Rebecca Harris, Research Manager & Kate Slater, Associate Director
3 Pavilion Lane, Strines,
Stockport, Cheshire, SK6 7GH
+44 (0)1663 767 857
djsresearch.co.uk

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Analysis of cases resulting in doctors being erased or suspended from the medical register

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Executive summary

Background and methodology

As the independent regulator for doctors in the UK, one of the roles of the GMC is to ensure that only those medical practitioners who are fit to practise are registered, and to take action when this is in doubt. In 2014, 157 doctors were erased or suspended from the medical register.

This report provides an analysis of the type of cases that resulted in suspension or erasure from the medical register in 2014.

The analysis excludes temporary restrictions on practice resulting from Interim Order Panel decisions and cases where the panel was held in private, usually as a consequence of health-related issues. In total, 119 cases were included in the analysis.

All cases were reviewed qualitatively and information captured in a database. The GMC also provided additional data on the cases, which was merged into the database for analysis.

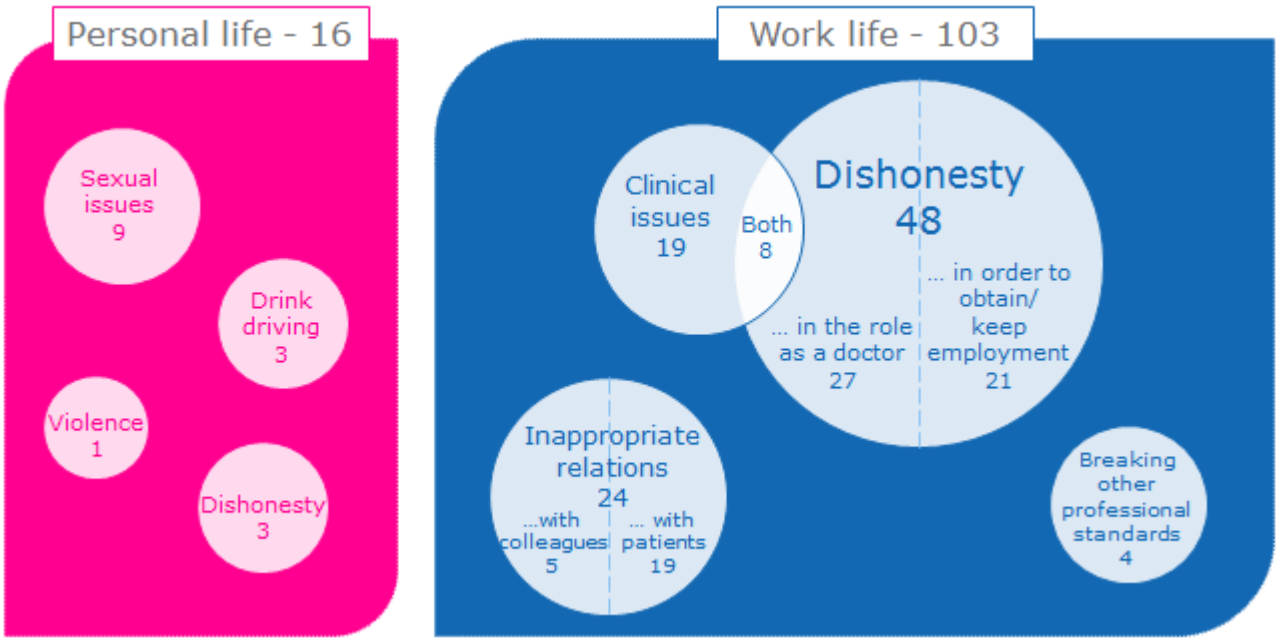
Notes on this report

- In this report, registered medical practitioners are simply referred to as 'doctors'.
- When 'cases' are referred to in this report, this indicates the doctors who are within the scope of this analysis (i.e. doctors suspended or erased from the medical register in 2014 but excluding Interim Order Panel decisions and cases where the panel was held in private).
- The main body of this report examines the different types of cases and provides illustrative examples. In Appendix 1, we consider various factors which have an impact on case outcome and in Appendix 2 review the demographic profile of the doctors involved in the cases.
- When analysis has been carried out on all cases (i.e. 119 cases), figures are shown as a percentage; however when analysis has been carried out on a sub-group (such as a certain type of case) the figures are shown as counts due to the low base size.
- Where comparison figures have been provided for all doctors, this is all doctors with a licence to practise as at 31st December 2014.
- This report relates to cases in the most recent year and the patterns reported are unlikely to be exactly replicated in future years.
- It should also be noted that there are over 230,000 licensed doctors in the UK and only 119 cases of this nature concluded in erasure or suspension in 2014.

Key findings

Types of cases

This diagram shows the types of cases and their incidence.



The majority of cases that resulted in suspension or erasure from the medical register were in relation to an incident in a doctor's working life, but there were some cases in relation to a doctor's personal life.

For an incident in one's personal life to have such consequences, we can infer that it must have been extreme. The most common type of case in relation to a doctor's personal life was 'sexual issues' (9 cases) but there were also cases involving drink driving offences (3 cases), dishonesty (3 cases) and violence (1 case). Cases that were in relation to doctors' personal lives were more likely to be of a criminal nature (6 out of 16) than cases in relation to doctors' working lives; and were brought to the fore due to a conviction. The police have a duty to report such incidents to the GMC.

Overall, the most common type of case was dishonesty (48 cases), either in order to obtain or keep employment or in the role of a doctor. Good Medical Practice (2013), states that doctors must *'be honest and open and act with integrity.'* Thus, dishonest conduct constitutes a serious departure from fundamental tenets of GMP and the standards expected of a doctor. This is taken very seriously by Medical Practitioners Tribunal Service (MPTS) panels.

The second most common type of case was inappropriate relations with both patients and colleagues (24 cases); but most frequently with patients (19 of the cases).

The third most common type of case was clinical issues (19 cases) although there was a further proportion of clinical issues cases that also involved dishonesty and clinical issues together (8 cases), and so we may consider this to be the second most common type of case if we combine the two groups together (which would equate to 27 cases).

A further small proportion of cases were classified as 'breaking other professional standards' (4 cases). These cases were varied.

Characteristics of cases

Employers were the most common source of complaint against a doctor leading to a case resulting in erasure or suspension, with over a third being raised by employers.

The doctor was present at the panel hearing in just over half of all cases and was represented in just under half of the cases.

In half of the cases, the doctor admitted some or all of the allegations made.

It is relatively rare in cases resulting in erasure or suspension for the doctor to show insight and demonstrate remediation (25% of cases), but there are indications that in doing so, the final outcome is more likely to be suspension than erasure.

Demographics

Males were much more likely to feature in these cases than females (82% of cases featured a male in comparison to 18% of cases featuring a female). Doctors aged over 49 years were slightly more likely to feature than doctors aged up to 49 years (52% of doctors were over 49 years in comparison to 48% being aged up to 49 years); and doctors of Black and Minority Ethnic (BME) origin were more likely to feature than white doctors (50% of doctors were BME and 23% were white, the ethnicity of the remaining 27% was unknown). Previous research has found that male doctors, doctors over the age of 50 and BME doctors are also more likely to be complained about (The state of medical education and practice in the UK (SoMEP), 2014).

The cases were more likely to involve doctors that qualified outside of the UK (69%) than doctors that qualified in the UK (31%).

These demographic groups were also over-represented amongst these cases in comparison to all licensed medical practitioners in the UK in 2014.

Doctors who were suspended or erased didn't tend to be newly practising in the UK, with the average amount of time the doctor was practising in the UK when they received the sanction being 17 years. However, there was a relatively high frequency of suspension or erasure during the first 20 years of practising in the UK (36% had been practising for up to ten years and a further 30% had been practising in the UK for eleven to twenty years).

Introduction

Background

The General Medical Council (GMC) is an independent organisation that helps to protect patients and improve medical education and practise across the UK.

The GMC only registers doctors who are properly qualified and fit to practise and takes action when a doctor's fitness to practise is in doubt.

The Medical Practitioners Tribunal Service (MPTS) hears cases against doctors where serious concerns have been raised, and as a result, their fitness to practise has been called into question by the GMC. In the most serious of cases, a doctor can be erased or suspended from the medical register.

DJS Research Ltd, an independent market research agency, was commissioned by the GMC to carry out an analysis of cases to help illuminate why a doctor may be suspended or erased from the medical register.

The research will help to inform a chapter exploring professional standards and the relationship with fitness to practise in the GMC publication, *The state of medical education and practice in the UK (SoMEP),* 2015 report.

Objectives

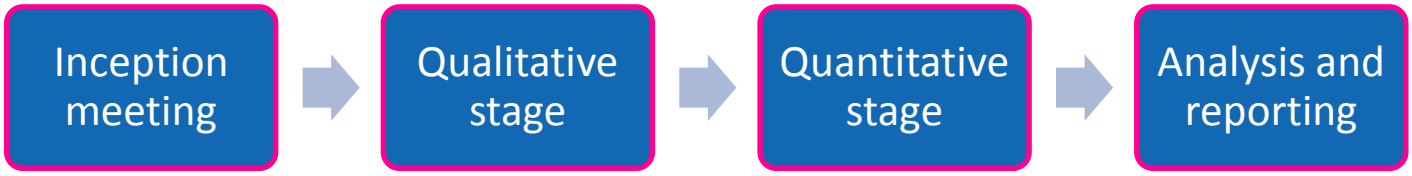
The overarching objective of the research was to analyse the cases resulting in doctors being suspended or erased from the medical register to illuminate why a doctor may be suspended or erased from the medical register, beyond what is evident from numerical data held by the GMC.

The specific objectives were to:

- Categorise groups of similar cases
- Highlight any key themes common to many cases
- Identify any differences by source of complaint and in particular referrals from employers
- Produce five or six short vignettes from actual cases or combinations of cases to illustrate the main themes emerging from the analysis.

Approach & scope

There were four key stages to the research, as follows:



1. Inception meeting

At this meeting, the analysis team was fully briefed by the GMC. The items to be captured during the qualitative stage were discussed, analysis requirements were agreed and the scope confirmed.

2. Qualitative stage

During the qualitative stage, the public determination for each case was reviewed and the items agreed at the inception meeting were captured in a database (Excel spreadsheet). The items captured were:

- GMC reference number
- Brief description of the case
- Type of case
- Admission at the hearing
- Evidence of remediation or insight
- Evidence of any non-medical stress
- Details of any conviction/penalties
- Doctor present and/or represented at the hearing

Each item was coded so that it would be possible to quantify and identify commonalities.

In order to ensure the items were captured accurately, the items coded in each case were checked by a different team member.

3. Quantitative stage

The GMC provided a database of quantitative data that included the following items for each case:

- Doctor's name, UID
- Reason why fitness to practise impaired
- Gender
- Age at determination
- Ethnic origin
- Country/region in which Primary Medical Qualification obtained
- Specialist/GP flag
- Specialties on the register
- Doctor grade
- Source of complaint

- Allegation(s)
- Hearing outcome
- Time practising in the UK (from first registration)

On completion of the qualitative stage, the qualitative data was merged with the quantitative data supplied by the GMC to create one single database for analysis.

4. Analysis & reporting

Data tables were created from the single database and were analysed along with the cases themselves.

Vignettes to illustrate different types of cases were created from the actual cases.

Scope

The analysis included 119 cases of doctors who were erased or suspended from the medical register in 2014. This encapsulates all MPTS cases that resulted in an outcome of suspension or erasure from the medical register in 2014, excluding Interim Order Panel decisions which may have resulted in a doctor's registration being restricted while allegations were being resolved.

The analysis also excluded cases where the panel was held in private (these cases are usually in relation to a doctor's health) or where the public determination was heavily redacted. It should therefore be noted that a limitation of the analysis is that it was not possible to identify any possible themes in relation to a doctor's health.

