ALMOST EVERY MEDICAL practitioner chose their profession with the aim of improving patients’ health and wellbeing. So it seems doubly ironic that the very infrastructure that is in place to ensure patients are looked after safely and effectively is, in some places, undermining the wellbeing of practitioners.

Obstetrics is a high litigation specialty; in 2015/16, obstetrics was the highest in terms of the value of claims paid out. In addition, 80% of units have reported gaps in their middle-grade rotas, making service delivery very challenging. The combination of a high-risk specialty and workforce supply issues has led to an atmosphere of fear, and a culture of blame and shame within many hospitals and Trusts.

Nobody would deny that complaints processes are necessary – indeed, they can be an effective tool in helping to improve health services – but it is increasingly evident that more needs to be done locally to support both employers and doctors to manage complaints more effectively.

In 2016, there were just over 9,000 complaints about doctors reported to the GMC. Of these, nearly 8,000 were closed after initial investigation, with 200 referred to a tribunal and 160 of those resulting in suspension or erasure from the medical register. These figures demonstrate that the vast majority of complaints to the GMC are unnecessary.

It’s unfortunate, then, that the GMC is obliged to investigate each one, with two harmful consequences: firstly, that more serious complaints relating to genuine wrongdoing will take longer to process; and secondly, that those under investigation, who perhaps shouldn’t be, will suffer the stress and uncertainty of the process unnecessarily.

The effect on this latter group is of great concern, as extensive research carried out by Imperial College and led by Professor Tom Bourne, Consultant Gynaecologist at Queen Charlotte’s and Chelsea Hospital, demonstrates. Their most recent paper, published last year, showed for the first time an association between the way complaints are handled and symptoms of anxiety, depression and defensive medical practice in doctors.

Further complicating the process is a media interested in ‘blaming and shaming’ Trusts and practitioners – so we end up with a situation where Trusts are more likely to suspend a doctor at the first hint of a complaint, and then carry out an investigation, rather than risking a trial by media.

This often leads to the doctor in question feeling exposed, vulnerable and lacking peer support, with potential ill effects on their health as outlined above.

“Complaints processes are necessary but it is increasingly evident that more needs to be done locally to support both employers and doctors to manage complaints more effectively”

In harm’s way

All this is alarming in itself, but there’s another factor highlighted in Professor Bourne’s research, too: the adverse effects on patient care. Because if doctors are worried about being the subject of a complaint, or are under investigation, they are more likely to practise defensively by over-prescribing drugs and tests, and avoiding high-risk patients and procedures.
The Supporting our Doctors Task Group aims to open a dialogue with the profession about how complaints are being handled and to advocate for a more consistent, open and progressive approach.

The group has identified five core principles it believes should underpin a good complaint-handling process:

1. **INCLUSION** – exclusion should be a last resort having demonstrated that no other realistic and acceptable work can be offered, e.g., limiting an area of practice or teaching.

2. **PEER SUPPORT** – doctors should be encouraged to support and speak to colleagues experiencing difficulties.

3. **TIMELINESS** – complaint handling and investigations must be completed in a timely manner.

4. **COMPETENCY** – training for everyone handling and investigating complaints.

5. **EQUALITY** – a nationally recognised and applied framework for complaint handling, to ensure parity and consistency across the profession.

To achieve this, the task group will:

- Set a strategy and coordinated approach for supporting doctors (and their employers) with their training and workplace-based conduct and practice challenges.
- Partner with organisations that provide services to doctors in difficulty to raise awareness of and signpost to support resources available outside the RCOG.
- Formalise links and establish respective roles with regulatory, indemnity and other relevant national bodies. Work with them to ensure fair, efficient and effective processes that benefit both doctors and their patients.
- Provide support and information on how to manage workplace challenges.
Worryingly, Professor Bourne’s research showed that these negative impacts are also prevalent with both formal and informal complaints that do not reach the GMC. “Unfortunately, O&G doctors are disproportionately affected by these processes,” observes Mr Christoph Lees, Honorary Consultant in Obstetrics and Head of Fetal Medicine at Imperial College. “It’s the collision of high patient expectations, medical science and media interest. In O&G, as in surgery, there are inevitably situations where whatever you do, you will never get the desired outcome. It does lend itself to both disappointment and upset at times, unfortunately, and someone often ends up being held responsible for that. An additional factor is that reproductive medicine is extremely newsworthy.”

A role for the RCOG
So we are in a situation that is detrimental to both doctors and patients, and the College believes there is a role for us all to play in supporting doctors who are affected by it. Rather than helping just those doctors or employers who contact the College, the RCOG has embarked upon a more proactive approach to benefit more doctors. The first step towards achieving this was taken last May, with the launch of the Supporting our Doctors Task Group.

