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Paper:

Chamberlain, J. (2011). The hearing of fitness to practice cases by the General Medical Council: Current trends and future research agendas. *Health, Risk & Society*, 13(6), 561-575.

<http://dx.doi.org/10.1080/13698575.2011.613984>

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The Hearing of Fitness to Practice Cases by the General Medical Council: Current Trends and Future Research Agendas

Introduction

This paper is concerned with the management of complaints against doctors and the hearing of fitness to practice cases by the General Medical Council (GMC). The GMC is the governing body responsible for overseeing the regulation of doctors in the United Kingdom (UK). The 2008 Health and Social Care Act introduced significant and far reaching reforms to medical regulation in the UK, the full affects of which will not be known for at least another generation (Chamberlain 2010a). The GMC was reformed, the performance surveillance and management tool revalidation introduced to ensure the continuing and rigorous on going appraisal of medical practitioners fitness to practice, while perhaps most importantly, the level of proof required for evidential purposes in the hearing of medical malpractice cases by the GMC was reduced from a criminal to civil standard (Chamberlain 2010b). These changes have been conceptualised in some quarters as suggesting there has been a shift toward the adoption of a risk-based approach to medical governance (Lloyd-Bostock and Hutter 2008). It has also been noted that the medical profession has collectively sought to respond to this changing regulatory landscape by internally reforming its self-regulatory institutions to modernise the training and regulation of doctors (Davies 2004). Bound up with which has been the rhetorical advocacy by medical elites of the need to shift toward a 'stakeholder model' of professional regulation that is professionally-led but requires the proactive involvement of the general public and other health and social care professions (i.e. see Irvine 2003).

Similar to the introduction of clinical governance in the National Health Service (NHS) professional-led medical regulation seeks to promote a 'risk-averse' working culture of transparency and accountability through the proactive use of clear performance standards and best-evidenced protocols and guidelines to inform decision-making processes (Irvine 2003, Chamberlain 2009a).

As a result of this mixture of externally and internally generated reform medicine's training programmes, disciplinary mechanisms and regulatory inspection regimes now possess clear standards that can be operationalised into performance outcomes against which the fitness to practice of members of the profession can be regularly checked in an apparently open, transparent and accountable manner (Irvine 2006). When taken alongside the rise of health care managerialism and the patient rights movement in the UK over the last three decades - which together have arguably led to the increasing third-party questioning of the medical decision making process - contemporary developments in medical governance and health care organisation and delivery seem to indicate that medical dominance and autonomy in the UK has been successfully challenged and is now in decline (Ahmad and Harrison 2000, Chamberlain 2009b). Others have argued that it is more appropriate to hold that the medical profession is being transformed into a more restratified open and accountable 'elite' and 'rank and file' form (Chamberlain 2010a). The latter increasingly being subject to surveillance and performance management by the former as medical elites respond to a more intrusive regulatory state. According to this viewpoint the regulatory state is increasingly seeking to proactively control institutionalized forms of specialist expertise (of which professions such as medicine are but one example) for a mixture of economic cost and risk-management reasons (Friedson 2001).

Against this shifting regulatory background the paper discusses descriptive statistical trends in the relatively under researched area of the hearing of fitness to practice cases by the GMC. Complaints are certainly not the only measure by which to analyse changes in the relationship between medicine and the general public. Additionally the analysis of complaint data is complicated slightly by the emergence of defensive medical practice as a seemingly legitimate but nevertheless ultimately self-defeating coping strategy. Defensive medicine occurs when diagnostic or therapeutic measures are used by a doctor as protection against possible accusations of negligence or underperformance, rather than because their patient really needs them (Summerton 1995). Studies show doctors are increasingly engaging in defensive medicine as a result of a rise in health care managerialism, an increase in patient complaints and greater emphasis being placed on patient choice (Nettleton 2006). This reinforces the need to approach raw complaint data with caution. For a complaint can arise because of tension between a patient's sense of personal entitlement and strategic health-care planning and rationing as much as because of the action of an attending medical practitioner. Although the GMC possesses a statutory duty to investigate every complaint it receives it is not always appropriate or reasonable for a complaint to lead to action being taken against a doctor (Stacey 1992, 2000). This must be born this in mind when using such data to analyse broader changes in the relationship between the medical profession and the general public. Nevertheless this paper argues that focusing longitudinally on the management of the complaints process and fitness to practice case hearings is in itself an invaluable tool from which to assess the impact of the current regulatory reform agenda on the day to day operation of the GMC. Dame Janet Smith (2005: 1174), at the end her governmental review of the GMC as part of her analysis of the Shipman case, was '*driven to the*

conclusion that, for the majority of GMC members, the old culture of protecting the interests of doctors lingers on'. The analysis of the handling of patient complaint by the GMC arguably allows some albeit restricted access to the medical club from which to tentatively identify if and how far, any cultural change has occurred since Smith's report. Any analysis of cultural change within the operation of the GMC could also be expected to look at complaint data in relation to the ethnicity of medical practitioners. For the little research available on this topic seems to indicate that overseas qualified doctors are more at risk of having action taken against them by the GMC (see Stacey 1992, Allen 2000). Similarly it would be useful to explore complaint data in relation to gender given the medical workforce may well become predominately female over the next decade if current recruitment trends continue (Winyard 2009). It was consequently decided to include consideration of gender and ethnicity in the analysis of GMC complaint data.