Please note that this analysis relates to cases in the most recent year and the patterns reported are unlikely to be exactly replicated in future years. The objective is to provide an easily accessible picture of the range of things that lead to erasure and suspension. These are behaviours that doctors should be certain they avoid, and it should also be remembered that there are over 230,000 licensed doctors and only 119 cases of this nature concluded in erasure or suspension in 2014.

Analysis of cases

This section describes the nature and types of cases that resulted in suspension or erasure from the medical register in 2014, a profile of the doctors involved in each type of case and details of the MPTS hearing.

Nature of cases

Most cases related to an incident in a doctor's working life (87%) as opposed to an incident in a doctor's personal life (13%).

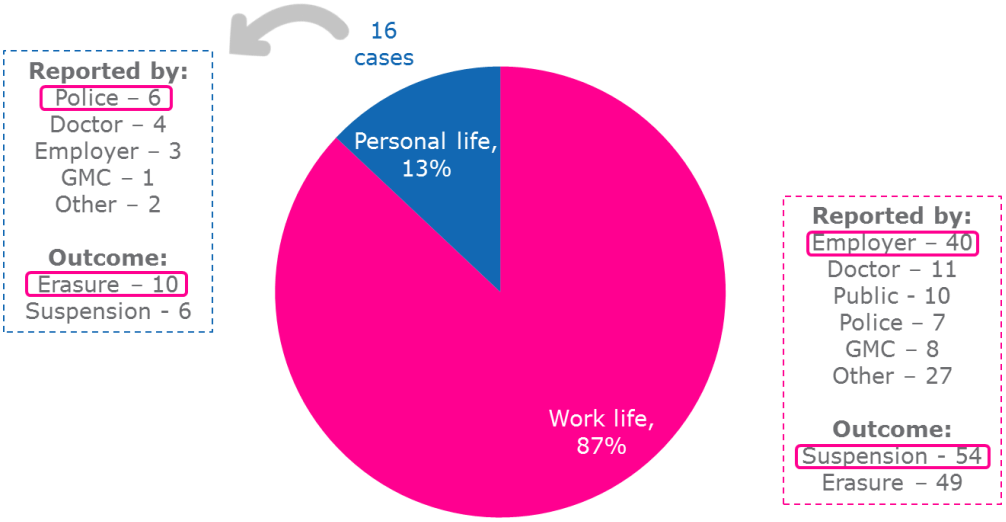
Cases related to a doctor's personal life were more likely to be of a criminal nature (being reported to the GMC by the police in 6 out of 16 cases) than cases that related to a doctor's working life.

Employers were more likely to report incidents in the doctor's work life than any other source and these incidents tended to be related to dishonesty and aspects of the doctor's non-medical performance. The public were more likely to report incidents relating to clinical issues and inappropriate relations with patients.

Cases in relation to a doctor's personal life were more likely to result in erasure than suspension, whereas cases in relation to work life were slightly more likely to result in suspension than erasure.

See figure 1.

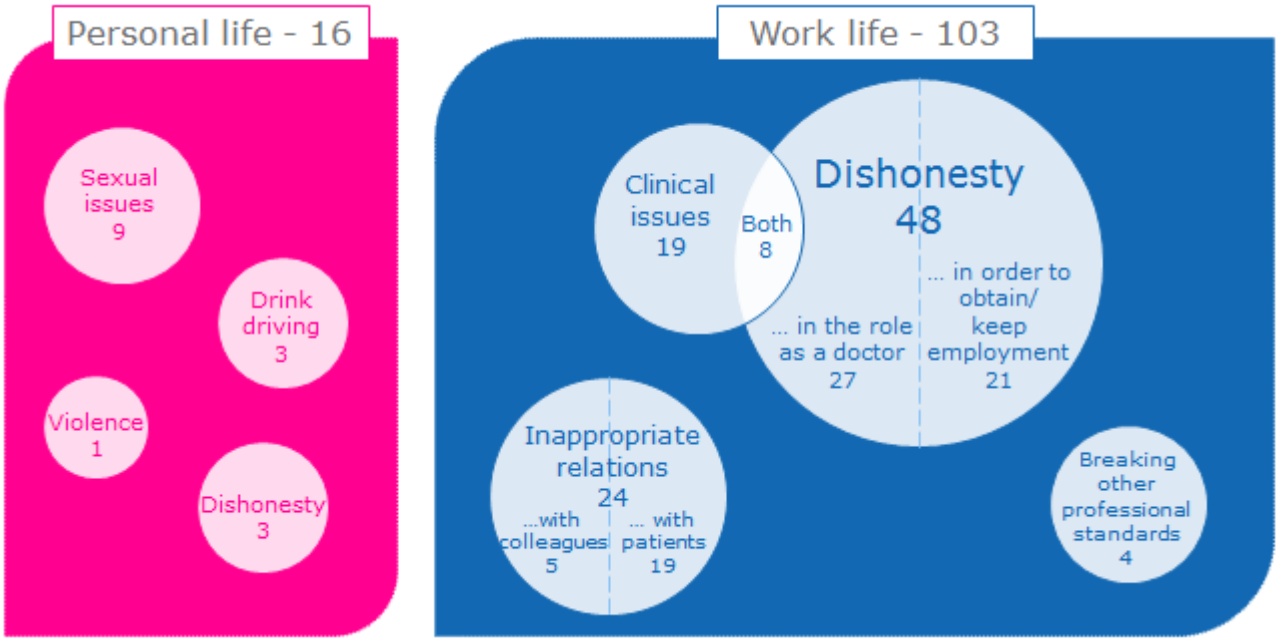
Figure 1: Nature of incident involved in cases, who reports cases and final outcome (Base n = 119 cases)



Types of cases

Overall, the majority of cases related to dishonesty in some way, either dishonesty in the role as a doctor or dishonesty in order to obtain or keep employment. The MPTS panel considers any form of dishonesty as very serious because of the impact it has on patient safety and the public's perception of the profession as a whole. Figure 2 shows the various types of cases and the prevalence of each type.

Figure 2: Type of cases (Base n = 119 cases)



Personal life

The types of cases that related to incidents in a doctor's personal life were most often associated with 'sexual issues' (9 cases) but there were also cases involving drink driving offences (3 cases), dishonesty (3 cases) and violence (1 case).

Personal life: Sexual issues

Cases that were categorised as 'sexual issues' involved incidents that spanned a broad spectrum of physicality, ranging from voyeurism to sexual assault (some cases involved multiple counts of such behaviour). All of the victims of the incidents were either women and/or minors (one case involved a minor under the age of 13).

Such cases are considered particularly serious by the MPTS panel when they either feature repetition of an offence(s), when the offence(s) is carried out over a prolonged period of time, and when there is a detrimental impact on another person.

The MPTS panel considered that the behaviour demonstrated by doctors in these types of cases *'undoubtedly brings the medical profession into disrepute and is likely to undermine public confidence in the medical profession'*. The outcome of these 'sexual issues' cases was

more likely to be a sanction of erasure rather than suspension, with 7 of the 9 'sexual issues' cases resulting in erasure. A description of one of these cases is provided in figure 3.

Figure 3: Vignette of 'sexual issues' in doctor's personal life case

Overview

Whilst travelling on public transport, a doctor positioned his pelvis towards another passenger and moved it back and forth several times and also exposed himself. He obstructed the passenger from moving away from him and prevented her from reporting his actions to the driver.

The doctor denied that he had any sexual intentions during the journey and claimed that he had been trying to get comfortable. However, the panel considered that it was unlikely that the doctor would move in such a way unintentionally on multiple occasions in order to get comfortable. They concluded that the doctor behaved in a manner that was, in fact, sexually motivated.

The panel determined that the doctor had not demonstrated any insight, as evidenced by his denial of his actions. Furthermore, they stated that there was no evidence that he had remediated his misconduct, and that in this circumstance there was a risk that he would repeatedly behave in this way.

Outcome

The doctor was legally represented but not present at the hearing. Although this incident did not take place in a clinical setting and the passenger was not aware at the time that the person was a doctor, the panel concluded that such conduct would be totally unacceptable behaviour from anyone, especially a doctor. The panel determined that the doctor's conduct had brought the medical profession into disrepute and that such behaviour might cause anxiety to female patients, in particular. He was erased from the medical register.

Personal life: Dishonesty

Dishonesty was less prevalent among personal life cases than work life cases, with three occurrences of such (dishonesty in work life cases is covered later on in this report and is the most prevalent type of case). All of these cases were completely different from each other in terms of the specific details, but they were all brought to the attention of the GMC due to a conviction.

Two of the three cases involved committing or assisting in fraudulent activity with respect to the government or police; and one of the cases involved a doctor making a gain or causing loss by deception with regards to a large retailer.

The MPTS panel considered that these cases of serious dishonesty signify '*a breach of some of the fundamental tenets of the medical profession*' and as such have the ability to '*seriously undermine public confidence in the profession'*. Two out of three of these cases resulted in a final outcome of erasure.

Personal life: Drink driving offences

Drink driving offence cases were equally as prevalent as dishonesty cases (3 cases). Drink driving offence cases were identified by the doctor receiving a conviction of driving while above the legal limit, or unfit through drink, contrary to Section 5(1)(a) of the Road Traffic Act 1988. The MPTS panel considers that such a conviction undermines public confidence in the profession and that in receiving such a conviction the doctor would have failed to maintain the standards of behaviour expected of a doctor. The MPTS panel believes that this behaviour brings the profession into disrepute.

Two out of the three drink driving offence cases involved a road traffic accident, and this was the reason that the conviction arose. In one of the cases, the doctor's car spun and collided with the central reservation of a motorway. Although in both cases, the doctor escaped largely unharmed and no other vehicles were apparently involved, the doctors involved showed a disregard for the safety of other road users.

In the other drink driving offence case, the doctor had been convicted of a drink driving offence twice over a period of several years. After the first offence, the doctor's registration was subject to conditions from a fitness to practise (FTP) panel hearing. The doctor had also previously assured the panel that they had reflected upon their actions and looked back on them with "regret and horror", and so the second conviction for the same offence was considered to be particularly serious.

The MPTS panel considers *'that a conviction for driving with excess alcohol is a serious matter'* and in all of these cases, the outcome was a suspension with immediate effect. In two out of three of the cases, the doctor was disqualified from driving for a period of time and in two out of three cases, the doctor incurred a fine.

Personal life: Violence

There was one case of violence, which involved a conviction of violent disorder. More specifically, a doctor was involved in an altercation with two men, in which one of the men was knocked to the ground and was repeatedly hit with a hard object by the doctor. He was sentenced to imprisonment and ordered to pay a fine.

The MPTS panel considered that the doctor in this case displayed a '*reckless disregard for the principles set out in Good Medical Practice*' and his behaviour constituted a '*very serious departure from the fundamental tenets of the profession'*.

The MPTS panel also stated that the doctor's behaviour was '*unacceptable and fundamentally incompatible with his continued registration'*. The outcome on this case was therefore erasure from the medical register.

Personal life (overall) - Profile

Demographically, those involved in cases relating to their personal lives tended to be male doctors, aged under 49 years and/or doctors of BME origin. Notably, of the 16 personal life cases, 5 doctors were male and aged under 49 years and of BME origin. Figure 4 outlines the

demographic profile of doctors involved in all 'personal life' cases (note that there are too few cases within each of the case types to look at them individually).

Figure 4: Demographic profile of those involved in personal life cases (Base n = 16 cases relating to personal life)

	All cases (119)	Personal life (16)
Female	18%	1
Male	82%	15
Age – under 49 years	48%	10
Age – over 49 years	52%	6
BME	50%	9
White	23%	3
Unknown	27%	4

In terms of qualification, considering the doctors involved in cases relating to their personal lives, there is approximately an equal split between UK qualified and non-UK qualified doctors and similarly there is an equal split between doctors who have been practising in the UK for 15 years or fewer and more than 15 years. Figure 5 outlines the place of qualification and length of time practising in the UK of doctors involved in all 'personal life' cases.

