Attitudes to Medical Regulation and the Revalidation of Doctors 2005

Research among the General Public, GPs and Hospital Doctors

Research studies conducted for the Department of Health

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Volume I: Research among the General Public and GPs - July 2005

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July 2005

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Introduction

The Government has decided to review the GMC's proposed new system of doctor revalidation in the light of Dame Janet Smith's report on the Shipman case. As part of this review, the GMC, the medical profession and other interested parties are being consulted.

The main aims of the review are to:

- strengthen procedures for assuring the safety of patients in situations where a doctor's performance or conduct poses a risk to patient safety or the effective functioning of services;
- ensure the operation of an effective system of revalidation; and to
- modify the role, structure and functions of the GMC.

Against this background, MORI was commissioned to conduct research exploring the following:

- public perceptions of how doctors are regulated, and awareness of and attitudes towards revalidation of doctors; and
- GPs' attitudes towards regulation and the GMC's proposed new system of revalidation.

This report presents the findings of research carried out among the UK public and UK GPs. The research was conducted by MORI Social Research Institute on behalf of the Department of Health.

The findings will inform the Consultation Advisory Group being Chaired by Sir Liam Donaldson, which is deliberating on the future of medical regulation.

Methodology: The research methodology comprised qualitative and quantitative research among both the general public and doctors (using a GPs omnibus for the quantitative part of the research among doctors). These stages are described further below.

General Public Qualitative Research: For research among the general public, a combination of 6 discussion groups and 6 in-depth telephone interviews among harder-to-reach people and BMEs was used. The locations for the focus groups were: North of England (Leeds): 2 groups; Midlands (Birmingham): 2 groups; and London: 2 groups.

Quotas were set by: age, social class, area and 'life stage' (single, parents, grandparents, carers, and elderly people themselves) to provide insight into some of the key differences between social and demographic groups.

The following people were recruited for each group:

Group 1 **North (Leeds)**	All 55+; all C2DE; 7 men/ 4 women; 8 grandparents; all in-patients/out patients in the last year, or visited someone in hospital, or visited their GP/practice nurse.
Group 2 **North (Leeds)**	All 35-54; all ABC1; 5 men/ 5 women; 5 with children under 16; 1 carer for disabled person(s); 1 carer for elderly person(s); 7 in-patients/out patients in the last year, or visited someone in hospital, or visited their GP/practice nurse.
Group 3 **Midlands (Birmingham)**	All 55+; all ABC1; 5 men/ 5 women; 8 grandparents; 1 with children under 16; 1 carer for disabled person(s); 1 carer for elderly person(s); all in-patients/out patients in the last year, or visited someone in hospital, or visited their GP/practice nurse.
Group 4 **Midlands (Birmingham)**	All 35-54; all C2DE; 3 men/ 7 women; 3 grandparents; 4 with children under 16; 3 unemployed; 1 carer for disabled person(s); 1 carer for elderly person(s); 1 carer for elderly person(s) and disabled person(s); all in-patients/out patients in the last year, or visited someone in hospital, or visited their GP/practice nurse.
Group 5 **London**	All 18-34; All ABC1; 5 men/ 5 women; 3 with children under 16; 1 carer for elderly person(s); all in-patients/out patients in the last year, or visited someone in hospital, or visited their GP/practice nurse.

Group 6 **London**	All 55+; all C2DE; 5 men/ 5 women; 6 grandparents; 2 carer for disabled person(s); all in-patients/out patients in the last year, or visited someone in hospital, or visited their GP/practice nurse.

Half of the groups were conducted among older people, to reflect the fact that they are more likely to have chronic illnesses and to be users of the health service.

Six in-depth interviews were conducted by telephone among the following hard-to-reach groups:

- 4 depths with carers of elderly and/or disabled person(s), one of whom was elderly and one of whom was disabled themselves.
- 2 depths with people from BME groups (who represent 6% of the British population), one of whom was elderly and disabled.

All had been in-patients/out patients in the last year, or visited someone in hospital, or visited their GP/practice nurse.