The paper is divided into three sections. The first section outlines the procedure followed by the GMC when it receives a complaint about a medical practitioner. This sets the necessary background for section two, which discusses complaint data and figures relating to the hearing of fitness to practice cases by the GMC. The final section discusses the findings presented and in doing so it argues for the need to undertaken further analysis of data held by the GMC concerning its activity. The paper concludes by arguing that the findings presented provide an invaluable baseline from which such an analysis could be undertaken against the background of the emergence of an increasingly economic cost-focused and risk-averse regulatory state.

The GMC and the hearing of fitness to practice cases

Currently there are 231,415 doctors on the GMC register (GMC 2010). The GMC is responsible for removing doctors from this register by dealing firmly and fairly with medical practitioners whose fitness to practise has been questioned (Chamberlain 2010a). The GMC does not deal with complaints against NHS systems (although it may deal with complaints against individuals that illustrate system failings). Nor does it arrange for complainants to receive an apology, an explanation of what happened, or provide help and support for compensation claims (1). The GMC only deals with complaints that call into question a doctor's fitness to practise (GMC 2004a). Under Section 35C(2) of the *Medical Act* (1983), alongside the guidance to good practice provided in its document *Good Medical Practice* (2009), the GMC focuses upon complaints that highlight instances where a doctor has made serious or repeated mistakes in carrying out medical procedures or in diagnosis (i.e. by prescribing drugs in a dangerous way), has not examined a patient properly or responded appropriately to their medical need, has committed fraud, dishonesty or serious breaches of a patient confidentiality, and finally, has received a criminal conviction or has developed a physical and/or mental health issue (Chamberlain 2010a).

Since 2004 the GMC's fitness to practice procedures have been divided into two separate stages: investigation and adjudication. Previous to this cases were dealt with by three separate committees (Health, Conduct and Performance). During the investigative stage what is known as the initial 'triage' process involves making an initial decision as to whether or not to proceed with the case (GMC 2004a). Some cases are clearly outside of the GMC's remit. For example, a complaint may not be concerned with an individual medical practitioner. If necessary the GMC will refer

the matter to the doctors' employer so local procedures can be used if necessary to respond to it. If the initial information points toward a criminal conviction then the matter will be immediately referred to a fitness to practice panel for adjudication (GMC 2004a).

If the triage process confirms that the complaint requires further consideration the GMC will proceed to the full investigative stage. Here the GMC will disclose the complaint to the doctor in question and their employer to ensure a complete picture of the doctor's practice can be obtained. All cases are overseen by two case examiners, one of whom is a non-medical practitioner and one a medical practitioner. Witness statements and supportive material will be collected and analysed, including copies of patient medical records or other formal documentary material (i.e. employer reports). Where there is a concern with performance or health, appropriate tests will be completed at this stage (Etheridge et al 2009). The investigation period concludes with either no further action been taken, a warning being issued, a practitioner agreeing to what are referred to as 'undertakings', or a case being referred to a fitness to practice panel for adjudication (GMC 2010) (2).

The adjudication stage involves a formal hearing of a case by a fitness to practice panel. The panel is made up of medical and non-medical lay members. If needed, the panel will be advised by a specialist health or performance advisor. There are five main outcomes of a fitness to practice panel meeting: no further action, giving a doctor a formal warning, putting restrictions on a doctor's professional practice (i.e. imposing supervision or requiring they undertake further training), suspending a doctor from the medical register so they may not practice for a given period of time, and finally, erasing a doctor from the medical register. It is the intention of the GMC when they erase a doctor from the medical register that this normally will be for life.

A doctor has twenty-eight days to appeal against a decision which they lodge at the High Court.

Since 2005 all GMC fitness to practice decisions have been reviewed by the Council for Healthcare Regulatory Excellence. Under section 29 of the *National Health Service Reform and Health Care Professions Act* (2002) the Council can refer a decision to a High Court for review if it considers a GMC decision to be unduly lenient. The Council for Healthcare Regulatory Excellence forwarded 4 such cases in 2005, 6 in 2006, 0 in 2007, 1 in 2008, 1 in 2009 and 0 in 2010 (Council for Healthcare Regulatory Excellence 2005, 2006, 2007, 2008, 2009 and 2010a). This reduction in referrals could be held to reflect an increasingly rigorous stance on behalf of the GMC towards fitness to practice cases (Allsop 2006).