Figure 5: Place of qualification and length of time practising in the UK of those involved in personal life cases (Base n = 16 cases relating to personal life)

	All cases (119)	Personal life (16)
UK qualified	30%	7
Non-UK qualified	70%	9
Practising – 15 years or less	54%	8
Practising – More than 15 years	46%	8

Personal life – Hearing details

At the hearing, doctors were fairly likely to admit some or all of the allegations made in relation to events or behaviour in their personal lives (11 out of 16 cases), particularly in

comparison to all cases (for which the figure is 50%). However, despite admitting some or all of the allegations, doctors involved in these cases did not demonstrate remediation.

Those whose case involved an incident in their personal life were not particularly likely to attend the hearing or be represented, with about half present or being represented.

Figure 6 outlines the MPTS hearing details of all personal life cases.

Figure 6: Hearing details among those involved in personal life cases (Base n = 16 cases relating to personal life)

	All cases (119)	Personal life (16)
Admitted allegations	50%	11
Present at MPTS hearing	56%	8
Represented at MPTS hearing	48%	9
Showed insight	24%	3
Demonstrated remediation	11%	0

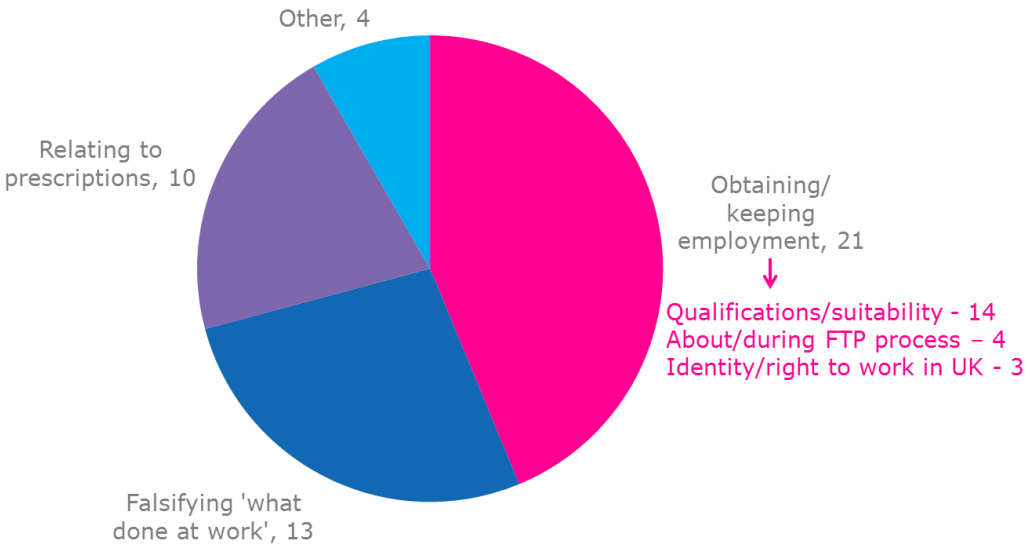
Work life

The main type of case (both overall and amongst cases in relation to work life) was dishonesty (48 cases), followed by inappropriate relations (24 cases) and clinical issues (19 cases). The fourth most common type of case was a combination of two of these case types: clinical issues and dishonesty. In some of these types of cases, we identified further sub-themes which are explored below.

Work life: Dishonesty

Dishonesty (either in the role of a doctor or dishonesty in order to obtain or keep employment as a doctor) was the most prevalent reason why a doctor was suspended or erased from the medical register (48 out of all 119 cases were categorised in this way). Figure 7 shows the types of cases that fall under this category. Being dishonest in order to obtain or keep employment was the most prevalent type of case in this category.

Figure 7: Work life – dishonesty case types (Base n = 48 cases relating to dishonesty (only) at work)



Good Medical Practice (2013), states that doctors must *'be honest and open and act with integrity.'* Thus, dishonest conduct constitutes a serious departure from fundamental tenets of GMP and the standards expected of a doctor.

In the vast majority of cases in this category, there was no evidence that any patients were harmed, but dishonesty in these cases was seen to put patients at risk in the future.

Obtaining/keeping employment

Those who had been dishonest in order to obtain or keep employment tended to falsify documents such as qualifications, CVs and references (14 cases). For example, cases included falsely claiming to be a specialist, failing to reveal 'provisional' registration status, providing false references and forging documentation for completed courses/qualifications and one's CV. The MPTS panel considers that such dishonesty can cause '*actual risk to the public and to public safety'*, should the doctor be successful in obtaining or keeping employment and practising when they are in fact not qualified or suitable to do so.

There were four cases of dishonesty in order to obtain or keep employment in which a doctor failed to disclose to their employer (or potential employer) that their practice was either under investigation by the GMC or subject to conditions imposed by the GMC (as they were required to do so).

There were three cases of dishonesty in order to obtain or keep employment whereby the doctor was dishonest about his or her identity and/or right to work in the UK. Examples of this included falsely claiming to have a UK visa and possessing illegal identity documents. The MPTS panels take such behaviour very seriously, with the outcome of all three of these cases being erasure.

Falsifying 'what done at work'

The second most prevalent type of dishonesty that features in cases resulting in suspension or erasure is dishonesty in terms of what has been done at work (13 cases). This category included making false claims about the number of hours worked and about clinical tasks performed.

In terms of clinical tasks, this was claiming to have carried out a task (such as visiting a patient) and/or completing patient records falsely, or carrying out a task incorrectly and then denying it.

In such cases, the outcome was more likely to be suspension than erasure, with 11 of the 13 cases having a final outcome of suspension and two of erasure.

Relating to prescriptions

Ten of the cases that were in relation to dishonesty in a doctor's work life concerned prescriptions and included theft, forgery and fraud. MPTS panels consider these to be *'all very serious offences'* and convictions for such offences *'inevitably undermine the confidence and trust that the public is entitled to place in the medical profession'* (three of the cases involved a conviction). Specific examples included: doctors attempting to acquire medication for their own personal use, prescribing for people who are non-UK residents, stealing prescriptions and forging prescriptions.

The final outcome with regard to dishonesty in relation to prescriptions was mixed with half being given a sanction of suspension and half a sanction of erasure.

To illustrate the types of cases within dishonesty at work, three vignettes are shown below for the three main sub-categories:

- Qualifications/suitability (see figure 8)
- Falsifying 'what done at work' (see figure 9)
- Relating to prescriptions (see figure 10)

Figure 8: Vignette of work life dishonesty – qualifications/suitability case

Overview

The doctor worked as a trainee and was employed through a medical locum agency. He was referred to the GMC following a criminal conviction for providing a falsified reference whilst applying for locum employment. His fraudulent actions were reported after a colleague expressed concerns about the doctor's clinical performance during a locum shift, which led him to take steps to verify the doctor's references. Enquiries were made to the nominated referee who indicated that he had not provided the reference nor had it been sent from his email address. The doctor admitted that he had created both the reference and email address from which it was sent.

The panel considered evidence from the doctor that he was facing difficult personal circumstances at the time of the misconduct, namely that he had lost multiple members of his family in a tragic accident.

The panel stated that it is difficult to demonstrate remediation in cases involving dishonesty, and that there was little evidence to suggest that the doctor had remediated the issues in the case. In particular, the panel drew attention to the limited evidence of meaningful insight. They accepted that he was experiencing difficult personal circumstances at the time of submitting the fraudulent reference and that he had expressed remorse. However, they concluded that the doctor did not recognise that the proper course of action would have been to decline the post, having neither completed his training nor obtained the appropriate references. The panel could not conclude with confidence that his insight was developed to guard against the risk of repetition during a future period of personal or professional difficulties.

Outcome

The doctor was not present but was legally represented at the hearing. At his prior criminal hearing, he pleaded guilty having been charged with fraud and making and supplying articles for use in fraud. He was sentenced to a short period of imprisonment and ordered to undertake community service. The panel concluded that his fitness to practise was impaired due to his conviction. Furthermore, they considered that falsifying documents relating directly to clinical practice carried an inherent risk for patients, which brings the reputation of the medical profession into disrepute. The GMC submitted that the appropriate sanction would be erasure given that the doctor had persisted and covered up his dishonesty. However, the panel sanctioned the doctor with a 12 month suspension. The panel considered this a sufficient period for the doctor to improve his insight and mitigate future risks of repetition.

Figure 9: Vignette of work life dishonesty – falsifying 'what done at work' case

Overview

The doctor worked as a locum for various healthcare providers. On multiple, separate occasions, he claimed payment for hours that he had not worked including forging the counter-signature of another doctor on the medical agency's timesheet.

In all cases, the doctor provided evidence that he believed he was entitled to claim for the hours as he had switched his mobile phone on and could be contacted for consultation purposes during the normal working hours set out in the timesheet. However, the panel stated that the doctor would be required to be in the vicinity of the hospital for the claim to be valid. They did not consider that being available on the phone constituted a normal working day. Furthermore, the panel highlighted that being available by phone would not attract the same payment as a normal working day in hospital.

The doctor cited non-medical stress as a mediating factor in explaining his actions. He stated that at the time, a relative was terminally ill and that he had found it particularly stressful performing his usual duties. The panel believed that the doctor had demonstrated some insight into his misconduct. They partially accepted his belief that having his phone switched on constituted working. However, the panel agreed that this insight was limited and that he had not accepted full responsibility for his actions. In addition, the panel determined that he would have known that forging another doctor's signature was a dishonest act.

Outcome

The doctor was present and legally represented at the hearing. The GMC submitted that the doctor should be erased from the medical register, as they considered this the only means of protecting the public interest given his misleading and dishonest actions. The panel determined that the doctor be suspended for 12 months, stating that this would send a clear message to the doctor, whilst maintaining public confidence in the profession, and upholding proper standards of conduct and behaviour.

Figure 10: Vignette of work life dishonesty – relating to prescriptions case

Overview

The doctor worked at a hospital and over a period of less than a year, stole multiple prescriptions, some of which he forged in the names of non-existent patients and non-existent prescribing doctors. He fraudulently presented some of the stolen prescription forms at various local pharmacies. A criminal investigation commenced after an NHS investigator noted that the prescribed medication was not typical of that used within the department in which he worked. As a precaution, local pharmacies were alerted to maintain vigilance in relation to dispensing the medication.

The doctor attempted to present a further stolen prescription form at one of the local pharmacies. The pharmacist, who was aware of the NHS alert, immediately contacted the local Head of Counter Fraud. The pharmacist declined to prescribe the medication, instead advising the doctor that he could pay for the tablets as part of the Patient Group Directive (PGD). Following the incident, the doctor was arrested, and the police found further blank prescriptions and an additional prescription that had been forged and was ready for presentation at a pharmacy.

In response to the allegations, the doctor defended that he had stolen the prescriptions to treat a medical condition that he was suffering. He sought to minimise the gravity of his behaviour by describing his actions as a "stupid mistake" and a "one-off". The panel stated that despite some indication of insight, the doctor's premeditated and prolonged behaviour indicated that he had an underlying attitudinal problem which was fundamentally incompatible with being a doctor.

Outcome

The doctor was present and legally represented at the hearing. At his prior criminal hearing, he pleaded guilty and was convicted of two counts of theft and seven counts of forgery. He was sentenced to a period of imprisonment and ordered to pay a monetary fee in compensation and prosecution costs. The panel concluded that his fitness to practise was impaired due to his conviction and gave a sanction of erasure from the medical register.

Work life: Dishonesty - Profile

In cases where doctors were suspended or erased from the medical register for dishonesty in the workplace, doctors were more likely to be under the age of 49 (35 of 48 cases) than over the age of 49 (13 cases). Males were more likely to feature in these cases than females (35 males in comparison to 13 males). Notably, only men featured in cases of dishonesty in relation to prescriptions. Doctors in these cases were more likely to be of BME origin (25 of 48 cases) than white (12 of the 48 cases). Figure 11 outlines the demographic profile of doctors involved in each type of work life dishonesty case in comparison to all suspension and erasure cases.

