The IMPACT study – how complaints impact on the welfare and practice of doctors

Department of Primary Care and Public Health Lunchtime Seminar

Tom Bourne
Imperial College London and KU Leuven
“DEATH BY A 1000 ARROWS”
Serial or parallel processes
Complaints and disciplinary procedures in New Zealand
"No matter the fact I was not found guilty, if my kids go on Google, put my name in, they will find headlines in papers from Spain, Portugal, Poland, Japan, China.... all round the world," he said.
GP trainee died by suicide after fearing GMC suspension

25 November 2015  | By Jaimie Kaffash

“His kindness and radiance left an impression upon so many including colleagues and patients, both young and old, in his journey to becoming a well-respected doctor.

“We are so proud of him with what he achieved and who he was. A massive void has been left and a beautiful person has been lost.”

“It was after his death we found out he had been awarded Trainee GP of the Year 2015. I had correspondence with his medical supervisor who said he was an outstanding doctor and very well loved.”
Doctors avoiding risky operations due to prosecution threat, survey finds

Patients at risk of being denied life-saving treatments by physicians adopting a defensive style of medicine to avoid legal action

Haroon Siddique
Saturday 30 January 2016
06.59 GMT

Save for later

The poll found that 86% of physicians were practising ‘defensive’ medicine, while 48% said the threat of legal action was deterring them from high-risk patients. Photograph: RGB Ventures / SuperStock / Alamy/Alamy
### Referrals to the GMC:

- Increasing numbers
- Incredibly non-specific

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

*a very blunt instrument*
In England 2013-2014

175,000 formal written complaints
(3300/week or 479/day)

Professor Terence Stephenson recently predicted that most doctors will face a GMC complaint at some point in their career.
What about all doctors and all complaints processes?

• What about the health of doctors who do not commit suicide?
• Does this “complaints culture” alter how doctor’s practice?
• Does it lead to better care and protect patients?
• Doctors can be subject to: internal investigations (formally and informal), an SUI, or be reported by anyone even to the GMC
• These may be parallel or sequential events
The impact of complaints procedures on the welfare, health and clinical practise of 7926 doctors in the UK: a cross-sectional survey

Tom Bourne, Laure Wynants, Mike Peters, Chantal Van Audenhove, Dirk Timmerman, Ben Van Calster, Maria Jalmbrant

IMPACT study – all types of complaint

• What is the impact of complaints and investigations on the psychological and physical welfare of doctors?

• How do complaints impact on how doctors treat patients. Do they lead to defensive practice or improve care

• What is the impact by complaint type: informal, formal, serious clinical incident review (SUI), regulator (GMC)
IMPACT study: participants

- 95,600 invites – 10,930 responses (11.4%)
- 7,900 completed the survey (8.3%)
- The sample was broadly representative of all UK doctors in terms of gender, specialty, and place of qualification.
IMPACT study: design

Three groups depending on when complaint occurred:

• Ongoing or recent complaint (within last 6 months)

• Past complaint, looked at physical and mental health at the time - recall

• No complaint – but had observed processes in others
Used Validated Instruments

• **ANXIETY**: Generalised Anxiety Disorder scale-GAD

• **DEPRESSION**: Patient Health Questionnaire-PHQ

• **DEFENSIVE PRACTICE** - New scale measuring two factors:
  – **HEDGING**
    – including over referral/prescribing/investigating/admitting to hospital when unnecessary
  – **AVOIDANCE**
    – including not performing high-risk procedures, stopping certain activities e.g. surgery, avoiding complex patients, abandoning procedures early

**SINGLE ITEM QUESTIONS:**
– Stress related illness
– Suicidal ideation
– Attitude to complaints

• Participants were guaranteed that their responses were anonymous and untraceable
Results – depression, anxiety, suicidal ideation “current feelings”