There is a growing perception within the medical profession that the GMC is far less tolerant of infractions than it was previously (Dyer 2010a, 2010b, 2010c). Many practitioners are concerned with what they perceive to be the increasing politicisation of the operation of the GMC (Chamberlain 2010a). For example, during each stage of the complaint process a case must pass what is called 'the realistic prospect test'. Meaning that allegations will only proceed if there is a realistic prospect of establishing that a medical practitioner's fitness to practice can be called into question to such a degree that justifies the GMC taking action on their registration status (GMC 2004a). Under the *Health and Social Care Act* (2008) the level of evidence required to secure a guilty verdict has been reduced from a criminal (absolute) to civil (on the balance of probabilities) standard. This change was justified by the regulatory state on the grounds that the GMC has often in the past been unable to remove a doctor from the medical register, even when doubt existed over their clinical performance, because the level of evidence required to do so was too high

(see Irvine 2003 and Allsop 2006). After the Shipman case many members of the profession agreed changes were needed to update the organisation and working culture of the GMC so underperforming doctors could be more easily stopped from continuing to practice. But it has also been argued that moves to reduce the level of evidence needed to remove a doctor from the medical register have become bound up with of a wider politically motivated and unrealistic tendency, on behalf of the regulatory state, to seek to minimise clinical risk and cost by turning medical work into a series of routine step-by-step rules and procedures against which individual clinician performance can be measured and judged (Chamberlain 2010b). Identifying if there had been a substantial rise in the number of doctors removed from the medical register as a result of changes in the level of evidence needed to pass the realistic prospect test, formed an important part of the analysis of GMC data outlined in the following section of this paper.

Trends in complaints and the hearing of fitness to practice cases

Having outlined the process by which a fitness to practice complaint proceeds, this section of the paper focuses upon data pertaining to the hearing of fitness to practice cases by the GMC. The rest of this section of this paper details the main features of the data obtained directly from the GMC for between 2006 and 2009, with data from earlier years being discussed where possible (3). It is important to begin by recognising that although the figures discussed do descriptively illustrate the operation of the GMC they should not be taken as a representation of its total activity for each calendar year. Not least of all because the nature of the process is such that a complaint received in 2009 may not reach resolution until 2010. This said, having

year on year comparative data does allow for descriptive statistical trends to emerge, as the paper will now turn to discuss. Table 1 shows the total number of complaints received by the GMC for between 1999 and 2009. It also shows the number of complaints received by the GMC in 1995 and in 1998. The figures for 1995 and 1998 were obtained from available published GMC documents (GMC 2003a, 2004b). Aside from 2006 when the number of complaints for some reason reduced sharply, taken together the figures show that the number of complaints received by the GMC has roughly trebled over the last 15 years, from 1503 in 1995 to 4722 in 2009. 4722 complaints represent 2% of all medical practitioners currently on the GMC register (n= 231,415). The dip in complaints in 2006 cannot be attributed to any major change in the organization or role of the GMC during this year, so it may well simply be a statistical aberration, as does happen sometimes when dealing with longitudinal data.

Table 1: Number of complaints received by the GMC (1999 – 2009)

Year	Number of Complaints
2009	4722
2008	4166
2007	4118
2006	2788
2005	4128
2004	4005
2003	3962
2002	3937
2001	4504
2000	4470
1999	3001
1998	3066*
1995	1503*
	* source (GMC 2003a, 2004b)

It appears that complaints doubled between the mid and late 1990s, with the number trebling into the beginning of the new millennium, before evening off slightly

(aside from in 2006) until increasing back up again in 2009. It is too early to tell yet if the slight jump in the number of complaints in the last year will persist. The available figures do seem to reinforce the validity of the view that in the last two decades there has been an increase in the questioning of medical authority and autonomy, with the result that individuals are more likely to complain about their doctor and/or the treatment they have received (Nettleton 2006). Bound up with this may well be the fact that high profile medical malpractice cases, such as the respective Bristol Infirmary and Shipman cases for example, have significantly raised the profile of the GMC in the eyes of the news media and general public, with the result that the number of complaints it receives has increased (Chamberlain 2010b).

Next it is necessary to identify the source of complaints. This analysis was complicated by the fact that the GMC reporting of complaints received by each main category - i.e. members of the public, a fellow doctor, a person acting in a public capacity – is different in the data source documents for between 2000 and 2005 (GMC 2000, 2001, 2004, 2005) than for the 2006 to 2009 years (GMC 2010). But it was possible to combine the categories into a simple public/other dichotomy to help paint a broader picture of patterns in the source of complaints received by the GMC. This data, displayed in Table 2, shows that the majority of complaints received come from the general public, but there has been a gradual increase in complaints from other sources in recent times. This may well reflect the fact that the GMC has recently taken a more proactive stance toward working with local NHS employers and private healthcare providers as it seeks to promote a working culture which encourages complainants to come forward with their concerns without fearing negative consequences for their career, particularly as this has been recognised as a key issue in the past (Department of Health 2009).