Figure 11: Demographic profile of those involved in work life dishonesty cases (Base n = 48 cases relating to dishonesty (only) at work)

	All cases (119)	Obtaining / keeping emp'mnt (21)	Falsifying what done at work (13)	Relating to pres-criptions (10)	Other (4)
Female	18%	9	3	0	1
Male	82%	12	10	10	3
Age – under 49 years	48%	16	9	6	4
Age – over 49 years	52%	5	4	4	0
BME	50%	11	5	7	2
White	23%	5	5	1	1
Unknown	27%	5	3	2	1

In terms of qualifications, non-UK qualified doctors were more likely to feature in these cases of dishonesty overall than UK qualified doctors; however the opposite was found for dishonesty in relation to prescriptions (UK qualified doctors were more likely to feature than non-UK qualified doctors). Those who had been practising in the UK for 15 years or less were more likely to be dishonest in order to obtain or keep employment in comparison to those who had been practising for more than 15 years, which is logical given that we may assume doctors who have been practising for a shorter period of time are less likely to have established employment than those who have been practising for a longer period of time. Figure 12 shows qualifications and time practising in the UK of doctors involved in work life dishonesty cases.

Figure 12: Place of qualification and length of time practising in the UK of doctors in cases relating to dishonesty at work (Base n = 48 cases relating to dishonesty (only) at work)

	All cases (119)	Obtaining /keeping emp'mnt (21)	Falsifying what done at work (13)	Relating to pres-criptions (10)	Other (4)
UK qualified	30%	5	7	8	1
Non-UK qualified	70%	16	6	2	3
Practising – 15 years or less	54%	17	8	7	4
Practising – More than 15 years	46%	4	5	3	0

Work life: Dishonesty – Hearing details

At the hearing, very few doctors admitted some or all of the allegations made against them in relation to obtaining or keeping employment (two out of 21 cases) and none of them admitted some or all of the allegations made in relation to prescriptions (0 out of 10 cases). Most of the doctors that were involved in falsifying 'what done at work' admitted some or all of the allegations (nine out of 13 cases).

A high proportion of doctors were present (11 out of 13 cases) and were also represented (11 out of 13 cases) at the MPTS hearing of dishonesty cases in relation to falsifying what has been done at work.

Considering all dishonesty cases, few doctors demonstrated remediation (5 out of 48), although as the MPTS panel state *'dishonesty, by its very nature, is difficult to remediate'.*

Figure 13 outlines details of the MPTS hearing.

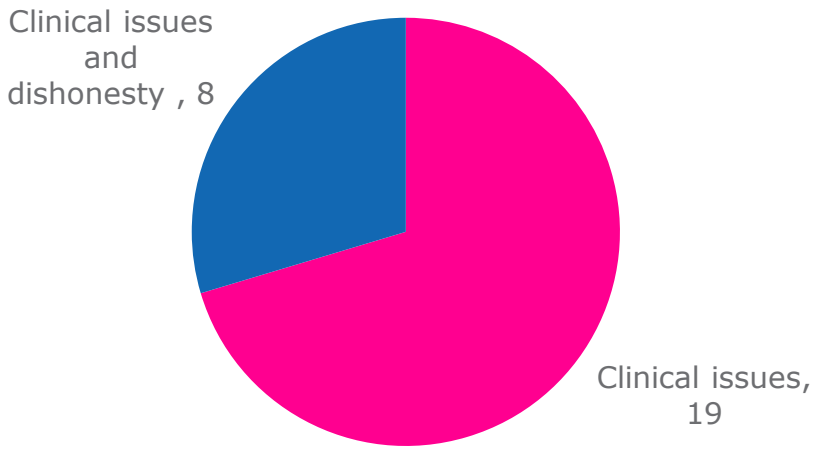
Figure 13: Hearing details among cases relating to dishonesty at work (Base n = 48 cases relating to dishonesty (only) at work)

	All cases (119)	Obtaining / keeping emp'mnt (21)	Falsifying what done at work (13)	Relating to pres-criptions (10)	Other (4)
Admitted allegations	50%	2	9	0	0
Present at MPTS hearing	56%	12	11	7	4
Represented at MPTS hearing	48%	7	11	6	4
Showed insight	24%	5	5	2	1
Demonstrated remediation	11%	2	3	0	0

Work life: Clinical issues

A clinical issue was the second most common case type after dishonesty, with 19 cases categorised in this way. However, there were a further eight cases which involved clinical issues and dishonesty about such practice and so they were considered in this report alongside each other. Figure 14 shows the proportion of these case types.

Figure 14: Clinical issues cases (Base n = 27 cases relating to clinical issues & clinical issues and dishonesty)



Clinical issues cases tended to be very complex. They involved a series of diagnosis and treatment failings which may or may not be related, such as:

- Prescribing/arranging tests/scans etc
- Referral to appropriate body (e.g. social services)

- Recognition of symptoms
- Assessments (including taking blood).

A clinical issues case could also involve poor record keeping or be brought about following notification of a doctor's performance being below par (when assessed).

Cases where there was an element of dishonesty as well as a clinical issue usually resulted from a doctor attempting to hide their clinical failings or being dishonest to patients. A specific example of such dishonesty was failing to record details of examinations on medical records, falsifying them thereafter and denying doing so.

The final outcome in these clinical issues cases (including those that involved an element of dishonesty) was more likely to be erasure rather than suspension.

Below are three vignettes to illustrate clinical issues cases. There are two vignettes illustrating clinical issues (see figures 15 and 16) and one where clinical issues were compounded by dishonesty (see figure 17).

Figure 15: Vignette of clinical issues case (1)

Overview

The doctor was investigated by the GMC for failing to provide good clinical care to a patient following routine surgery under general anaesthesia. While there were no concerns with his treatment of the patient during the surgery itself, he failed to be vigilant about the possibility of deterioration in the patient's condition during her transfer from the operating theatre to the recovery area. During this period of transfer, her condition rapidly deteriorated. Her condition was identified at the recovery area by the Operating Department Practitioner (ODP) who assessed her airway and breathing and found that the patient did not have a pulse. The ODP called for assistance from the crash team and commenced CPR.

The panel stated that there are two distinct phases in relation to the failings of the doctor. First, that he did not observe the patient appropriately and failed to establish that she had demonstrated physiological stability before attempting a handover. Second, that after the ODP had intervened to highlight the condition of the patient, the doctor did not exert the professional command expected of somebody in his role. In particular, he did not take responsibility or lead his team in the urgent assessment of the patient or initiate the corrective measures necessary to reverse her deterioration.

The doctor denied that his treatment of the patient was below standard, stating that he would not have done anything differently for her. He considered that he had been in control of the patient's situation and had led the team responding to her deterioration. The panel considered that the doctor lacked insight and a willingness to reflect upon and learn from the event. They highlighted that there was no evidence that the doctor had expressed concern about the serious extent to which the patient's life had been compromised or any expression of regret. They concluded that the doctor demonstrated deeply ingrained attitudinal problems.

Outcome

The doctor was present but not represented at the hearing. The panel stated that the acts and omissions of the doctor led to a situation in which a patient's life might reasonably be said to have been at risk. Furthermore, the outcome for the patient would have been very different had it not been for the attention she received from other practitioners. The GMC submitted that a sanction of at least suspension would be appropriate, given his serious departure from the principles set out in Good Medical Practice. The panel determined that the care the doctor provided to his patient fell seriously below the standard expected of a doctor. The doctor was erased from the medical register.

Figure 16: Vignette of clinical issues case (2)

Overview

The doctor worked as a GP at his own practice for many years, without any complaints from patients. However, the Trust in which he worked identified deficient professional performance and placed him on review by the Trust's Poorly Performing Doctors Panel. The Trust also informed the GMC of this and they in turn invited him to undertake a Performance Assessment into his standard of professional performance, which he did. The assessment included a Peer Review, Tests of Competence and Simulated Surgery. The report of the Assessment Team concluded that the doctor's performance was unacceptable in five areas: assessment, treatment, record keeping, maintaining good medical practice, and patients.

The doctor claimed that he had undertaken remediation whilst his registration was restricted by keeping up to date with prescribing guidelines, attending CGC and local meetings, BMJ learning, observing in other GP practices, having discussions with colleagues and targeting some issues raised by his Assessors. He submitted that because of his attempts to remediate the likelihood of repetition had been reduced. Furthermore, he stated that he would like to return to work but not as a single-handed practitioner. He said: "I will have to change".

However, the panel considered that they had not seen enough evidence that the doctor had insight and did not feel satisfied that he was prepared to develop this or that he had an intention to retrain. The panel accepted the findings of the GMC Assessors that remediation was not likely to succeed in this case and considered that he lacked the frame of mind to recognise and properly remediate his failings.

Outcome

The doctor was present and represented at the hearing. The panel found that his professional performance had fallen short of the standard expected of a reasonably competent GP on more than one occasion which amounts to deficient professional performance and has the potential to place patients at risk of harm. He was erased from the medical register.

Figure 17: Vignette of clinical issues and dishonesty case

Overview

Due to concerns with a doctor's performance, a review of his work was undertaken by four colleagues which showed errors in around a third of his cases sampled. These errors included: multiple instances of inadequate dissection, sampling or macroscopic description, as well as multiple instances of discrepancy in microscopy relating to diagnosis, clinical correlation and reporting. The reviewers concluded that the error rate was unacceptable and had the potential to put patients at risk. The review also highlighted multiple counts of dishonesty. The reviewers submitted that the doctor had added a Consultant's name to a pathology report without her knowledge and contrary to her initial advice, and falsely claimed that another doctor agreed with his interpretation of a biopsy report.

The reviewers claimed that despite the doctor's high error rate that it was possible that his performance could be improved by further training. However, the panel had not received any evidence to indicate that the doctor had undergone further training or was prepared to do so. The panel were concerned at the doctor's total lack of insight. He provided no evidence that he understood the seriousness of his deficient professional performance or his dishonest misconduct. Furthermore, the panel expressed concerns that the dishonesty was not isolated but repeated over a period of time and that some of the dishonesty had been used to cover up previous poor performance.

Outcome

The doctor was neither present nor legally represented at the hearing. The panel determined that the wide-ranging nature of the doctor's clinical errors and dishonesty indicated a pattern of deficient performance which raised concerns about his overall competence as a doctor. The doctor was erased from the medical register.

Work life: Clinical issues - Profile

Demographically, male doctors, doctors over 49 years of age and doctors of BME origin featured more frequently among clinical issues cases which resulted in erasure or suspension than female doctors, doctors under 49 years of age and white doctors. Figure 18 outlines the demographic profile of doctors involved in 'clinical issues' cases.

Figure 18: Demographic profile of those involved in clinical issues cases (Base n = 27 cases relating to clinical issues & clinical issues and dishonesty)

	All cases (119)	Clinical issues (19)	Clinical issues and dishonesty (8)
Female	18%	3	2
Male	82%	16	6
Age – under 49 years	48%	3	3
Age – over 49 years	52%	16	5
BME	50%	9	2
White	23%	3	3
Unknwon	27%	7	3

In terms of qualifications and experience, there was a higher incidence of non-UK qualified doctors (21) than UK qualified doctors (6) and a higher incidence of those with in excess of 15 years' experience of practising in the UK (17) than those with less than 15 years' experience of practising in the UK (10) among clinical issues cases resulting in erasure or suspension. This suggests that clinical issues cases were more likely to be among those who had been practising for a longer period of time; however this may not be the case as we do not know whether the doctors had been practising in another country before they commenced work in the UK. See figure 19.