General Public Quantitative Research: A large-scale quantitative survey was conducted to assess public opinion across the UK on the regulation and revalidation of doctors. Questions were placed on the MORI Omnibus, the regular MORI survey among the general public. A nationally representative quota sample of 2,195 adults (aged 15 and over) was interviewed throughout the UK. Of these, 2,085 were interviewed by MORI in Great Britain and 110 were interviewed by MORI Ireland in Northern Ireland.

Interviews were carried out face-to-face, in respondents' homes, with the aid of CAPI terminals (laptops) in Great Britain and on paper in Northern Ireland. Fieldwork was conducted between 16 and 20 June 2005.

Qualitative Research Among Doctors: This stage comprised two mini-groups – one in central London, and one in outer London - each of 6 doctors; and 2 in-depth telephone interviews**.** The central London group had a mixture of junior doctors and medical students (two medical students, a house officer, an SHO and two registrars) and the outer London group had a mixture of hospital doctors and GPs (three of each). The depth interviews were conducted with a practice Partner involved in training, and a trainee with experience of general practice.

Quantitative Research Among Doctors: Survey questions were placed on a GP Omnibus survey, providing a sample of 200 GPs. Interviews were conducted via the Internet between 23 and 25 of June 2005.

It is not possible to draw firm conclusions on the differences of opinion between doctors – by gender, date of qualification, number of GPs in Practice or the location of the Practice – as the sub-group sizes are not sufficient to provide robust statistical findings. Further detailed research would be required to prove conclusively whether any apparent differences between these sub-groups highlighted by the research represent 'real' differences.

Reporting: In the graphs and tables, the figures quoted are percentages. The size of the sample base from which the percentage is derived is indicated. Note that the base may vary – the percentage is not always based on the total sample. Caution is advised when comparing responses between small sample sizes.

As a rough guide, please note that the percentage figures for the various sub-samples or groups generally need to differ by a certain number of percentage points for the difference to be statistically significant. This number will depend on the size of the sub-group sample and the percentage finding itself - as noted in the appendices.

Where an asterisk (*) appears it indicates a percentage of less than half, but greater than zero. Where percentages do not add up to 100% this can be due to a variety of factors – such as the exclusion of 'Don't know' or 'Other' responses, multiple responses or computer rounding.

Publication of Data: Our standard Terms and Conditions apply to this, as to all studies we carry out. Compliance with the MRS Code of Conduct and our clearing is necessary for any copy or data for publication, web-siting or press releases which contain any data derived from MORI research. This is to protect our client's reputation and integrity as much as our own. We recognise that it is in no-one's best interests to have survey findings published which could be misinterpreted, or could appear to be inaccurately, or misleadingly, presented.

Nota Bene: It is worth noting that during the fieldwork period several news stories involving the competence of medical professionals were being aired through the media. Most notable was the case of Professor Dick van Velzen who was ordered to be struck off by the GMC on 20 June, following a three week tribunal. Professor van Velzen was found guilty of removing and retaining organs from the bodies of dead children without their parents' permission at Liverpool's Alder Hey hospital. Pertinent to this study, Chair Ian Chisholm said of the Professor: "He has undermined trust placed in medical practitioners to such an extent it has damaged the medical profession as a whole".[1]

[1] Source: BBC News website: http://news.bbc.co.uk/1/england/mereyside/4112232.stm

Other relevant news stories included the case of Dr Alan Williams who was found guilty of misconduct and barred from undertaking any Home Office pathology work or coroner's cases for the three years. Dr Williams was accused of carrying out sub-standard post-mortem examinations and not disclosing evidence that could have helped clear Sally Clark, who was wrongly convicted of murdering her two young sons.[2] Paediatrician Sir Roy Meadows also faced charges of serious professional misconduct during the fieldwork period, relating to his use of statistical evidence during the Clark case.[3]

[2] Source: BBC News website: http://news.bbc.co.uk/1/hi/health/4595839.stm
[3] Source: BBC News website: http://news.bbc.co.uk/1/hi/health/4111002.stm

Executive Summary

Few members of the general public know anything about the current system of assessment of doctors after qualification.