The task group aims to open a dialogue with the profession about how complaints are being handled and to advocate for a more consistent, open and progressive approach where Trusts, doctors and their patients all feel supported through the process. The group also plans to capture what’s working well and to share examples of good practice, providing an opportunity for the profession to learn from and better support each other.

Chaired by Dr Alison Wright, Vice President, UK & Global Membership, it includes about 20 members – a mixture of experienced clinicians and trainees along

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Fitness to practise in numbers

<table>
<thead>
<tr>
<th>Total enquiries to GMC</th>
<th>9,146</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enquiries closed after triage</td>
<td>6,759</td>
</tr>
<tr>
<td>Investigated</td>
<td>1,296</td>
</tr>
<tr>
<td>Provisional enquiry</td>
<td>616</td>
</tr>
<tr>
<td>Medical practitioner tribunals</td>
<td>200</td>
</tr>
<tr>
<td>Outcomes</td>
<td>193</td>
</tr>
</tbody>
</table>

Includes erasure, suspension, conditions, undertakings, warnings and voluntary erasure. Source: GMC Fitness to practise statistics 2016. Tables 1, 2a, 4
Working together

The RCOG has been working closely with the membership, through focus groups and surveys, to understand the extent and nature of their workforce challenges and to develop meaningful and sustainable solutions, and is keen that all members have the opportunity to input into this important area of work.

GET IN TOUCH

If you have ideas or feedback, particularly if you have examples of approaches that are working well in your Trust, then we want to hear from you. Please contact workforce@rcog.org.uk and we’ll contact you to capture your feedback.

“...we’d like to encourage people to seek our help and assistance at an earlier stage”

With representatives of the GMC and a medical defence organisation. “Many of the senior clinicians have had an experience of being through, or supporting others through, a disciplinary process themselves. Steve Powis, National Medical Director, NHS England, has recently joined the group, and we aim to co-opt members from other relevant organisations too,” explains Alison.

The group aims to engage with relevant bodies to help create a system that is less adversarial and more conducive to learning from mistakes. It is also putting in place systems to support colleagues experiencing a complaints procedure.

Christoph, who is also a member of the task group, adds: “It’s still early days, but it is very encouraging to see strong backing from the most senior officers of the RCOG, and engagement with the GMC. The group is a very cohesive one where strong opinions can be voiced and debated – it’s a very energising experience.”

Over the past year, the group’s priorities have been to ascertain the scale of the problem, and whether there is indeed a need for this group (there is); to set up partnerships and links with other bodies – including, importantly, the GMC – and to collate useful resources.

Peer to peer support

As a result of the task group, a body of senior clinicians has begun to provide an informal Peer to Peer Support Service for those who are looking for guidance on workplace issues. This is not intended as a formal mentoring service, but as a way for members to talk to other members who are willing, and in a position, to offer guidance on handling issues – mainly non-clinical ones.

Christoph is one member providing guidance in this way, and explains that he comes across three main categories of enquiries. “First, there are doctors who simply find themselves caught up in a dysfunctional Trust, where there is a department under special measures and they feel that they are responsible, or are being held to be responsible, for care deficiencies that are outside their control. These doctors often find themselves very isolated, poorly supported and guilty by association. In other cases, there are doctors who are going through either Trust investigations and/or disciplinary procedures, or GMC investigations, and are simply very bewildered by the process and where it may end. In many cases the first reaction of these doctors is to want to leave medicine, and they’re wondering how they are actually going to do the basic things like pay their bills. Our job there is putting into perspective what is likely to happen; what the range of outcomes is likely to be.

“The third major category is where there are serious interpersonal difficulties between doctors. These may not have led to formal procedures, but there are concerns about how cases are being managed. Often cases are about to enter some sort of formal process, and people are contacting us just before that happens to ask what we do, or they can do.

The parameters of support

“In all these cases, it’s important to stress that the support offered doesn’t come from a trade union representative or a defence union representative,” says Dr Alison Wright, who is also part of the peer to peer service. “We’re simply offering a supportive, listening ear and a sense of perspective, and from our experience we may very well be able to point doctors towards services or people that are appropriate. We have to be very clear about where our advice can start and end.

“But a lot of doctors just find it helpful to talk to someone – particularly someone who might have been in a position similar to theirs and is familiar with the processes. Occasionally it may be a case of pastoral care, and we may have more idea of the resources available. For example, the GMC has Employer Liaison Advisors, who employers can contact to see whether or not a case should be sent to the GMC, but
that’s something a lot of people don’t even know about.

“Something we’d really like to emphasise is that we’d like people to seek our help and assistance at an earlier stage – the sooner we hear about concerns or problems, the better. All too often we are approached by a doctor or Trust when a situation is already at a difficult stage, and that means it’s much harder to unpick and work out if it’s a clinical issue or whether there might be other issues within the team.”