Figure 19: Place of qualification and length of time practising in the UK of doctors involved in clinical issues cases (Base n = 27 cases relating to clinical issues & clinical issues and dishonesty)

	All cases (119)	Clinical issues (19)	Clinical issues and dishonesty (8)
UK qualified	30%	5	1
Non-UK qualified	70%	14	7
Practising – 15 years or less	54%	6	4
Practising – More than 15 years	46%	13	4

Work life: clinical issues – Hearing details

At the MPTS hearing, very few doctors involved in clinical issues cases were present, represented, admitted the allegations, showed any insight or demonstrated any remediation. See figure 20 for hearing details of clinical issues cases. Many complaints about clinical issues were resolved with undertakings so a case would only be referred to a panel if it was exceptionally serious and/or the doctor lacked insight. This may explain why doctors erased or suspended for clinical issues showed less insight.

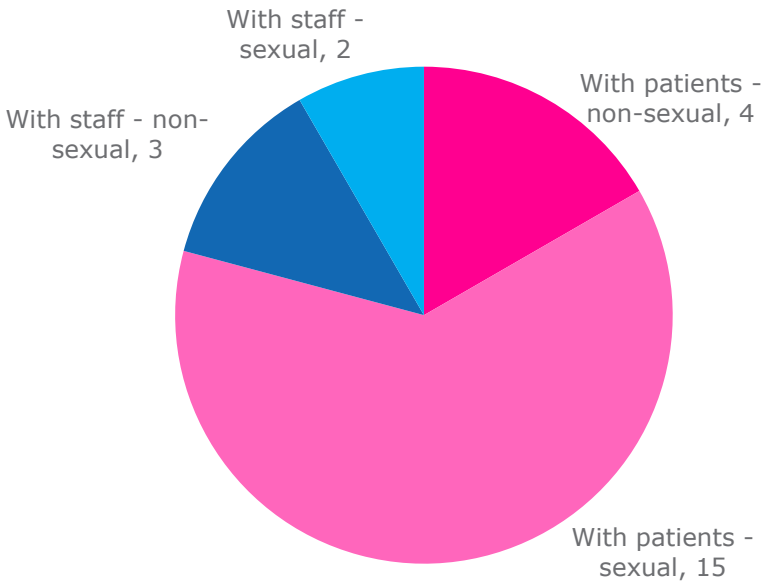
Figure 20: Hearing details of clinical issues cases (Base n = 27 cases relating to clinical issues & clinical issues and dishonesty)

	All cases (119)	Clinical issues (19)	Clinical issues and dishonesty (8)
Admitted allegations	50%	2	2
Present at MPTS hearing	56%	5	5
Represented at MPTS hearing	48%	1	5
Showed insight	24%	0	2
Demonstrated remediation	11%	0	2

Work life: Inappropriate relations

Inappropriate relations with patient or colleagues was the third most frequent type of case, after dishonesty and clinical issues. Most inappropriate relations of this kind were with patients and were of a sexual nature (15 cases). Figure 21 outlines the proportion of different case types in this category.

Figure 21: Work life – inappropriate relations case types (Base n = 24 cases relating to inappropriate relations)



Examples of cases involving sexual relations with patients included engaging in consensual (sexual) relationships with patients, touching patients inappropriately, sexual assault and sexually motivated examinations (often without a chaperone).

There are 4 cases of doctors being involved in non-sexual relations with patients. Examples of such relations included using inappropriate and insensitive language with patients and adopting an inappropriate 'carer' role with patients (i.e. going beyond what is appropriate in the role of a doctor).

There are 5 cases of inappropriate relations with staff or colleagues, of which 3 of the cases were non-sexual relations and 2 were sexual relations. Examples of inappropriate non-sexual relations with staff or colleagues included verbally offensive behaviour towards colleagues and accessing colleagues' emails without permission. Examples of inappropriate sexual relations with staff or colleagues included inappropriately touching a colleague and sexual assault of a colleague.

The sanction given in cases of inappropriate relations seemed to be primarily dependent on whether there was a sexual element to the case or not. Erasure was more likely than suspension among those cases where sexual relations have occurred. However, cases in which the incident(s) occurred in a clinical setting and on repeated occasions were also more likely to result in an erasure than a suspension sanction.

Four vignettes are shown below to illustrate the types of behaviours demonstrated within the category of inappropriate relations and the reason given for the sanctions. The vignettes illustrate inappropriate relations with staff and patients of both a sexual and non-sexual nature (figures 22, 23, 24 and 25).

Figure 22: Vignette of inappropriate relations with patients – sexual case

Overview

The doctor had worked as a GP for many years and was considered a kind, skilful and hardworking doctor by his colleagues. However, he was referred to the GMC after visiting the home of a vulnerable patient and engaging in sexual activity with her. The panel determined that the doctor's actions were sexually motivated.

The doctor submitted that he had visited the patient to deliver a letter. He claimed that he did not visit the patient's home with the intention of having sexual activity with her, and that the sexual activity arose suddenly and was not anticipated. During the sexual activity, the doctor submitted that he had realised that what he was doing was wrong and immediately ceased the activity. In addition, he claimed that he had not previously made any inappropriate advances towards the patient.

In an interview with the police, the doctor immediately admitted and accepted responsibility for his actions, in spite of receiving legal advice which noted that he should decline to comment. He made it clear throughout the hearing that he did not seek to minimise the gravity of what he had done by attaching any blame to the patient, and agreed that his actions had brought the medical profession into disrepute.

The panel considered evidence from the doctor's adult children that he was under various personal stresses at the time of the incident. The panel determined that although this cannot be considered as independent evidence they accepted the credibility of the witnesses and were satisfied with the measures the doctor had since put in place to alleviate his stress.

Outcome

The doctor was present and legally represented at the hearing. The GMC submitted that the doctor should be erased from the medical register, as they considered this the most appropriate and proportionate sanction given his sexual misconduct. However, the panel accepted that his sexually motivated misconduct, although extremely serious, was completely out of character. The panel were satisfied that he had full insight into the wrongness of his misconduct and that there was little likelihood of repetition. The doctor was suspended for 12 months. The panel noted that this length of suspension would send a message to the public and the profession that such sexually motivated misconduct will not be tolerated. They considered that, given the mitigating factors in this case, erasure would be a disproportionate sanction.

Figure 23: Vignette of inappropriate relations with patients – non-sexual case

Overview

The doctor was referred to the GMC after he inappropriately engaged in a relationship as a carer for a patient - an elderly lady who suffered with dementia. He had been her GP for many years and got on well socially with her. The doctor regularly stayed overnight at the patient's home and for a period of time, visited her twice a day to ensure that she was fed. On one occasion, he locked her in her own home so that she had no means of exit which caused her distress.

The doctor fully accepted that he had overstepped the appropriate boundaries in his dealings with the patient and that his behaviour fell far short of that expected of a registered medical practitioner. He admitted that he was trying to be kind to a patient that he had known for many years. He accepted that this was an error of judgement and that the role of carer should have been undertaken by Social Services. He said that he did not intentionally mean to lock the patient in her home but that he believed he was acting in her best interests by preventing her from leaving the house. He expressed deep regret for his actions and the distress that he caused to her. He indicated his desire to take voluntary erasure from the medical register.

The panel considered that although the doctor had admitted and provided explanations for his actions and expressed remorse, that there was no evidence that he understood how his actions constituted a failure to uphold professional standards, nor was there any evidence that he understood the risks to the patient. The Panel stated that remediation is less important in the context of the numerous serious errors of judgement made. They furthered that it was not possible to rule out the possibility of a repetition of his misconduct.

Outcome

The doctor was legally represented but not present at the hearing. The Panel concluded that his standard of care and treatment fell seriously below that expected of a reasonably competent GP. The panel determined that it would have been appropriate for the doctor to act as either the patient's carer or GP, but not both. The doctor was erased from the medical register.

Figure 24: Vignette of inappropriate relations with staff – sexual case

Overview

The doctor was referred to the GMC following a criminal conviction of sexual assault on a female receptionist. He inappropriately touched her and forcibly tried to kiss her on a number of occasions during his shift.

The doctor did not initially admit the allegations as he believed that the receptionist had consented to his actions, furthering that he considered himself a tactile person. The doctor submitted that since the incident he had completed a Maintaining Professional Boundaries course which had helped him understand the significance of his power. Following this training, the doctor created a development plan in which he sought to address the way in which he personally interacted with colleagues, including understanding physical boundaries and not asking personal questions to colleagues.

In spite of his evidence, the panel considered that the doctor's insight was extremely limited. They stated that throughout the process he had maintained his own view of the incident and that he continued to minimise his role in it. Furthermore, the panel were concerned that he had not considered the impact of his actions on the receptionist, but instead had concentrated on how his actions had affected his family and professional life. The panel determined that the sexual nature of the doctor's misconduct did not lend itself easily to remediation.

Outcome

The doctor was present and legally represented at the hearing. At his prior criminal hearing, the doctor was sentenced to community service and required to register under the Sexual Offences Act. In addition, he was ordered to pay back costs. The GMC submitted that his conduct was so serious that it was incompatible with continued registration, particularly as his actions related to an abuse of power and a sustained assault on a colleague. The panel concluded that his fitness to practise was impaired due to his conviction. However, the doctor was suspended for nine months. The panel determined that a sanction of suspension was proportionate given the remedial actions that the doctor has attempted to take and that his conviction arose from a single incident of sexual misconduct.

Figure 25: Vignette of inappropriate relations with staff – non-sexual case

Overview

The doctor was referred to the GMC following poor professional performance and concerns about his behaviour. During a surgical procedure, the doctor became aggravated by the actions of the assistant consultant. He subsequently shouted at many members of staff, behaved in an obstructive and argumentative way, and used expletives. After the event, the doctor sent an inappropriate email to several colleagues that was highly unprofessional and which was written in a tone and language that was not appropriate for his colleagues.

The panel determined that the doctor had not shown any signs of remorse, had taken no responsibility for his own actions, and had developed no insight. Further, he had not taken any steps to remediate his misconduct. The panel stated that the doctor's loss of control and inappropriate email to colleagues amounted to a serious departure from the standards of behaviour expected of a doctor. They furthered that it was a particularly bad example to set to trainees who were present in the theatre.

Outcome

The doctor was not present or legally represented at the hearing. The GMC submitted that given the doctor's blatant disregard for the system of registration that nothing short of erasure would be appropriate. The panel concluded that there can be no excuse for the doctor's inability to maintain personal and professional control in this occasion. Whilst no actual harm was caused during the procedure, the panel were concerned about the impact of his behaviour on others in the theatre and how this placed the patient at unwarranted risk of harm. The doctor was suspended for a period of 12 months. The panel stated that this allowed a period of time for an otherwise competent surgeon to demonstrate that he had taken steps to remediate his misconduct.

Work life: Inappropriate relations - Profile

Male doctors and doctors over 49 years are much more likely to feature among inappropriate relations cases resulting in erasure or suspension than females and doctors under 49 years. All the doctors involved in sexual cases are male. Figure 26 outlines the demographic profile of doctors involved in cases of inappropriate relations.

Figure 26: Demographic profile of cases relating to inappropriate relations (Base n = 24 cases relating to inappropriate relations)

	All cases (119)	With patients: non-sexual (4)	With patients: sexual (15)	With staff: non-sexual (3)	With staff: sexual (2)
Female	18%	1	0	1	0
Male	82%	3	15	2	2
Age – under 49 years	48%	0	4	2	0
Age – over 49 years	52%	4	11	1	2
BME	50%	2	9	0	2
White	23%	1	4	1	0
Unknown	27%	1	2	2	0

In terms of qualifications and experience, inappropriate relations cases tended to involve non-UK qualified doctors (17 out of 27 cases) and those who had been practising for over 15 years (15 out of 27 cases). Given these cases were more likely to involve doctors aged over 49 years, it follows that they would also be the most experienced doctors, in terms of length of time practising.