<table>
<thead>
<tr>
<th>PHQ-9 &amp; GAD-7</th>
<th>No complaint n=1780 (22.5%)</th>
<th>Past complaint n=3889 (49.1%)</th>
<th>Recent/current complaint n=2257 (28.5%)</th>
<th>Total n=7926 (100%)</th>
<th>Relative risk for past complaint group/mean difference (95% CI)</th>
<th>Relative risk for recent complaint group/mean difference (95% CI)</th>
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</thead>
<tbody>
<tr>
<td><strong>Depression (PHQ-9)</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>3.7 (4.3)</td>
<td>3.4 (4.2)</td>
<td>5.1 (5.6)</td>
<td>3.9 (4.7)</td>
<td>-0.3 (-0.6, -0.0)</td>
<td>1.4 (1.1, 1.7)</td>
</tr>
<tr>
<td>Moderate to severe depression n (%)</td>
<td>169 (9.5%)</td>
<td>303 (7.8%)</td>
<td><strong>381 (16.9%)</strong></td>
<td>852 (10.8%)</td>
<td>0.81 (0.65, 1.01)</td>
<td>1.77 (1.48, 2.13)</td>
</tr>
<tr>
<td>Thoughts of ‘self-harm’ n (%)</td>
<td>83 (4.7%)</td>
<td>221 (5.7%)</td>
<td><strong>218 (9.7%)</strong></td>
<td>522 (6.6%)</td>
<td>1.22 (0.93, 1.61)</td>
<td>2.08 (1.61, 2.68)</td>
</tr>
<tr>
<td><strong>Anxiety (GAD-7)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>3.1 (3.8)</td>
<td>3.0 (3.8)</td>
<td><strong>4.5 (4.9)</strong></td>
<td>3.5 (4.2)</td>
<td>-0.1 (-0.4, 0.2)</td>
<td>1.4 (1.1, 1.7)</td>
</tr>
<tr>
<td>Moderate to severe anxiety n (%)</td>
<td>131 (7.3%)</td>
<td>234 (6.0%)</td>
<td><strong>338 (15.0%)</strong></td>
<td>703 (8.9%)</td>
<td>0.80 (0.57, 1.13)</td>
<td>2.08 (1.61, 2.68)</td>
</tr>
</tbody>
</table>
Results – recalling how they felt (past) and how they feel (current)

<table>
<thead>
<tr>
<th>Condition</th>
<th>No complaint</th>
<th>Recent or current complaint</th>
<th>Past complaint</th>
<th>RR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=1780 (22.5%)</td>
<td>n=2257 (28.5%)</td>
<td>n=3889 (49.1%)</td>
<td></td>
</tr>
<tr>
<td>Cardio-vascular problems (e.g. high blood pressure, angina, heart attack)</td>
<td>124 (7.0%)</td>
<td>280 (12.4%)</td>
<td>405 (10.4%)</td>
<td>1.78 (1.44-2.20)</td>
</tr>
<tr>
<td>Gastro-intestinal problems (e.g. gastritis, IBS, ulcers)</td>
<td>217 (12.2%)</td>
<td>426 (18.9%)</td>
<td>934 (24.0%)</td>
<td>1.55 (1.32-1.82)</td>
</tr>
<tr>
<td>Depression</td>
<td>187 (10.5%)</td>
<td>490 (21.7%)</td>
<td>1148 (29.5%)</td>
<td>2.07 (1.74-2.45)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>476 (26.7%)</td>
<td>1108 (49.1%)</td>
<td>3045 (78.3%)</td>
<td>1.84 (1.65-2.04)</td>
</tr>
<tr>
<td>Anger and irritability</td>
<td>358 (20.1%)</td>
<td>928 (41.1%)</td>
<td>2406 (61.9%)</td>
<td>2.04 (1.77-2.35)</td>
</tr>
<tr>
<td>Other mental health problems</td>
<td>12 (0.7%)</td>
<td>54 (2.4%)</td>
<td>256 (6.6%)</td>
<td>3.45 (1.80-6.60)</td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>44 (2.5%)</td>
<td>211 (9.3%)</td>
<td>519 (13.4%)</td>
<td>3.78 (2.68-5.32)</td>
</tr>
<tr>
<td>Sleep problems / insomnia</td>
<td>479 (26.9%)</td>
<td>1137 (50.4%)</td>
<td>288 (74.1%)</td>
<td>1.87 (1.67-2.10)</td>
</tr>
<tr>
<td>Relationship problems</td>
<td>187 (10.5%)</td>
<td>458 (20.3%)</td>
<td>911 (23.4%)</td>
<td>1.94 (1.63-2.30)</td>
</tr>
<tr>
<td>Frequent headaches</td>
<td>242 (13.6%)</td>
<td>432 (19.2%)</td>
<td>1027 (26.4%)</td>
<td>1.41 (1.19-1.65)</td>
</tr>
<tr>
<td>Minor colds</td>
<td>492 (27.6%)</td>
<td>509 (22.5%)</td>
<td>5447 (14.0%)</td>
<td>0.82 (0.73-0.92)</td>
</tr>
<tr>
<td>Recurring respiratory infections</td>
<td>77 (4.3%)</td>
<td>143 (6.3%)</td>
<td>306 (7.9%)</td>
<td>1.47 (1.11-1.95)</td>
</tr>
</tbody>
</table>
## Definitions of depression