Table 2: Source of Complaint

Source of Complaint	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
General Public	73%	75%	76%	77%	74%	73%	66%	70%	68%	64%
Other	27%	25%	24%	23%	26%	27%	34%	30%	32%	36%

The next step is to break down the initial complaints made against doctors against their ethnicity and gender. It was not possible to obtain data pertaining to complaints received in relation to ethnicity prior to 2006 from the documents made available by the GMC. It has been noted that the GMC did not routinely collect data pertaining to ethnicity prior to the introduction of a new electronic recording system in 2005, as well as that subsequently to this in the 2007 to 2008 reporting period it *'undertook a major exercise to improve the quality and coverage of its ethnicity data'* (Humphrey et al 2009:19). In part this has been because of growing concerns over possible discrimination and racism, as doctors who qualified overseas and subsequently came to practice in the UK seem to be at higher risk of being referred to the GMC as well as having high impact fitness to practice decisions made against them i.e. having limitations placed upon their practice or being struck off the medical register (Allen 2000, West et al 2006). Humphrey et al (2009) in their review of available data for between 2006 and 2008 found that UK doctors from ethnic minorities were not at greater risk of being subject to high impact decisions or being struck off the medical register, however overseas doctors were. It should be noted that Humphrey et al (2009) were cautious concerning their findings due to the limited data available to them. The data made available for this paper by the GMC concerning the percentage breakdown of initial complaints by ethnicity, as displayed in Table 3, shows relative consistency in the complaints by category over the last four years. It seems to be the case that Asian or Asian British ethnic minorities are overrepresented

in terms of complaints made against them. It is not know how many of those individuals classified as Asian or another ethnic minority by the GMC data-set, come from overseas. 2001 census data shows that 7.9% of the United Kingdom population belong to an ethnic minority and that the Asian or Asian British category accounts for 4% of the population as well as 50% of all ethnic minorities (Office of National Statistics 2001). The available data reinforces the need for a doctor's ethnicity to be as far as possible recorded when a complaint is received as currently 'unspecified' remains a major response category. This may be expected somewhat given that it is not always possible for a complainant to know a doctors ethnicity. But it would nevertheless be expected that the 'unspecified' category would decline if the GMC were to adopt a more proactive (and possibly more retrospective) stance on the recording of ethnicity data in relation to initial complaints received. Although perhaps an unavoidable factor at play here may well be, as will be discussed in more detail shortly, that the majority of complaints do not make it past the initial triage stage as this obviously complicates the retrospective collection of ethnicity data in relation to initial complaints received.

Table 3: Breakdown of complaints received by Ethnicity

Ethnicity	2006	2007	2008	2009
Asian or Asian British	18%	17%	18%	19%
Black or Black British	3%	3%	3%	4%
Mixed	1%	1%	2%	1%
Not Stated	0%	0%	0%	0%
Other Ethnic Groups	3%	3%	3%	3%
Unspecified	29%	29%	26%	27%
White	46%	47%	48%	45%

The breakdown of complaints by a medical practitioner’s gender can be found in Table 4. It was possible to extract from GMC documents available online data pertaining to complaints against male and female doctors for 2002 onwards. However it was not possible to obtain data for the 2005 year. Similar to ethnicity, reliable data has only become available relatively recently due to the recent review and computerization of GMC records. The available data suggests that complaints are more likely to be made about male doctors than female doctors, although it does appear to be the case that complaints against female doctors rose slightly over the last four years. The greater emphasis on male doctors may well reflect the fact that the medical workforce has traditionally been male dominated and that the GMC caseload mix includes breaches of fitness to practice which are perhaps more commonly associated with male rather than female risk-taking behaviour i.e. improper sexual relationships with patients, criminal activity and substance/alcohol abuse (Stacey 1992, 2000). The proportion of female doctors in the profession has risen significantly in the last decade, with projections suggesting that by 2017 the majority of doctors will be female, which may help explain the slight proportionate rise in complaints against female doctors (Winyard 2009). The data in Table 4 could be used as a baseline from which to comparatively analyse changes (if any) in complaints received by the GMC in relation to gender as the makeup of the medical workforce changes.

Table 4: Breakdown of complaints received by Gender

Gender	2002	2003	2004	2005	2006	2007	2008	2009
Male	83%	82%	81%	Unknown	79%	81%	78%	77%
Female	17%	18%	19%	Unknown	21%	19%	22%	23%

Having looked at the number of complaints made, it is now necessary to look at the figures relating to the progression of cases from the investigation and adjudication stages. It was impossible to identify with certainty comparative figures

prior to 2006. The reports available online via the GMC website which contain complaint data for between 2000 and 2005 suffer from the complication that the process by which the GMC handles complaints changed during this period as part of reforms introduced in light of the Shipman case (Chamberlain 2010b). Until 2004 the GMC's fitness to practice procedures were governed by separate legislation involving different committees concerned with three aspects of a doctors fitness to practice: Health, Conduct and Performance. The available figures for the operation of each committee make it difficult to identify with certainty data pertaining to case outcomes, not least of all because there was some natural overlap with the handling of cases by each committee. It should also be noted that some reports (for example for the 2004 year) only break down the data for part of the year (in the case of the 2004 report for between January and October 2004) making it impossible to compare data year on year. Nevertheless the available data for between 2006 and 2009 does reveal some interesting trends concerning the GMC handling of complaints.