- Almost half assume that regular assessments already take place, with over one in five thinking they already happen on an annual basis.

There is widespread support for regular assessments, both among the general public, and general practitioners.

- The public and GPs alike feel checks on doctors are necessary, despite high levels of trust in the profession.
- Nine in ten members of the public and seven in ten GPs think it is important that doctors' competence be assessed every few years.
    - Nearly half the public think these assessments should be done on an annual basis, while GPs favour less frequent assessments.
- Although doctors are more likely than the general public to agree that inspecting all doctors regularly would be a waste of time and money, overall, a greater proportion of both groups think the benefits outweigh the negative implications.

The public favours a mixture of qualified medical professionals and knowledgeable people with no medical qualifications to assess doctors. GPs on the other hand, favour being assessed by other medical professionals only.

- Both groups are critical of the GMC however, and are worried about the implications of self-regulation.

The key element of any potential assessment for both the public and GPs is evidence that doctors are keeping up-to-date with medical developments.

- Doctors are less keen than patients on having the success rates of their treatments monitored however, or on having their qualifications re-checked.

Most people would welcome giving feedback on aspects of their doctor's abilities, particularly on their communication skills.

This illustrates that improved procedures for assuring the safety of patients would be welcomed by both the public and GPs.

Summary of Findings

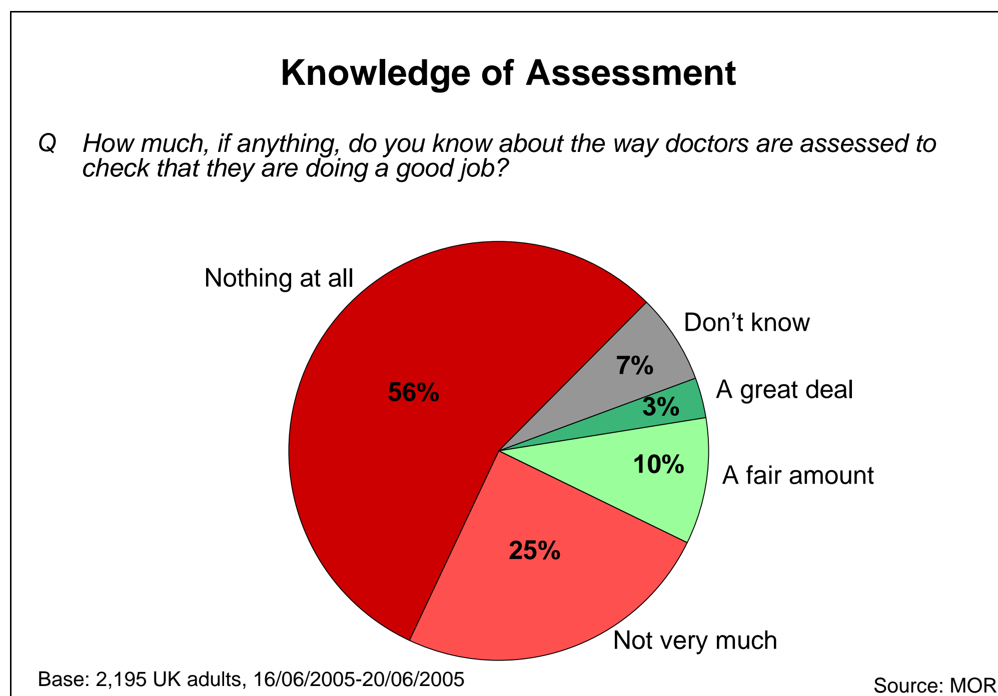
Setting the Scene

We interviewed 2,195 members of the public during the quantitative phase of this study. Of these, 85% had accessed healthcare services during the past year, with three-quarters visiting a GP. This makes GPs the main means of contact with the NHS, and one should consider that it is probably therefore GPs who come to mind most often when the public comments about doctors.