**Expert Opinion Service**

One of the most pressing priorities of the task group is to support Trusts and doctors to resolve more complaints locally and specifically to avoid exclusion wherever possible and appropriate to do so. It is about to trial an Expert Opinion Service, which will be key to achieving this.

“I think this is probably the most important part of our work,” asserts Christoph. “One of the hardest things for a doctor is to be excluded pending an investigation – it’s incredibly isolating and damaging – and it has knock-on effects in terms of rota gaps, operating lists, teaching and so on, making it harder for the department or Trust. This new service could help avoid that happening in many cases.”

The Expert Opinion Service will be able to play a part as long as both the Trust and their doctor agree to engage with it. A small group of experienced clinicians will look at the prima facie documents from the Trust and doctor, examining the allegations, and provide an opinion on the situation to help determine what should happen next.

“Again, it’s important to point out that we’re not legally qualified,” says Christoph, who has been instrumental in setting up this pilot. “It would be our place to say, is this doctor really a danger to patients, or are the allegations such that, even if proven, they would lead to concern about this? It may be a situation where the doctor could be redirected from gynaecological theatre to obstetric sessions, or the other way around, or could be practising in another way that is still useful.”

“That way the doctor in question would still be in contact with other professionals and still functioning, albeit perhaps not quite the full range as they were previously,” he concludes.

Christoph estimates that 50-75% of exclusions could be avoided if approached in a different way, potentially avoiding catastrophic damage to doctors and expenses for Trusts. “Obviously, there would be no compulsion for the Trust to follow the recommendation, but the feeling is that this balanced external opinion will give enough influence to lead to a more proportionate outcome in many cases.”

In all of this we must acknowledge, of course, that it is crucial to have a complaints and disciplinary system in place. “There is increased scrutiny on all our clinical practice and I think that’s
“We are all consumers of healthcare and it’s in our interests to get it right for all parties”

absolutely appropriate. It’s quite right that we are accountable – that’s as it should be,” observes Alison.
“Complaints are inevitable, and regulatory processes are essential,” agrees Christoph.
“The aim of the Task Group is to see the process made more humane and fairer to doctors – and, of course, provide fairness to those that may very well have legitimate complaints. We are all consumers of healthcare and it is in our interests to get it right for all parties. But demoralising the workforce doesn’t improve patient care.”

**Useful resources**

**RCOG RESOURCES**

**Confidential peer to peer support**
The College offers informal peer to peer support to members who are looking for guidance from their peers on workplace issues. The service is treated as strictly private and confidential.

**Clinical Directors Leadership Forum – 21 June 2018**
This one-day event for clinical leaders covers job planning, workplace behaviours, CQC preparation and guidance on how to effectively manage complaints and serious incidents.

**Improving workplace behaviour**
This resource aims to help trainees/trainers become more aware of the difficult issues surrounding undermining and bullying in the workplace, illustrating various methods on how to tackle this.

**Undermining toolkit**
In conjunction with the Royal College of Midwives (RCM), we have developed a freely accessible undermining toolkit to improve workplace behaviours.
[bit.ly/2GTHJ1B](https://bit.ly/2GTHJ1B)

**GMC: Responsible Officers**
Helping to make sure a doctor who has restrictions on their practice is appropriately and safely managed.

**GMC: Employer Liaison Service**
Advising employers on whether a case should be referred to the GMC.

**Building a supportive environment: a review to tackle undermining and bullying in medical education and training**
Outlines the findings from a series of undermining and bullying check visits to O&G and surgical units.

**Royal College of Surgeons of Edinburgh**
An online resource to tackle bullying and undermining.

**Academy of Medical Royal Colleges**
The AoMRC has produced Creating Supportive Environments to combat undermining in the workplace.

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**BAWA-GARBA**

**THE RECENT BAWA-GARBA case** has brought many of the issues in this article into sharp relief, and in particular the impact that the law of Gross Negligence Manslaughter has when it is applied within the context of a complex healthcare system and the consequences for regulating individual practitioners. The Department of Health and Social Care and the GMC have commissioned reviews to explore the issues raised by this case, and the RCOG is actively contributing to both, with input from the Supporting our Doctors Task Group and Trainees Committee. The RCOG’s written response, together with further information, can be found at [rcog.org.uk/bawa-garba](https://www.rcog.org.uk/bawa-garba).

Doctors’ perception of support and the processes involved in complaints investigations and how these relate to welfare and defensive practice; a cross-sectional survey of the UK physicians. By Tom Bourne et al. Published Wednesday 22 November in BMJ Open.

“We are all consumers of healthcare and it’s in our interests to get it right for all parties”

**Advice for O&G trainees**
Advice for trainees on dealing with undermining in the workplace.

**Workplace Behaviour Champions**
Helping trainees to address undermining and bullying at work.

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