Table 5 displays what happened after each complaint was received by the GMC. In pure numerical terms the data shows that more warnings and rehabilitative undertakings occurred in 2008 and 2009 than in previous years, as well as that more cases are being referred for adjudication than previously. For year on year comparative analysis purposes the data has also been broken down into the relative percentages for each action category based on the total number of complaints received during a year. This reveals some important consistencies in the GMC handling of complaints received and subsequent actions undertaken, in spite differences in the number of complaints received each year. Table 5 shows that the majority of complaints are closed with no further action either at the initial triage stage (between 68% and 71% of complaints received over the 4 year period) or after the initial

investigation has been completed (between 85% and 90% of all complaints received over the four year period). When disciplinary action is taken at this stage the doctor in question either agreed to rehabilitative undertakings (between 1% and 2% over the four year period) or has been issued with a written warning (between 3% and 5% over the four year period). Importantly then, although more complaints were referred for adjudication via a fitness to practice panel in 2009 than 2006, proportionally speaking only a relatively small percentage of complaints made it past the investigative stage (minimum 10% in 2007 and maximum 15% in 2008 over the four year period between 2006 and 2009). Finally, as already noted, in 2009 the GMC received complaints concerning 2% of all doctors on the medical register (n= 231,425) and Table 5 shows that 0.14% of all doctors on the medical register were referred to a fitness to practice panel for adjudication during that year (n= 319).

Table 5: Breakdown of GMC response to complaints received

	2006		2007		2008		2009	
	Number	%	Number	%	Number	%	Number	%
Complaints Received	2788	100%	4118	100%	4166	100%	4722	100%
Concluded at Triage	1970	71%	2953	71%	2872	69%	3226	68%
Concluded at Investigation	472	17%	769	19%	658	16%	870	18%
Concluded (Both)	-	(88%)	-	(90%)	-	(85%)	-	(86%)
Warning Issued	86	3%	159	4%	168	4%	212	5%
Undertakings Agreed	44	1%	40	1%	109	2%	95	2%
Referred for Adjudication	216	8%	196	5%	359	9%	319	7%

Having identified how complaints are handled by the GMC at the initial investigative stage, it is now necessary to detail the outcomes of cases heard at the adjudication stage by a fitness to practice panel. Table 6 details the outcomes of fitness to practice panel hearings for between 2006 and 2009. For year on year

comparative purposes the data has been broken down into relative percentages for each action category based on the total number of cases heard per year (the total number of cases referred is also included for information purposes). This reveals less year on year consistency in the types of action taken at the adjudication stage than at the investigative stage. But it also reinforces that at the adjudication stage the hearing of complaints is more likely to result in high impact decisions, such as conditions being placed on a doctors practice (between 15% and 21% over the four year period), suspension from the medical register (between 29% and 37% over the four year period), or erasure from the medical register (between 17% and 25% over the four year period). Relatively few doctors receive undertakings or warnings at adjudication stage: it seems that the most common outcome of the adjudication stage is either a high impact decision or the decision that there was no impairment in a doctors' practice. There also appears in the last four years to have been an increase in the relative proportion of doctor's being erased from the medical register as well as a decline in the decision that there was no impairment in a doctor's practice. Nevertheless, it does not seem that the shift to a civil standard of evidential proof has resulted in an immediate and significant increase in doctor's being erased from the medical register, as was feared it would by some quarters of the profession (Chamberlain 2010a). Finally, taken together Tables 5 and 6 show that 0.14% of doctors on the medical register (n=231,425) were referred to a fitness to practice panel for adjudication in 2009 (n= 319) and 0.03% (n= 68) were erased from the medical register.

Table 6: Breakdown of GMC fitness to practice committee activity

	2006		2007		2008		2009	
Cases referred for Adjudication	216	n/a	196	n/a	359	n/a	319	n/a
Cases heard	221	100%	257	100%	204	100%	270	100%
Impairment – no action	8	4%	13	5%	4	2%	4	1%
No Impairment – no action	47	21%	36	14%	28	14%	44	16%
Voluntary Erasure	3	1%	2	1%	0	0%	3	1%
Undertakings	4	2%	4	2%	3	1%	3	1%
Reprimand	1	1%	1	1%	0	0%	1	1%
Warning	14	6%	8	3%	22	11%	22	8%
Conditions	38	17%	55	21%	30	15%	48	18%
Suspension	69	31%	78	30%	75	37%	77	29%
Erasure	37	17%	60	23%	42	20%	68	25%

Discussion

The data outlined highlights several key trends in the complaints received by the GMC and the types of action which subsequently occur. In summary, the number of complaints has tripled since the mid-1990s, although it should be noted that the number of complaints remains low i.e. in 2009 the GMC received 4722 complaints which represents 2% of all doctors on the medical register (n= 231,425) and 0.03% were erased from the medical register in that year (n= 68). The GMC receives more complaints from members of the public than from other sources (although this seems to be rising) as well as more complaints about male doctors than female doctors. This may well be a reflection of the fact that the GMC caseload mix includes breaches of fitness to practice more commonly associated with male than female risk-taking behaviour i.e. improper sexual relationships with patients, criminal activity and substance/alcohol abuse (Stacey 1992, 2000). Although the majority of complaints are made against white doctors, it seems that Asian or Asian British doctors are over represented in terms of initial complaints received. But this finding must be treated with extreme caution, as the breakdown of ethnicity data for initial complaints is

incomplete, while published research shows that doctors from an ethnic minority are not more likely to be subject to a high impact decision, but it seems doctors who qualified overseas are (Allen 2000, Humphreys et al 2008). This said, it clearly is important that this issue be explored further at both a NHS and GMC complaint level.