Across all inappropriate relations cases, non-UK qualified doctors that have been practising for more than 15 years represent 11 of all 24 cases. Figure 27 outlines the qualification details of these doctors.

Figure 27: Place of qualification and length of time practising in the UK of doctors involved in cases relating to inappropriate relations (Base n = 24 cases relating to inappropriate relations)

	All cases (119)	With patients: non-sexual (4)	With patients: sexual (15)	With staff: non-sexual (3)	With staff: sexual (2)
UK qualified	30%	2	4	1	0
Non-UK qualified	70%	2	11	2	2
Practising – 15 years or less	54%	0	5	3	1
Practising – More than 15 years	46%	4	10	0	1

Work life: Inappropriate relations – hearing details

Overall, at the hearing of cases of inappropriate relations, doctors admitted some or all of the allegations, were present and were represented at around half of them. The proportion that demonstrated insight and remediation was low but was higher in cases that involved sexual relations with patients than it was in other types of inappropriate relations cases.

Figure 28: Hearing details among cases relating to inappropriate relations Base n = 24 cases relating to inappropriate relations)

	All cases (119)	With patients: non-sexual (4)	With patients: sexual (15)	With staff: non-sexual (3)	With staff: sexual (2)
Admitted allegations	50%	2	10	1	1
Present at MPTS hearing	56%	2	10	0	1
Represented at MPTS hearing	48%	2	9	0	1
Showed insight	24%	2	7	1	1
Demonstrated remediation	11%	0	5	0	1

Work life: Breaking other professional standards

There were 4 cases of breaking other professional standards. Examples of the types of cases in this category were:

- Lack of indemnity cover (and being dishonest about it)
- Use of company IT equipment for non-work activity during work hours (such as watching pornography or managing a business)

The sanction received in cases of breaking other professional standards was divided between erasure and suspension. Erasure tended to be the final outcome in cases that were more complex (for example, cases that feature multiple allegations, or prolonged offending).

The case vignette below (figure 29) illustrates an example of a 'breaking other professional standards' case.

Figure 29: Vignette of breaking other professional standards case

Overview

The doctor practised for nine months without holding public indemnity insurance (PII). He failed to inform the hospital that his PII had lapsed and in response to requests to provide a copy of his PII certificate during this period, he falsely reported to staff that a copy would be forthcoming. The doctor gave excuses for not presenting the certificate including that he had forgotten it, that he had lost it, and that he was waiting for a new copy to be sent to him.

The doctor admitted his misconduct, apologised and expressed regret for his actions. In addition, he submitted that he believed that he could gain PII retrospectively. However, the panel noted that the doctor had not accepted that he was acting dishonestly and accepted evidence that he did not acknowledge the length of time that he had no PII. The panel viewed this insight as being very limited as the doctor appeared unable to comprehend the seriousness of his dishonest and persistent actions. Further, the panel stated that his dishonesty towards staff at the hospital was difficult to remediate and that they had seen no evidence of remediation. Prior to the hearing, he submitted a request for voluntary erasure from the medical register.

Outcome

The doctor was not present but was legally represented at the hearing. The panel determined that he knew that he needed PII to practise at the hospital; he knew that he needed to renew his PII as he had done so previously on an annual basis and he knew that, although he had obtained quotes from a selection of insurance companies, he had not paid the insurance premium. The panel determined that the doctor had knowingly practised at the hospital without PII. In light of this, the panel determined that the doctor had a disregard for the public interest and the safety of patients by practising without PII. Given his misleading and dishonest actions, the doctor was erased from the medical register.

Work life: Breaking other professional standards - Profile

There were very few cases in the category of 'breaking other professional standards' and so the base for analysis was small. All 4 of these cases involved males aged over 49 years. Figure 30 outlines the demographic profile of doctors involved in 'breaking other professional standards' cases.

Figure 30: Demographic profile of those involved in breaking other professional standards (Base n = 4 cases relating to breaking other professional standards)

	All cases (119)	Breaking other professional standards (4)
Female	18%	0
Male	82%	4
Age – under 49 years	48%	0
Age – over 49 years	52%	4
BME	50%	1
White	23%	2
Unknown	27%	1

In terms of time practising in the UK, most of those involved in cases of 'breaking other professional standards' had been doing so for in excess of 15 years (three out of the four cases). This was not surprising, given that the doctors involved in these cases were all over 49 years of age. There were an equal number of doctors who qualified in the UK and outside of the UK within these cases.

Figure 31: Place of qualification and length of time practising in the UK of doctors involved in breaking other professional standards (Base n = 4 cases relating to breaking other professional standards)

	All cases (119)	Breaking other professional standards (4)
UK qualified	30%	2
Non-UK qualified	70%	2
Practising – 15 years or less	54%	1
Practising – More than 15 years	46%	3

Work life: Breaking other professional standards – Hearing details

At the hearing, none of the four doctors involved in these cases demonstrated insight or remediation. Figure 32 outlines the hearing details of these cases.

Figure 32: Hearing details of those involved in breaking other professional standards (Base n = 4 cases relating to breaking other professional standards)

	All cases (119)	Breaking other professional standards (4)
Admitted allegations	50%	3
Present at MPTS hearing	56%	2
Represented at MPTS hearing	48%	2
Showed insight	24%	0
Demonstrated remediation	11%	0

Conclusions

This analysis has highlighted the different types of cases which resulted in a final outcome of suspension or erasure from the medical register in 2014. Needless to say, all of the types of cases were very serious and some were particularly extreme. The cases also tended to be complex, involving multiple allegations or repetition of offences.

The majority of cases related to incidents or behaviour in a doctor's working life rather than their personal life.

Events in a doctor's personal life that resulted in suspension or erasure from the medical register were usually of a criminal nature and were usually associated with 'sexual issues'.

Dishonesty - both in the role as a doctor and also in order to obtain or keep employment as a doctor - was the single most common type of case that resulted in suspension or erasure. Dishonesty is clearly taken very seriously by the GMC and the MPTS not only because of the potential consequences of the dishonesty but also because of the potential impact on the public's perception of the medical profession. Good Medical Practice (2013), states that doctors must *'be honest and open and act with integrity.'* Thus, dishonest behaviour constitutes a serious departure from fundamental tenets of good medical practice and the standards expected of a doctor.

It is however reassuring for the public that in the vast majority of the dishonesty cases, there was no evidence to suggest that a patient was harmed.

Demographically, the cases were more likely to involve male doctors, doctors aged over 49 years and doctors of BME origin in comparison to the proportion of all licensed doctors practising in the UK in 2014. These cohorts of doctors are also more likely to be complained about.

All of the cases were very complex and many included multiple allegations or repetition of the same allegation, sometimes over a prolonged period of time. In some cases it was suggested that the doctor had previously received a lesser sanction (such as an order to practise under certain restrictions) but had breached the sanction. Therefore we can conclude that cases which reach the stage of an MPTS hearing and whereby the final outcome is suspension or erasure really are the cases in which the doctor has persistently or repeatedly offended, often with intent.

Appendix 1 - Characteristics of cases

This section provides an overview of the source of the complaints made against doctors that result in suspension or erasure cases, the final outcome, details of the MPTS hearing and non-medical stress.

Complainant

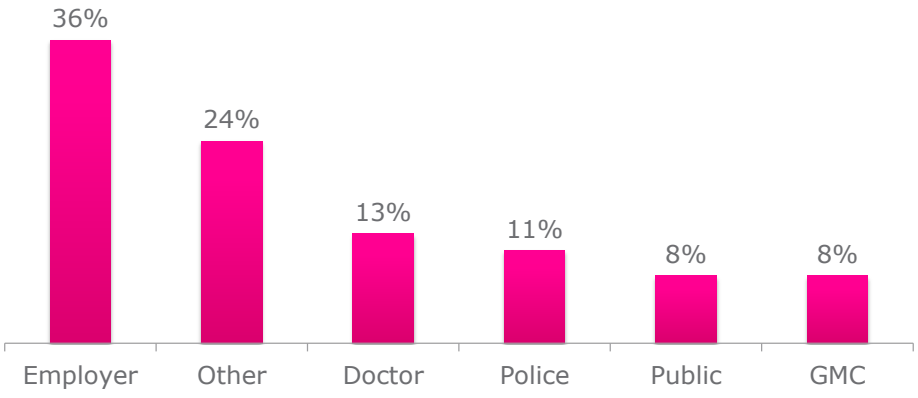
Most complaints resulting in suspension or erasure were made by employers (36%). Figure 33 shows the proportion of each complainant type.

The most common type of case that resulted from complaints made by employers was dishonesty in the doctor's working life, accounting for 19 of the 43 cases, followed by inappropriate relations, accounting for 10 of the 43 cases (9 of these being inappropriate relations with patients and 1 being with a colleague) and then clinical issues (including cases with an element of dishonesty) accounting for 9 of the 43 cases.

Doctors were the source of complaint in 13% of cases. More specifically this tended to be colleagues but also included the doctor reporting themselves in some cases (for example, if they had received a conviction).

The police have a duty to report any convictions involving doctors to the GMC. In six out of the 13 cases reported by the police, the MPTS panel determined that the doctor's practice was impaired due to a conviction (sometimes in addition to other impairments such as misconduct). Six out of the 13 cases reported by the police were in relation to something in the doctor's personal life (3 of these cases being sexual issues, 1 being drink driving, 1 being violence and 1 being dishonesty). Inappropriate relations in the doctor's working life accounted for 5 of the remaining 7 cases (4 of these being with patients, 3 of a sexual nature and 1 being with a colleague, of a non-sexual nature).

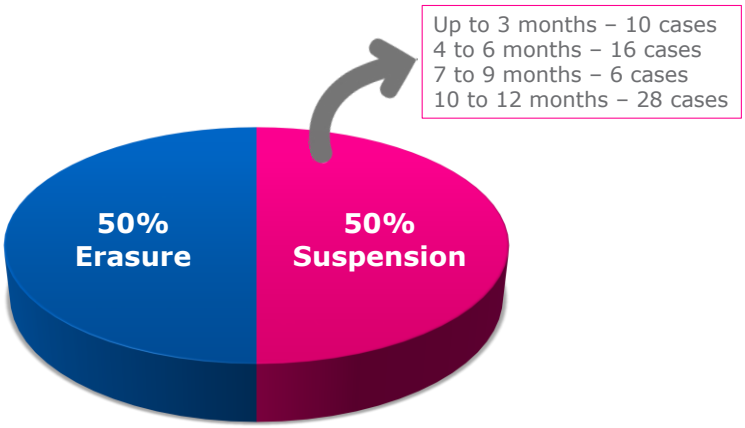
Figure 33: Complainant (Base n = 119 cases)



Hearing details

Overall, the outcome of all cases was evenly split between suspension and erasure. The period of suspension ranged from up to three months to between 10 and 12 months. See figure 34.

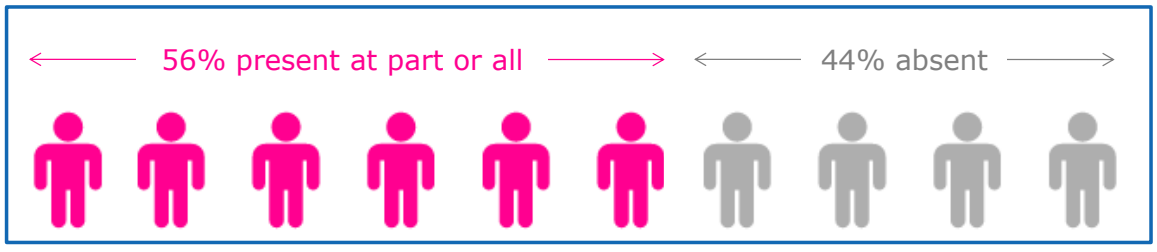
Figure 34: Outcome of all cases (Base n = 119 cases)



In almost six out of 10 cases (56%), the doctor was present at the MPTS hearing. See figure 35.