Persistent sadness or low mood and/or loss of interests or pleasure
Fatigue or low energy

At least one of these, most days, most of the time for at least 2 weeks

- disturbed sleep
- poor concentration or indecisiveness
- low self-confidence
- poor or increased appetite
- suicidal thoughts or acts
- agitation or slowing of movements
- guilt or self-blame

- **Moderate:** 5 to 6 symptoms
- **Severe:** 7 or more with or without psychosis

- Assessed using the Patient Health Questionnaire-PHQ
### Results by complaint process (current)

<table>
<thead>
<tr>
<th></th>
<th>Informal complaint n=362 (16.0%)</th>
<th>Formal Complaint n=1196 (53.0%)</th>
<th>SUI n=280 (12.4%)</th>
<th>GMC referral n=374 (16.6%)</th>
<th>No complaint n=1780 (22.5%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression (PHQ-9)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>4.2 (5.0)</td>
<td>4.8 (5.4)</td>
<td>5.1 (5.6)</td>
<td>6.6 (6.7)</td>
<td>3.7 (4.3)</td>
</tr>
<tr>
<td>Moderate to severe</td>
<td>45 (12.0%)</td>
<td>190 (15.6%)</td>
<td>46 (16.1%)</td>
<td>100 (26.3%)</td>
<td>169 (9.5%)</td>
</tr>
<tr>
<td>depression n (%)</td>
<td>(6.4%)</td>
<td>(9.0%)</td>
<td>(9.3%)</td>
<td>(15.3%)</td>
<td>(4.7%)</td>
</tr>
<tr>
<td>Thoughts of ‘self-harm’</td>
<td>24 (6.4%)</td>
<td>110 (9.0%)</td>
<td>27 (9.3%)</td>
<td>58 (15.3%)</td>
<td>83 (4.7%)</td>
</tr>
<tr>
<td>n (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety (GAD-7)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD)</td>
<td>3.8 (4.3)</td>
<td>4.4 (4.7)</td>
<td>4.7 (5.1)</td>
<td>5.7 (5.7)</td>
<td>3.1 (3.8)</td>
</tr>
<tr>
<td>Moderate to severe</td>
<td>44 (12.0%)</td>
<td>165 (13.5%)</td>
<td>44 (15.3%)</td>
<td>85 (22.3%)</td>
<td>131 (7.3%)</td>
</tr>
<tr>
<td>anxiety n (%)</td>
<td>(13.5%)</td>
<td>(15.3%)</td>
<td>(15.3%)</td>
<td>(22.3%)</td>
<td>(7.3%)</td>
</tr>
</tbody>
</table>
• 20% felt victimised after whistle blowing

• 38% experienced bullying going through an investigative process

• 27% took one month or more off work following a complaint

It destroyed me. I had a profound & lasting depressive illness which I am still struggling with

I seriously considered suicide and fear I might well take it as an option in the future.

I felt completely humiliated and was having daily thoughts of suicide
Bear in mind:

• There was an 11.4% response rate (but 7926 doctors responded).

• It must also be remembered that doctors most traumatised by the complaints may be unable to take part in the survey – avoidance

• No complaints group had observed colleagues going through procedures

• Those no longer on the register (changed profession, erased, died) would not have been contacted
The Purpose of all this is to improve patient care and protect patients.

What we do - information for patients and the public

Our job is to protect you, the patient. All of our work is focused on helping make sure you receive good care from your doctor.

To achieve this, we are involved in every stage of a doctor’s career, from the moment they go to medical school to the moment they retire from practice.

Where is the evidence?
### How do doctors change how they treat patients?