Although the numbers remain relatively small in terms of total complaints made there can be no doubt that the data discussed reveals that more doctors are being subject to rehabilitative and disciplinary action by the GMC than previously. Importantly, however, it also illustrates that the shift toward a civil standard of proof does not seem to have had an immediate large-scale impact on GMC fitness or practice activity i.e. significantly more doctors have not been struck off the medical register. But it does seem that more cases have been referred to the adjudication panel in the last two years than previously. Yet it is perhaps too early to tell if the shift in the level of evidence required to meet the realistic prospective test will result in more complaints passing from the investigative to adjudication stage and more doctors being either struck off the medical register or subject to some form of disciplinary or rehabilitative action. The data presented in this paper is, consequently, an important starting point from which future trends in GMC activity can be tracked by interested parties as the impact of recent changes in medical governance in the UK take hold.

In addition to their long-term research value, the data has more immediate consequences for the contemporary study of medical regulation. Firstly, it arguably provides empirical evidence for the view that the operational culture of the GMC is indeed changing. In the past the GMC has been accused of being self-serving, biased in favour of doctors, failing to protect patients, being overly-secretive, as well as acting through expediency rather than principle (Chamberlain 2010a). Dame Janet Smith in her review as part of her analysis of the Shipman case was particularly

critical of the GMC and how it handles complaints (Smith 2005). Yet the growing emphasis being placed on taking rehabilitative or punitive action against doctors could be interpreted as providing evidence that an organizational and cultural shift toward a more risk-averse regulatory model as the GMC acts to regain public trust in its decision making processes (Allsop 2006). Whether this state of affairs best serves the long-term interests of the regulatory state, the public, or the medical profession itself, is a subject for ongoing analysis and debate.

Secondly, and taking this point further, an important consequence of this shift toward risk-averse forms of medical governance perhaps comes most clearly to the foreground when the GMC's administratively robust approach toward the handling of complaints is considered. Risk-based regulation relies heavily on seemingly objective decision-making processes where codified forms of knowledge are used to prescribe best-evidenced judgemental norms surrounding what constitutes appropriate action in a given situation (Llyod-Bostock and Hutter 2008). The relatively consistent administrative approach adopted by the GMC toward the handling of complaints in terms of the disposal pathway by which cases typically progress, as illustrated in Tables 5 and 6, could be said to be demonstrative of a growing organizational reliance on codified risk-averse procedural rules to assist in the day-to-day processing of complaints. There is a very real danger here that this may over time undermine the value placed on the tacit dimensions of professional expertise within the broader professional community as rank and file practitioners in particular become ever more wary of the GMC and its associated bureaucratic machinery. The concept of defensive medical practice, which was discussed earlier in this paper, provides an illustrative example of how the reliance on codified and routinized frameworks to guide action within health care systems can alter the behaviour of the wider

professional community in unforeseen ways as practitioners seek to adjust to changing circumstance and avoid the possibility of punitive action being taken against them. There is a real danger that the growth of risk-averse medical regulation may bring with it unintended negative consequences for patient care. Consequently targeted research into the impact of GMC reform on practitioner behaviour in everyday clinical decision-making situations is needed if we are to more fully examine the impact of the current regulatory reform agenda on professional practice.

This brings us to our third and final point. This is concerned with recent developments regarding the role of the GMC in the hearing of complaints. The 2008 Health and Social Care Act established the Office of Health Professions Adjudicator (OHPA) to take over the role of the GMC in the adjudication of fitness to practice cases. The stated aim of this change was to enhance impartiality and the independence of the fitness to practice hearing process within the Health Care Professions (Department of Health 2009). OHPA became a legal entity in January 2010. But in the summer of 2010 the UK government concluded that it was not persuaded of the need to introduce another regulatory body to take over the role of adjudicator in fitness to practice cases (Department of Health 2010). In part this decision was made in light of the stringent economic realities faced by public services in the UK as the state seeks to deal with the fall out of the recent global financial crisis. But it is also a reflection of the extent to which medical elites have successfully managed to subject rank and file practitioners to greater peer surveillance and control under the ever watchful gaze of the regulatory state and its managerial imperatives (Chamberlain 2009b). Yet it is arguable that the fact that a significant number of complaints do not make it past the initial triage and investigative stages raises legitimate questions about the GMC's gatekeeper role at each point in the decision making and follow up

process. The issue here is not a lack of action being taken against a doctor. Rather it is the lack of rigorous, ongoing and publicly accountable third-party surveillance and appraisal of the reasons for a lack of action. Not least of all because the little independent research into the GMC handling of complaints which exists has in the past revealed the presence of judgemental bias (i.e. Allen 2000, Smith 2005). A recent small scale independent review of a sample of GMC complaints found that *“articulate individuals who present their complaints clearly and in detail are more likely to have their cases taken up by the GMC”* (Hughes et al 2007:15). Similarly, although generally supportive of the GMC, the Council for Health Care Regulatory Excellence has stated in light of their recent audit of GMC operations that *“we consider that it [The GMC] needs to ensure that its decision makers have fully understood all the complainant’s concerns, and that complainants feel that they are encouraged to submit a complaint”* (Council for Health Care Regulatory Excellence 2010b:28). Bearing this in mind it is arguable that the data presented in this paper reinforces the need for further independent research into the GMC case management and hearing process to ensure recent reforms do not serve to underplay the legitimacy and value of the patient experience and perspective in all its multi-dimensional forms (Mulcahy 2003, Nettleton 2006). Such a research agenda should be undertaken in tandem with research into the practitioner experience of GMC reform to ensure a rounded picture is obtained of the impact of the shift toward risk-averse models of medical regulation.