Doctors who were present at the hearing were more likely to be suspended than erased (in 47 out of the 67 cases where the doctor was present, the final outcome was suspension). Conversely, those who were absent from the hearing were more likely to be erased than suspended (in 39 out of the 52 cases where the doctor was not present, the final outcome erased versus 13 suspended).

Figure 35: Doctor present at the hearing (Base n = 119 cases)



A hypothesis for this finding is that in the most serious of cases, doctors predict that they will be erased and so don't bother to attend the hearing (or perhaps request voluntary erasure).

Another hypothesis is that the presence of a doctor at the hearing suggests to the panel that the doctor is keen to continue practising – in fact, the doctors who are present at the hearing are also more likely to demonstrate remediation and show insight (something which is covered later in this section).

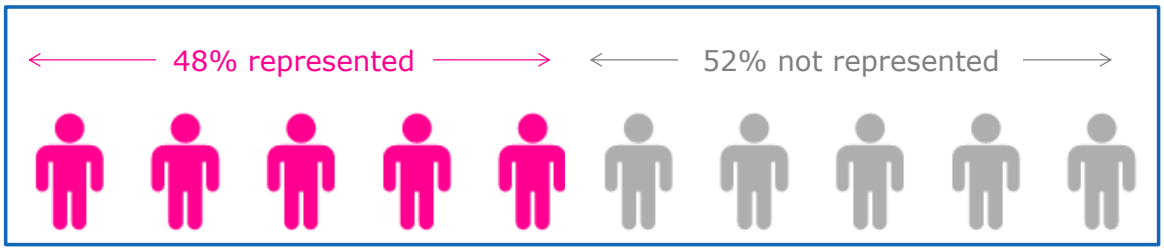
The type of case in which the doctor was least likely to be present at the hearing was clinical issues (including clinical issues and dishonesty cases), with the doctor being present in only 10 of the 27 cases.

Like attendance, the incidence of doctor representation was at a similar level with almost half of doctors (48%) being represented at the hearing. See figure 36.

Doctors who were represented were more likely to be suspended than erased (in 41 of the 57 cases where the doctor was represented, they were suspended); whilst those not represented were more likely to be erased (in 43 out of the 62 cases where the doctor was not represented, they were erased).

The type of case in which the doctor was least likely to be represented at the hearing was clinical issues (including clinical issues and dishonesty cases), with the doctor being represented in only 6 of the 27 cases.

Figure 36: Representation at the hearing (Base n = 119 cases)

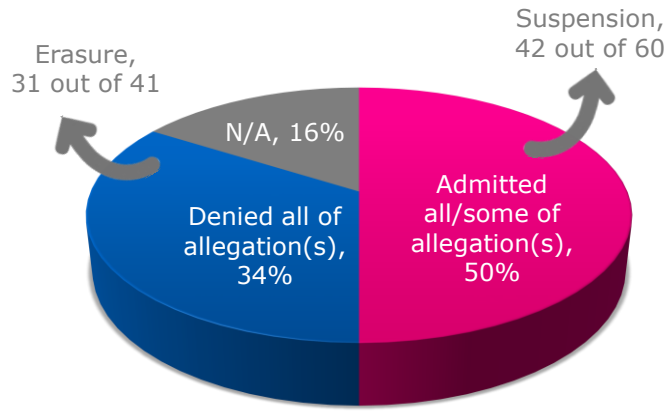


In half of all cases, the doctor admitted some or all of the allegations made during the case. See figure 37.

Doctors admitting to some or all of the allegations were more likely to be suspended than erased (in 42 of the 60 cases in which the doctor admitted some or all of the allegations, they were suspended), whereas those who deny all of the allegations were more likely to be erased (in 31 out of the 41 cases in which the doctor denied all of the allegations, they were erased).

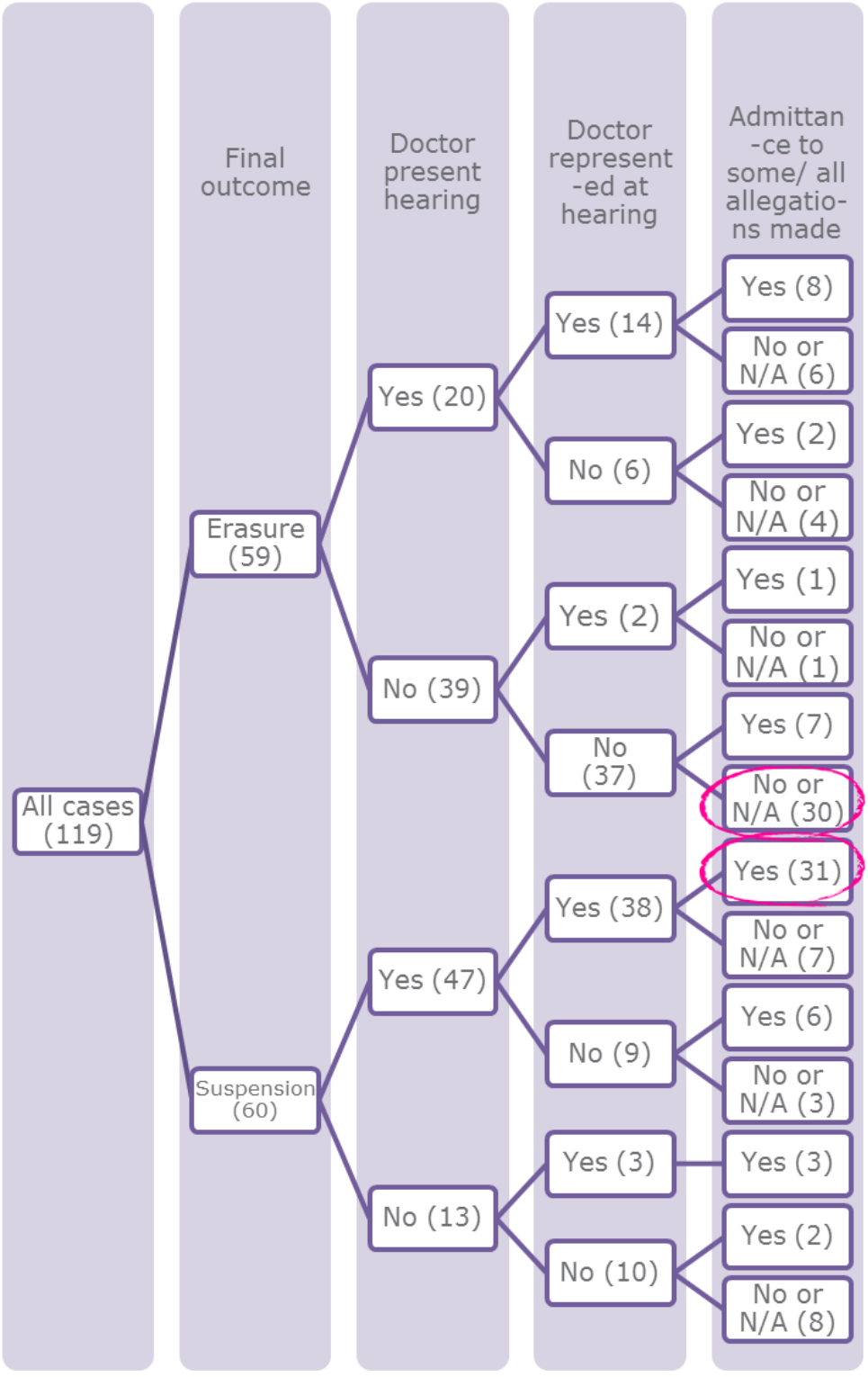
Notably, doctors involved in cases of clinical issues were the least likely to admit to any of the allegations made, with the doctor admitting to some or all of the allegations made in 11 of the 27 cases (involving clinical issues and dishonesty cases). Doctors involved in work life dishonesty cases were most likely to admit some or all of the allegations made, with the doctor admitting some or all of the allegations made in 28 of the 48 cases involving work life dishonesty.

Figure 37: Admittance or denial of allegations (Base n = 119 cases)



In around half of the cases which resulted in a final outcome of suspension (31 out of 60), the doctor was present at the hearing, represented at the hearing and admitted to some or all of the allegations made. Conversely, in around half of the cases (30 out of 59) that resulted in a final outcome of erasure the doctor was not present at the hearing, not represented at the hearing and did not admit to any of the allegations made. Figure 38 shows the number of cases that arose with all of the possible combinations of these variables.

Figure 38: Diagram to show number of cases by final outcome, doctor presence at hearing, doctor representation at hearing and admittance to some or all of the allegations made (Base n = 119 cases)



In the majority of cases there was no evidence of remediation or insight.

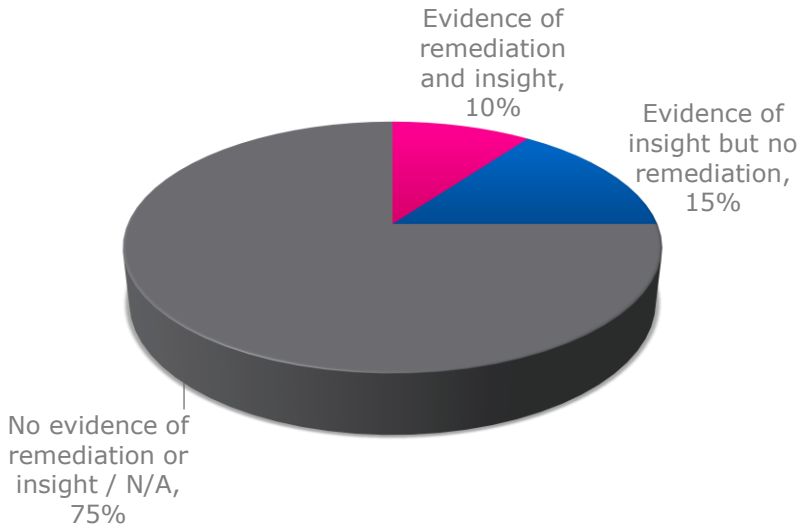
In a quarter of cases, doctors exhibited a mixture of insight with or without remediation. In 15% of cases there was evidence of insight but no remediation. In just a tenth of cases, there was evidence of both remediation and insight. See figure 39.

The final outcome in all cases where both remediation and insight was demonstrated was suspension (all 12 cases). Notably, in 10 of these cases the doctors also admitted to some or all of the allegations made (in the remaining two cases, admittance was not applicable).

In cases where insight was demonstrated but no remediation was shown, most cases also resulted in a final outcome of suspension (14 out of 17 cases).

In comparison, in cases where there was no evidence of remediation or insight the final outcome was more likely to be erasure than suspension, with 56 out of 90 cases resulting in this final outcome.

Figure 39: Evidence of insight and remediation (Base n = 119 cases)



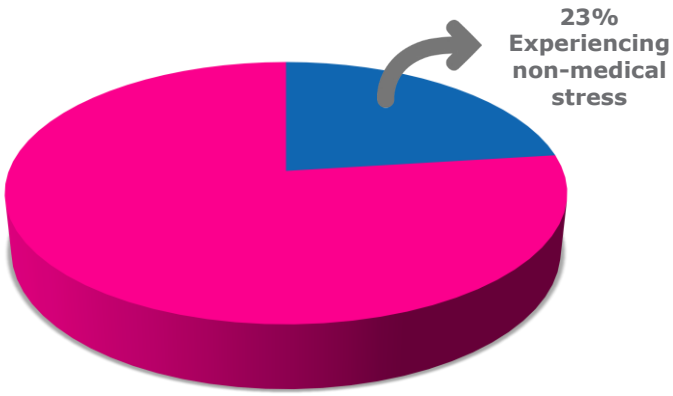
Almost a quarter of the doctors in the cases appeared to be experiencing non-medical stress. See figure 40.