<table>
<thead>
<tr>
<th>Because of your/other’s experiences with complaints, have you....</th>
<th>No complaint n=1780 (22.5%)</th>
<th>Past complaint n=3889 (49.1%)</th>
<th>Recent or current complaint n=2257 (28.5%)</th>
<th>Total n=7926 (100%)</th>
<th>Relative Risk for past complaint (95% CI)</th>
<th>Relative Risk for recent or current complaint (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changed the way of practicing medicine n (%)</td>
<td>1294 (72.7%)</td>
<td>3106 (79.9%)</td>
<td>1912 (84.7%)</td>
<td>6312 (79.6%)</td>
<td>1.10 (1.06,1.14)</td>
<td>1.17 (1.13,1.21)</td>
</tr>
<tr>
<td>Displayed hedging behaviour n (%)</td>
<td>1454 (81.7%)</td>
<td>3212 (82.6%)</td>
<td>1999 (88.6%)</td>
<td>6665 (84.1%)</td>
<td>1.01 (0.98,1.04)</td>
<td>1.08 (1.05,1.11)</td>
</tr>
<tr>
<td>Displayed avoiding behaviour n (%)</td>
<td>820 (46.1%)</td>
<td>1668 (42.9%)</td>
<td>1124 (49.8%)</td>
<td>3612 (45.6%)</td>
<td>0.93 (0.87,1.00)</td>
<td>1.08 (1.00,1.17)</td>
</tr>
<tr>
<td>Suggested invasive procedures against professional judgement n (%)</td>
<td>359 (20.2%)</td>
<td>902 (23.2%)</td>
<td>585 (25.9%)</td>
<td>1846 (23.3%)</td>
<td>1.15 (1.02,1.29)</td>
<td>1.29 (1.13,1.46)</td>
</tr>
<tr>
<td>Become more likely to abandon a procedure at an early stage n (%)</td>
<td>248 (14.0%)</td>
<td>515 (13.3%)</td>
<td>372 (16.5%)</td>
<td>1136 (14.3%)</td>
<td>0.95 (0.80,1.13)</td>
<td>1.18 (1.00,1.39)</td>
</tr>
<tr>
<td>Become less committed and worked strictly to job description n (%)</td>
<td>-</td>
<td>795 (20.5%)</td>
<td>613 (27.2%)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
The unintended consequence of medical regulation and complaints processes
Are there process issues in relation to investigations that influence response and behavior?
Are the views of doctors consistent with validated Instruments?
The whole experience was the worst time in my life even including being told that I had cancer. I felt victimised, isolated and that no one even bothered to listen to what I had to say. I had 3 young children and a single parent and frequently felt like harming myself. My children and I had no money so I struggled to pay bills and the mortgage. I felt on the poverty line.

I found it terrifying.

I felt very frightened and it felt out of control. This is the worst thing that has ever happened to me.

When the letter came I was on a weeks annual leave at home and almost took my own life.

It felt like it destroyed me as a person, not only in my working role. I have recovered to some extent but it will always scar me.
I felt I was raped by the system and completely let down. Every aspect of my life was turned over - and I teetered on the edge of financial meltdown.

If it was not for the support of some fantastic friends and very good independent legal advice I would probably have committed suicide at one point.

The result was I lost my job and was completely demoralized. I was off work for a year to recover. However it should never have come to that.

It has taken me years to get over the experience - and I have to still work hard not to feel angry and "live in the now"
As a result of the negative media coverage my son was physically assaulted by a class mate at university as he got academic scholarships and was told that his mother:

“got all the benefits that this country offered whilst in reality your f..king Mother is a f..king Killer of babies”

I also got my second episode of breast cancer during this period.
Complaint doctors face suicide risk

By PRESS ASSOCIATION

PUBLISHED: 02:08, 16 January 2015 | UPDATED: 02:09, 16 January 2015

'Defensive practice': Probing doctors over complaints puts patients at risk

Dr David Richmond, president of the Royal College of Obstetricians and

GMC investigations and complaints procedures have a serious impact on doctors’ health and risk harming patients, study suggests

Thu, 01/15/2015 -- Science News Desk
And as an extraordinary study published today shows, there are disturbing affects on doctors and patients from the rising number of complaints to the GMC and others.

In the biggest study of its kind in the UK, nearly 8,000 doctors were asked about their mental and physical health after a complaint.