Conclusion

The evidence discussed in this paper lends weight to the argument that the emergence of risk-averse medical regulation has led to the GMC taking a harder stance toward patient complaints. The governmental focus of the regulatory state for now has moved to ensuring that GMC reform continues to enforce a shift toward a rigorous and fair complaint and fitness to practice adjudication process. Possible options currently voiced for consultation include a greater focus on the use of rehabilitative measures within the complaints system when concerns about a doctor's clinical performance exist, alongside the development of a more streamlined 'in house' tribunal system, headed by an independent president, who would be responsible for overseeing fitness to practice cases separately from the complaint receipt and management process, the handling of which would be retained at a day to day level by the GMC (Department of Health 2010). Yet only time will tell what the next steps in the reform of the regulation of doctors in the UK will be. But one thing is certain. The balance of power and control has not shifted away from doctors and towards patients. Rather it is shifting toward specialist groups, some of whom operate inside the medical profession and some of whom operate outside of it, who although they may disagree on many things nevertheless share in common the belief that risk-averse systems of surveillance and control are the best way forward in ensuring rigour, transparency and accountability in medical regulation.

Footnotes

(1) The GMC is one of a number of bodies which deal with complaints against medical practitioners. NHS Hospital Trusts, Primary Care Trusts; alongside the National Clinical Assessment Service, the Healthcare Commission and the

Parliamentary and Health Service Ombudsman, are all important points of contact for dealing with medical malpractice and patient complaints. But the GMC remains the only body able to remove a doctor from the medical register and therefore stop them from practising medicine in the UK (Stacey 2000).

(2) Undertakings are an enforceable agreement between the GMC and a doctor. Their duration can last for a maximum period of three years. They might include restrictions on a doctor's future practice or behaviour, as well as the requirement that they commit to having medical supervision or re-training. All undertakings are regularly reviewed by the GMC, operating in liaison with a doctor's employer as well as postgraduate and specialist medical training providers (i.e. the royal colleges). In comparison, a warning occurs when there is a significant concern about a doctors' practice, but imposing restrictions on their practice is not held to be necessary.

(3) Contact was made with the GMC requesting under the Freedom of Information Act (2000) the release of data pertaining to complaints it received against doctors between 1990 and 2009. 2010 was excluded as yearly figures would not at the time of request be available. These dates were selected as they cover a period of time when the principle of professional self-regulation came under increased scrutiny and the GMC underwent significant internal reform. The request asked that the GMC to breakdown by gender and race how cases proceeded through the complaints process as it was felt these variables may yield interesting findings in relation to identifying possible trends in the data. The GMC provided the requested information on the hearing of fitness to practice cases for between 2006 and 2009. It was stated that the GMC have only held fully computerised record systems since 2006 and that the

resources which would need to be allocated to review the paper files to obtain the data requested would exceed the appropriate limit of costs incurred. This has been set at £450 for public authorities under the Freedom of Information (Fees and Appropriate Limit) Regulations (2004). The GMC noted it was possible to obtain some more limited data on the hearing of fitness to practice cases for the years 1999 to 2005 from documents published via the GMC website (see GMC, 2000, 2001, 2002, 2003b, 2004c, 2010).

References

- Allen, I (2000) *The Handling of Complaints by the GMC: A Study of Decision Making and Outcomes* London: Policy Studies Institute
- Allsop, J. (2006) *Regaining Trust in Medicine: Professional and State Strategies* *Current Sociology* 54 (4): 621-36
- Ahmad, W.I.U. and Harrison, S. (2000) *Medical Autonomy and the UK State: 1975 to 2025* *Sociology* (34) 1: 129-46
- Davies, C. (2004) *Regulating the Health Care Workforce: Next Steps for Research*, *Journal of Health Services Research and Policy* 9 (Supplement 1): 55 - 61
- Dyer, C (2010a) *GMC strikes off GP who arranged later abortion for her daughter* *BMJ* 340: 762
- Dyer, C (2010b) *Cardiologist let his ambition interfere with patients best interests, GMC is told* *BMJ* 340: 3510
- Dyer, C (2010c) *Surgeon found guilty of dishonesty is suspended for six months* *BMJ* 341: 1136

Chamberlain, J.M. (2009a) The Changing Medical Regulatory Context: Focusing upon Doctor's Educational Practices *Medical Sociology* 4 (2): 26 – 34 (Available online: <http://www.medicalsociologyonline.org/>)

Chamberlain, J.M. (2009b) Portfolio-based Appraisal: Superficial or Useful? *British Journal of Hospital Medicine* 70 (11): 176 – 177

Chamberlain, J.M. (2010a) Doctoring Medical Governance: Medical Self-Regulation in Transition New York: Nova Science Publishers