Non-medical stress was identified as any kind of difficult circumstances (outside of the case) which the doctor was experiencing at the time of the incident. This tended to be things going on in the doctor's personal life, such as grief, financial problems and relationship problems. It was often referenced in the doctor's defence. Those experiencing non-medical stress tended to be suspended rather than erased (of the 27 cases in which the doctor was experiencing some kind of non-medical stress, 19 resulted in suspensions and 8 resulted in erasure).

A hypothesis for this could be that the panel take the non-medical stress into account when deciding on the appropriate sanction. It was generally recognised by the panel whether incidents were 'out of character'.

Doctors experiencing non-medical stress were more likely to admit to the allegations made (20 out of 60 cases); show evidence of insight (13 out of 29 cases) and demonstrate remediation (12 out of 13 cases) in comparison to doctors not thought to be experiencing non-medical stress.

Figure 40: Doctors suffering from non-medical stress (Base n = 119 cases)



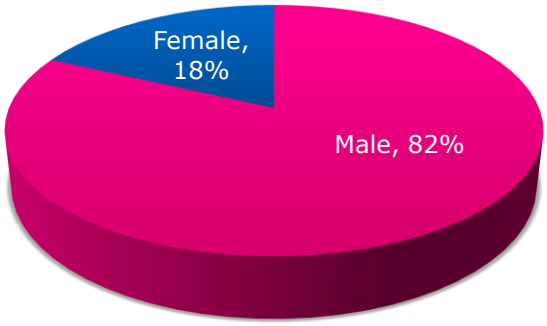
Appendix 2 - Demographics

In this section, the demographic profiles, qualifications, experience and types of doctor involved in the cases are analysed.

Gender

Most of the doctors involved in cases which resulted in suspension or erasure were male; on average, four out of five cases involved a male. Males were over-represented in the cases in comparison to all licensed doctors on the medical register, in which 55% are male and 45% are female. Previous research has found that female doctors are also less likely to be complained about and have a complaint investigated (SoMEP, 2014). Figure 41 outlines the gender split.

Figure 41: Gender (Base n = 119 cases)



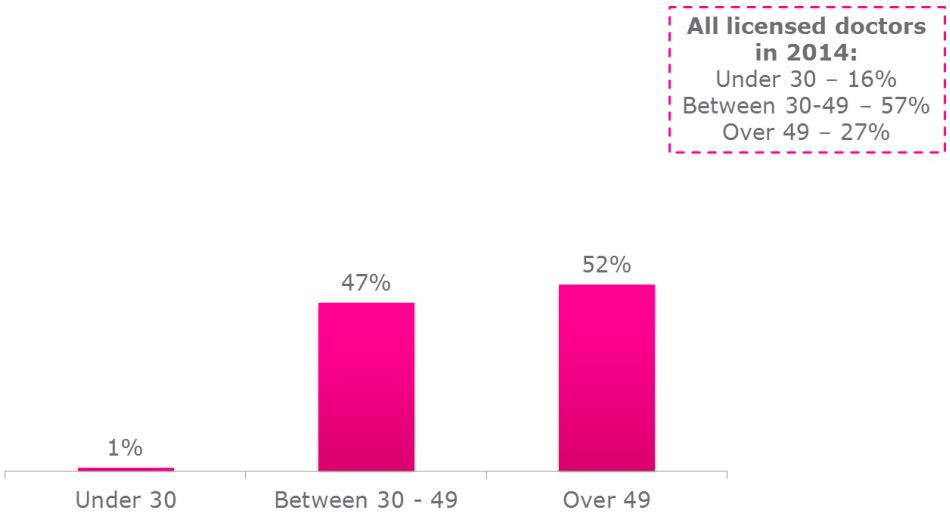
There seemed to be no impact of gender on the final outcome - males and females were equally likely to be suspended or erased.

Age

Doctors aged over 49 years were over-represented in cases that resulted in suspension or erasure in comparison to all licensed doctors on the medical register (where there is an approximately even split of doctors aged up to 49 and over 49 years of age). Previous research has found that doctors aged 50 and over are also more likely to be complained about, with doctors over 50 years old being about twice as likely as their younger counterparts to be complained about (SoMEP, 2014). Figure 42 outlines the age profile of doctors involved in all cases.

Like gender, age didn't seem to have an impact on the final outcome: those aged up to 49 and aged over 49 were equally likely to be suspended or erased.

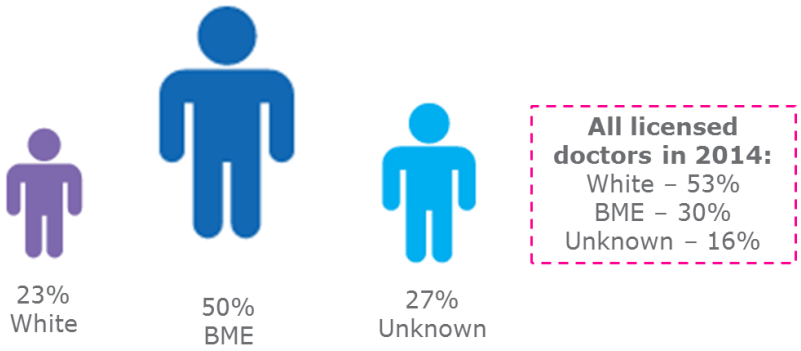
Figure 42: Age (Base n = 119 cases)



Ethnicity

Doctors of BME origin were over-represented among the cases in comparison to the proportion of all licensed doctors on the medical register (half of all cases involved a doctor of BME origin in comparison to 30% of all licensed doctors on the medical register being of BME origin). Previous research has found that BME doctors of all types and ages were also more likely to be complained about and have their complaints investigated than their white counterparts (SoMEP, 2014). Figure 43 shows the ethnic origin of the doctors involved in all cases.

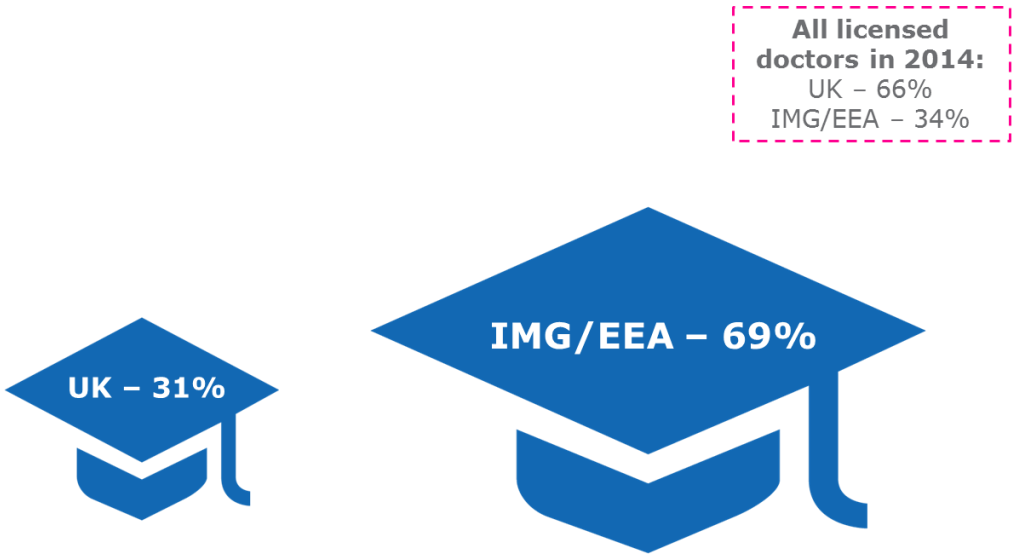
Figure 43: Ethnic origin (Base n = 119 cases)



Qualifications

Most of those who were suspended or erased qualified outside of the UK, this group being overly represented among cases in comparison to all licensed doctors on the medical register (two thirds of licensed doctors on the medical register qualified in the UK and only a third qualified outside of the UK; whereas, among the cases where the sanction was suspension or erasure, the reverse is the case with only 31% qualifying in the UK and the remaining 69% qualifying outside the UK). Previous research has shown that non-UK graduates were also more likely to receive a complaint and have that complaint investigated than UK graduates (SoMEP, 2014). The majority of those qualifying outside of the UK in the cases analysed were international medical graduates (IMG's) (57%) as opposed to European Economic Area qualified (12%). Figure 44 outlines the place of Primary Medical Qualification (PMQ).

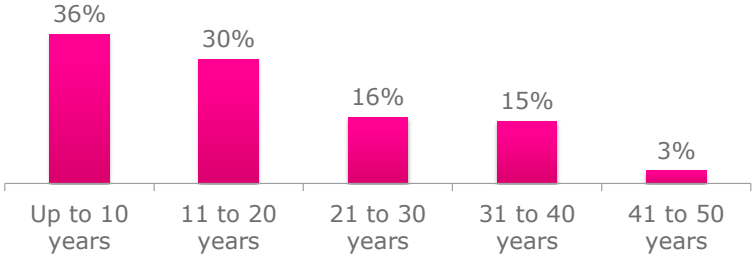
Figure 44: Place of PMQ of doctors involved in all cases (Base n = 119 cases)



Time registered in the UK

On average, doctors involved in the cases had been registered in the UK for 17 years when they were suspended or erased. There was a relatively high frequency of suspension or erasure during the first 20 years of practising in the UK, after which the likelihood was reduced (see figure 45). However, it is possible that this reduced likelihood of suspension or erasure with increased time practising in UK could have been a reflection of fewer doctors remaining in practice for this duration.

Figure 45: Time registered in the UK of doctors involved in all cases (Base n = 119 cases)



Those who qualified outside of the UK were suspended or erased earlier in their careers in the UK (on average after 15 years) than doctors who qualified in the UK (on average after 23 years). See figure 46. However, it is possible that the discrepancy could be accounted for by non-UK qualified doctors practising outside of the UK for a period of time before their arrival in the UK and so the total length of time in practice could be similar at the point of receiving such a sanction. Figure 46 shows the time practising in the UK of all cases.

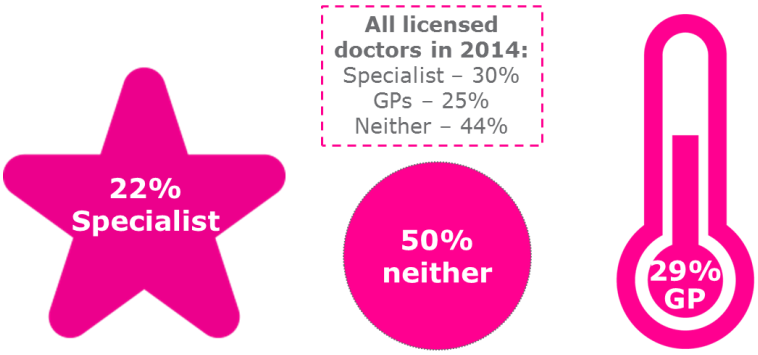
Figure 46: Time registered in the UK of doctors involved in all cases split by UK and non-UK qualified doctors (Base n = 119 cases)

Time registered in the UK	UK qualified doctors (n = 37)	Non-UK qualified doctors (n = 82)
Up to 10 years	10	33
11 to 20 years	3	33
21 to 30 years	11	8
31 to 40 years	11	7
41 to 50 years	2	1

Type of doctor

The proportion of Specialists and GPs that were suspended or erased was similar to all licensed doctors. See figure 47 for the type of doctors involved in the cases.

Figure 47: Type of doctor (Base n = 119 cases)



GPs were more likely to be suspended than erased (23 suspended and 12 erased out of 35 cases), whereas Specialists were equally likely to be suspended or erased (13 suspended and 13 erased out of 26 cases). Doctors with no specific flag were slightly more likely to be erased (35 out of 59) than suspended (24 out of 59).

Almost a quarter of all cases feature locum doctors (23%). On the whole, the case types are similar between locums and non-locums.

Contact us...

Rebecca Harris

Research Manager

DJS Research

+(0)1663 767 857

rharris@djsresearch.com

djsresearch.co.uk