They found that doctors with a recent or ongoing complaint had significantly higher rates of depression, anxiety and relationship problems, compared with those without a recent complaint.

But more worryingly, the paper shows a drift towards defensive medicine that could cause harm to patients. Doctors with a recent or ongoing complaint were significantly more likely to change their practise, displaying ‘hedging’ or avoiding behaviour.

Shockingly, nearly a quarter said they had suggested invasive procedures ‘against their professional judgment’.
Need to look at the “Open” Questions in a non-selective way

• Q1 “Try to summarise as best you can your experience of the complaints process and how it made you feel”

• Q2 “What were the most stressful aspects of the complaint?”

• Q3 “What would you improve in the complaints system?”
What did people say about their experiences?

The IMPACT study

82. (If relevant) Try to summarise as best you can your experience of the complaints process and how it made you feel.
What has to happen?

Recognise that fear is toxic to patient safety and physician health

• Recognize the need for change. There is no justification for doctors being made sick by poor processes
• Abandon blame as a tool
• Clinicians must be supported by clinicians – support your own colleagues – do not let them be isolated
• Supervisory and regulatory systems should be simple, clear and transparent – currently not fit for purpose
• Investigations must have fixed timescales
• There must be rapid resolution for vexatious complaints and consequences for vexatious or dysfunctional complaints by staff
• Those investigating complaints must be competent, up to date and fully understand process
THE FOLLOWING MATERIAL WILL NOT BE IN THE LECTURE BUT MAY BE OF INTEREST TO THE READER AND POINT THEM TO FURTHER READING
Doctors who commit suicide while under GMC fitness to practise investigation

Internal review

Paid by the GMC

Sarndrah Horsfall, Independent Consultant

14 December 2014

Reviewed 114 deaths whilst under UK regulators (GMC) investigation from 2005 to 2013
Review

Suicide whilst under GMC's fitness to practise investigation: Were those deaths preventable?

David Casey a, *, Kartina A. Choong b

a School of Medicine and Dentistry, University of Central Lancashire, Preston PR1 2HE, United Kingdom
b Lancashire Law School, University of Central Lancashire, Preston PR1 2HE, United Kingdom

allowed the GMC to place doctors in particularly stressful situations contributing to suicide without the coronial system sounding the alarm and reporting that the GMC's processes were not only contributing to deaths but also risking future deaths.
Recommendations for current GMC practice

1. GMC investigation process
The GMC needs to create an environment where doctors undergoing a fitness to practise investigation feel they are treated as ‘innocent until proven guilty’ – as with any judicial process. Investigations need to be conducted in a compassionate manner and as quickly and effectively as possible, taking into account legal constraints and the need to protect patients. Perhaps, inevitably, doctors undergoing the process feel that it can stigmatis e and often creates a culture of fear and discrimination.

- Clearly contrary to natural justice
- Doctors are guilty until proved innocent
- Process is not compassionate
- Protracted timescale
- Stigmatising
- Culture of fear and discrimination
The disciplined healthcare professional: a qualitative interview study on the impact of the disciplinary process and imposed measures in the Netherlands


Lise M Verhoef,¹ Jan-Willem Weenink,¹ Sjenny Winters,¹ Paul B M Robben,²,³ Gert P Westert,¹ Rudolf B Kool¹
Box 1 Psychological impact

Misery
“It’s a very negative experience and it’s annoying for the family as well. It gets you down and almost makes you depressed, although you get over it as well.”
“I had the impression that I had to pay [for my mistake]. It’s the impression I had from the moment I walked in [the disciplinary hearing], just by the way they treated me.”

Fear
“I was afraid afterwards (after the disciplinary hearing), because I had to walk outside and didn’t have the police guarding me. I was thinking about what that man (the complainant) would do. He was delusional and had developed paranoid delusions about his treatment. What was he going to do at the moment I walked outside alone?”
“I’m terribly afraid of white envelopes because the disciplinary boards’ letters are in a big A4 envelope that only has a postal code on it.”

Long-term impact
“I don’t relive being in front of the disciplinary board anymore. For about a year I would wake up every night at 3 AM and would start to explain what had happened.”