Chamberlain, J.M. (2010b) Performance Appraisal for Doctors: A Case of Paperwork Compliance *Sociological Research Online* 15 (1): 1 – 11 (Available online: <http://www.socresonline.org.uk/15/1/8.html>)

Council for Healthcare Regulatory Excellence (2005) Statistical Summary London: Council for Healthcare Regulatory Excellence

Council for Healthcare Regulatory Excellence (2006) Statistical Summary London: Council for Healthcare Regulatory Excellence

Council for Healthcare Regulatory Excellence (2007) Statistical Summary London: Council for Healthcare Regulatory Excellence

Council for Healthcare Regulatory Excellence (2008) Statistical Summary London: Council for Healthcare Regulatory Excellence

Council for Healthcare Regulatory Excellence (2009) Statistical Summary London: Council for Healthcare Regulatory Excellence

Council for Healthcare Regulatory Excellence (2010a) Statistical Summary London: Council for Healthcare Regulatory Excellence

Council for Health Care Regulatory Excellence (2010b) Fitness to Practise Audit Report: Audit of Health Professional Regulatory Bodies' Initial Decisions London: Council for Health Care Regulatory Excellence

- De Rez, P. (2002) Self-Regulation and Paragons of Virtue: The Case of Fitness to Practice *Modern Law Review* 10: 28 - 56
- Department of Health (2009) Health Care Regulation: Tackling Concerns Nationally
London: Department of Health
- Department of Health (2010) Fitness to Practice Adjudication for Health Professionals
London: Department of Health
- Dyer, C (2010a) GMC strikes off GP who arranged later abortion for her daughter
BMJ 340: 762
- Dyer, C (2010b) Cardiologist let his ambition interfere with patients best interests,
GMC is told BMJ 340: 3510
- Dyer, C (2010c) Surgeon found guilty of dishonesty is suspended for six months BMJ
341: 1136
- Etheridge, L, Sturrock, A, Conlon L and Dacre, J (2009) GMC Tests of Competence:
the assessment of poorly performing doctors *Clinical Risk* 15: 15-17
- Hughes J, Locke R, Humphrey C. (2007) An Independent Audit of Decisions in the
Investigation Stage of the GMC's Fitness to Practise process. London: King's College
London
- Humphrey, C, Gulliford, M, Esmail A and Cohen, D (2009). Clarifying the Factors
Associated with Progression of Cases in the GMC's Fitness to Practise procedures:
Full Research Report, ESRC End of Award Report, RES-153-25-0101. Swindon:
ESRC
- Fournier, V. (1999) The Appeal to 'Professionalism' as a Disciplinary Mechanism.
The Sociological Review 47: 280–307
- Friedson, E. (2001) Professionalism: The Third Logic Cambridge: Polity Press
- GMC (2000) Fitness to Practice Annual Statistics London: GMC

- GMC (2001) *Fitness to Practice Annual Statistics* London: GMC
- GMC (2002) *Fitness to Practice Annual Statistics* London: GMC
- GMC (2003a) *Stakeholder Research: Executive Summary* London: GMC
- GMC (2003b) *Fitness to Practice Annual Statistics* London: GMC
- GMC (2004a) *Guidance on GMC's Fitness to Practise Rules* London: GMC
- GMC (2004b) *Annual Review* London: GMC
- GMC (2004c) *Fitness to Practice Annual Statistics* London: GMC
- GMC (2009) *Good Medical Practice* London: GMC
- GMC (2010) *Fitness to Practice: Annual Statistics* London: GMC
- Irvine, D. (2003) *The Doctors Tale: Professionalism and the Public Trust* London: Radcliffe Medical Press
- Irvine, D. (2006) Success Depends Upon Winning Hearts and Minds *BMJ* 333: 965-6
- Lloyd-Bostock, S and Hutter, B (2008) Reforming Regulation of the Medical Profession: The Risks of Risk Based Approaches *Health, Risk and Society* (10) 1: 69-83
- Mulcahy, L (2003) *Disputing Doctors: The Socio-Legal Dynamics of Complaints about Medical Care* Maidenhead: Open University Press
- Nettleton, S (2006) *The Sociology of Health and Illness* London: Polity Press
- Office of National Statistics (2001) UK Population Ethnicity Data. Available at http://www.statistics.gov.uk/census2001/access_results.asp
- Rose, N. (2000) *Powers of Freedom: Reframing Political Thought*, Cambridge: Cambridge University Press
- Stacey, M. (1992) *Regulating British Medicine* London: John Wiley and Sons
- Stacey, M. (2000) The General Medical Council and Professional Self-Regulation, in

Gladstone, D. (2000, editor) *Regulating Doctors* London: Institute for the Study of Civil Society

Smith, J. (2005) *Shipman: Final Report* London: Department of Health

Summerton, N (1995) Positive and negative factors in defensive medicine: a questionnaire study of general practitioners *BMJ* 310: 27 - 28

West P, Bending M, Chaplin S. (2006) *A Descriptive Analysis of Fitness to Practise Data for 2005 Complaints*. University of York: York Health Economics Consortium

Winyard, G. (2009) The Future of Female Doctors *BMJ* 338: 2223 – 2224