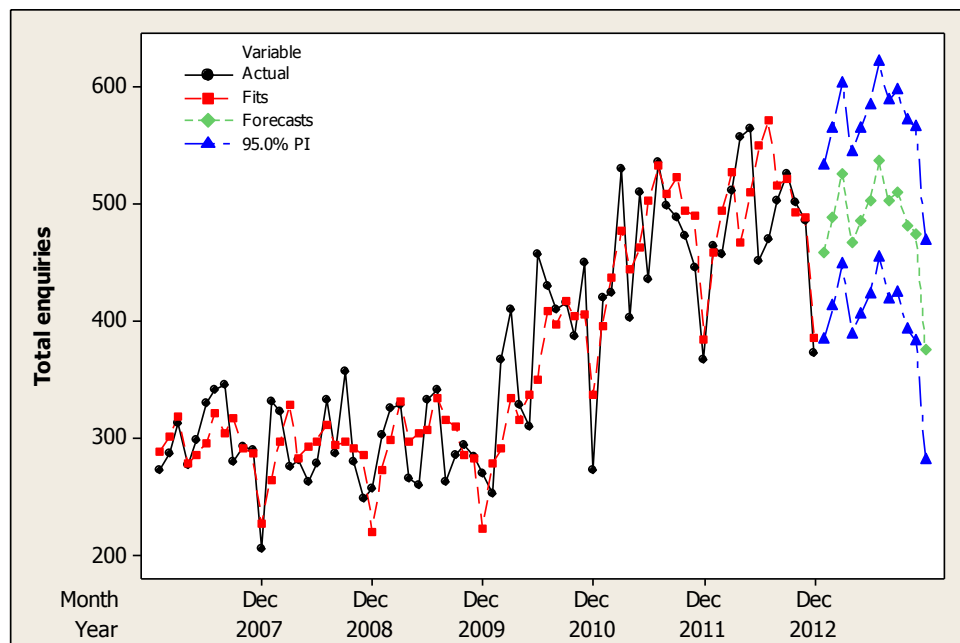


Figure 32: Holt-Winters time series model for the total number of enquiries per month.

Figure 6 shows the observed time series for the total number of cases, together with the fitted values, the 2013 predictions and 95% prediction limits. The model explains only 43% of the variation in the data and predicts a total of 2,262 enquiries in 2013, compared with 2,292 in 2012. The poorer fit of this model is most likely due to the uncharacteristic rise in cases during 2010.

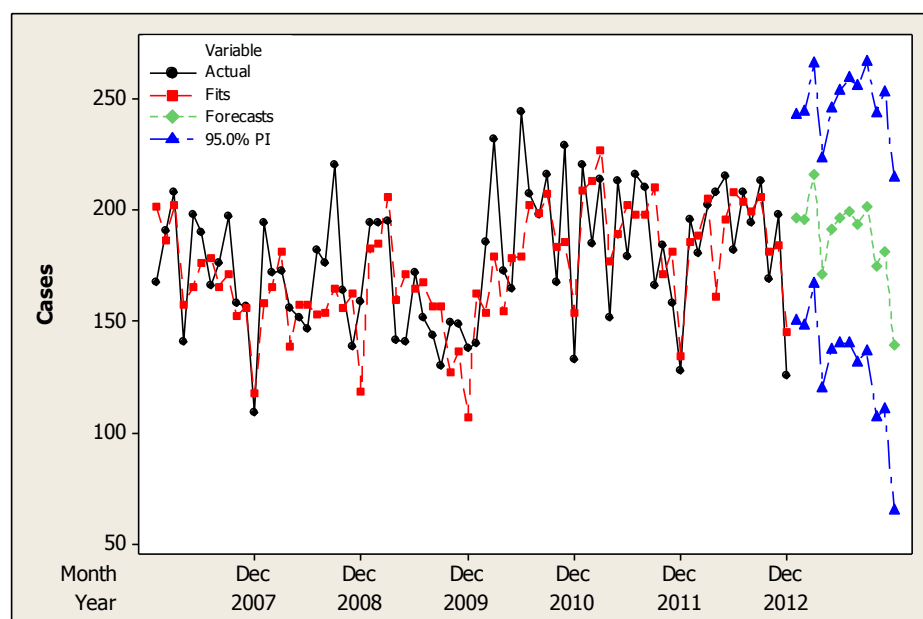


Figure 33: Holt-Winters time series model for the total number of cases per month.

Figure 7 shows the observed time series for the total number of cases closed at triage, together with the fitted values, the 2013 predictions and 95% prediction limits. The model explains 86% of the variation in the data and predicts a total of 3,823 enquiries in 2013, compared with 3,565 in 2012.

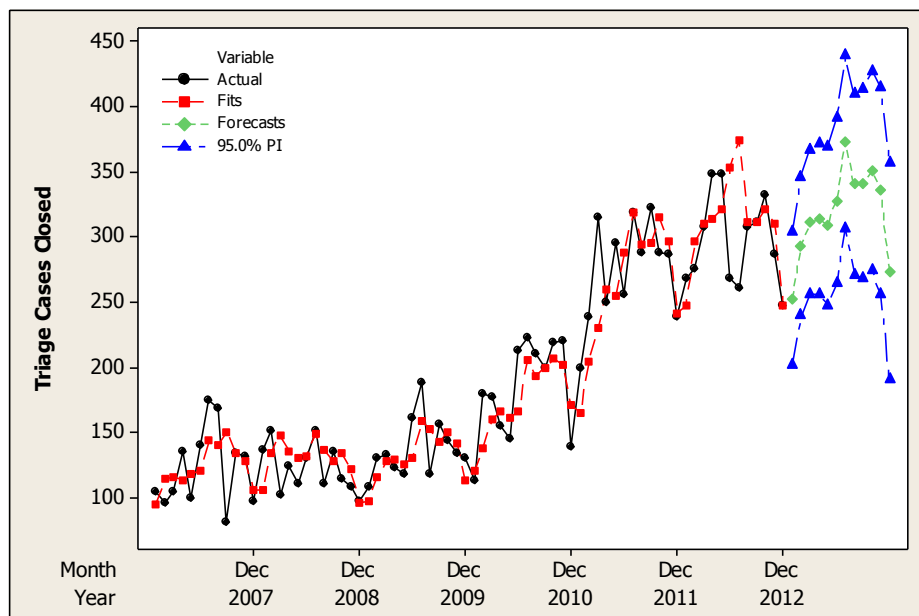


Figure 34: Holt-Winters time series model for the total number of triage cases closed per month.