Interviewer: “Did you receive any support or assistance in the period after you were suspended, or would you have required any?”
Professional: “No. I certainly needed it, but I arranged it myself. I needed counselling.”
Interference with patient care
Professional: “We took one or two weeks leave from work at the start of the disciplinary case, so we could prepare in peace. It’s not good if you’re thinking about these things.”
Interviewer: “While you’re working…”
Professional: “You just can’t take care of people [while preparing for the disciplinary hearing], so that’s what we did. But you can’t continue taking leave forever so, eventually, we returned to work. And then it takes about half a year before the disciplinary hearing takes place. That is a very long time for the people involved.”

Colleagues and organisation
“Look, I spoke to someone who had experienced the same thing, a psychiatrist. And that’s wonderful because you both have that same powerless feeling; that feeling that you try so hard, work so hard and make an effort, and then you get this for some nonsense. That is encouraging.”
“Well, I have zero trust in my colleagues. If we experience another situation that I expect might go the same way, then I’ll be the first to knock on the door of journalists to give my own explanation to a media organisation of my choice, rather than giving information to people who only want a sensational front page.”

Defensive practice
“Yes, I’m constantly hedging.”
“But I did become afraid. I used to be carefree in my practice but that has been affected, and for that I blame the system.”
“Well, initially you start to distrust people. You begin to wonder whether each of your patients could be a potential complainant. That’s the response you have.”

Financial consequences
“It has cost me a lot of money to go to the disciplinary board with a lawyer.”
“The impact is, in the way I experience it, that I get clients that are referred to me or received a recommendation for me. And after they’ve visited me, they search the internet, and then immediately cancel their treatment.”
Box 3  Factors enhancing psychological and professional impact

Publication of measures

“The reprimand comes with an ad in the newspaper. I can only say, that’s just abusive. Your surname, given name, profession and place of residence are all listed in the newspaper after you’ve made a wrong diagnosis. I mean how many people with that name live in the same city. A criminal is only listed with his initials, and they have done something wrong on purpose.”

“Imagine that your daughter comes to you and says: ‘Dad, what’s this thing I read about you on the internet?’”

“Publishing the measure with both given name and surname is unnecessarily hurtful, and it creates a lot of anxiety among patients. It gives patients the feeling of being unsafe. Patients can’t assess the grounds for such a verdict.”

Media coverage

“One of my colleagues spoke to the press. When you see the part that was aired on television, the part that they took from it, you see him saying three things, but they’ve excluded everything else he explained. So it sounds as everything went completely wrong.”

“Patients can say whatever they want in the media, but a doctor can’t defend himself because when he does say something, he violates the law of confidentiality.”

Duration of the disciplinary process

“It’s terrible, and it goes on and on. The complete process lasted four years.”

“I didn’t agree with it [the disciplinary verdict] completely, but thought it won’t help anyone going through all of this again.”
Are our results an anomaly?

‘You feel you’ve been bad, not ill’: Sick doctors’ experiences of interactions with the General Medical Council

Samantha K Brooks,1 Lilliana Del Busso,2 Trudie Chalder,1 Samuel B Harvey,3 Stephani L Hatch,1 Matthew Hotopf,1 Ira Madan,4 Max Henderson1

Key messages

- Patients’ complaints against general practitioners are increasing
- Negative experiences of a complaint were shock, being out of control, depression, suicide, doubts about clinical competence, conflicts with family and colleagues, defensive practice, and a decision to leave general practice
- A minority of participants expressed immunity towards complaints and a small minority saw complaints as a learning experience

Conclusions: While participants recognised the need for a regulator, the processes employed by the GMC and the communication style used were often distressing, confusing and perceived to have impacted negatively on their mental health and ability to return to work.
Preventing, rather than treating, stress in doctors under investigation

Maria C Jalmbrant clinical psychologist

Provision of a support service for doctors is laudable, if both its funding and actions are independent of the GMC. However, the real issue is that there is simply no justification for doctors to be made sick by poor processes—whether by the GMC, hospital trusts, or others, particularly now that we have data that show the risks. The glib statement that such processes are “inevitably stressful” understates the impact of these processes on doctors and may lead to patient care being compromised through defensive practice and a distressed and demotivated workforce.
Francis Report - freedom to speak up

The incidence of feeling victimised following whistleblowing – 20% […] will be a concern to those trying to build a culture in the NHS where it is safe to speak out [...] Given the large numbers involved, our study supports the view that whistleblowing in the NHS is not a safe action, that bullying is not uncommon and that these problems are not isolated events.65

4.10 From the evidence, the following themes emerged: the need for culture change, improved handling of cases, measures to support good practice, particular measures for vulnerable groups and extending legal protection.

4.11 These are summarised below and described further, with proposals on how to address them, in chapters 5-9. In addition, the evidence we collected provided a useful steer on what good practice looks like. This has also been summarised in chapters 5-9.

Culture change (see chapter 5)

4.12 Culture was one of the issues most commonly referred to:
- organisations need to create the right culture. There was evidence from the research that some, but by no means all, organisations are beginning to change their culture, but there is a long way to go. There were references to the need for a ‘no blame’ culture, but others suggested a ‘just culture’. More needs to be done to spread good practice
- raising concerns needs to become the norm. It is not yet the case that everyone considers it the right thing to do and the safe thing to do too often cases turn into adversarial employment issues instead of focusing on the safety issue. This appears to be driven by one or more of a number of factors.
- the legal protection is embedded in employment law: this encourages cases to be seen as raising issues about individuals and not about safety and systems
- HR is often responsible for the policies and for the management of difficult cases where concerns are raised, not those in the organisation responsible for safety or service delivery
- there is sometimes a failure to distinguish between grievances and whistleblowing
- sometimes employers receive risk averse legal advice which recommends a cautious response instead of an open and honest conversation
- middle management is sometimes responsible for ‘containing’ issues rather than passing them up the chain
- a serious concern amongst employers is the perceived use of whistleblowing to deter or delay management of poor performance or poor attendance.
- there is confusion about the meaning of the term ‘whistleblowing’, and also what protection is provided by the law
- there is variation in the quality of policies and procedures for handling whistleblowing
- bullying is a problem in the NHS. It takes a number of forms and it needs to be regarded as a safety issue. Those who bully must be held to account
- visible leadership is a necessary part of changing the culture. It is also a valuable way to keep in touch with what is going on but it is not universal practice
- people who raise concerns do not generally feel valued for doing so
- initiatives to encourage reflective practice as a means of exploring how things could be done better, and sharing issues and lessons learned bring benefits but this resource is being squeezed.

65 The impact of complaints procedures on the welfare, health and clinical practice of junior doctors in the UK: a cross-sectional survey
Licorne T et al [BMJ Open 2015]
Principle 14

Accountability: Everyone should expect to be held accountable for adopting fair, honest and open behaviours and practices when raising or receiving and handling concerns. There should be personal and organisational accountability for:

• poor practice in relation to encouraging the raising of concerns and responding to them
• the victimisation of workers for making public interest disclosures
• raising false concerns in bad faith or for personal benefit
• acting with disrespect or other unreasonable behaviour when raising or responding to concerns
• inappropriate use of confidentiality clauses.
Medical error: the second victim

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The doctor who makes the mistake needs help too

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SURGEON ACQUITTAL IN FEMALE GENITAL MUTILATION CASE

Dharmasena case illustrates what is wrong with complaints procedures

Tom Bourne consultant gynaecologist, On behalf of Phillip Bennett, Shabnam Bobdiwala, Arri Coomarasamy, Sadaf Ghaem-Maghami, Sharmistha Guha, Andrew Horne, Karen Joash, Emma Kirk, Christoph Lees, Maya Al-Memar, Aris Papageorghiou, Nick Raine-Fenning, Shyamaly Sur, Dirk Timmerman, and Austin Ugwamadu

Dharmasena has been suspended from the medical register since he was charged. He has faced death threats since the public announcement of the prosecution, and still faces an investigation by the General Medical Council and possible disciplinary action.
Suicide in doctors while under fitness to practise investigation

GMC review contains wide ranging proposals

Keith Hawton *professor and director*

Centre for Suicide Research, Department of Psychiatry, University of Oxford, UK
Medical regulation, spectacular transparency and the blame business

Gerry McGivern and Michael Fischer

The Department of Management, King’s College London, London, UK

Findings
In the following section we describe three key themes emerging from our interviews:

Doctors feel:

(1) “guilty until proven innocent”;
(2) “spectacular transparency”, and;
(3) the “blame business”.