Experiences of GPs are generally positive: 85% say that they are either very or fairly satisfied with their last visit, and only 8% that they are very or fairly dissatisfied.

Levels of satisfaction are particularly high among the elderly (with 89% of those aged 55+ saying they are either very or fairly satisfied with their last visit to a GP), as well as amongst those using only NHS services, and having used them in the last year (88% of this group are very or fairly satisfied).

Awareness and Understanding of Doctors' Assessments



Few people say they know anything about the way doctors are assessed to check they are doing a good job. This is in line with MORI's other work which has demonstrated that few people know about regulation in any domain[4]. More than half (56%) say they know 'nothing at all' about the way doctors are assessed, and

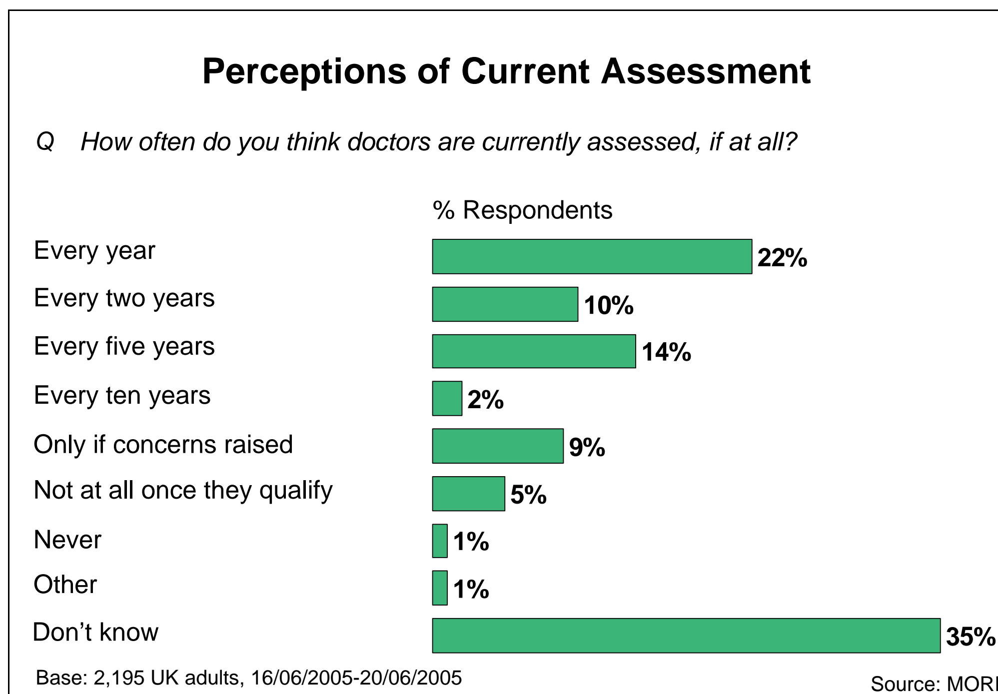
[4] This is based on MORI Local Government Research, Central Government Research and Political Research

a further 7% say they 'don't know'. A quarter say they do not know very much, whilst one in ten say 'a fair amount'. Only a tiny proportion feels well informed about the way doctors are assessed, with 3% saying they know a 'great deal'.

Age, class and traits such as newspaper readership, level of education and household income all seem to have an impact on this issue. Younger people are less likely to say they know nothing or not very much about the way that doctors are assessed. ABs are also less likely to say they know nothing or not very much on this subject, as are those reading broadsheets (77% vs. 82% of tabloid readers). There also seems to be a correlation between lack of knowledge of doctor assessment and level of education of respondents: 61% of those educated to GCSE level or equivalent say they know nothing at all about the way doctors are assessed, compared to 52% educated to A-level or equivalent and just 44% of those educated to degree level.

Although only 12% of respondents overall say they know a great deal or a fair amount about the way doctors are assessed, one in ten (9%) of those in the lowest income bracket say this, as compared to one in five of those in the highest income bracket.

Those who are satisfied with their GP are more likely to say that they know a great deal or a fair amount about the way doctors are assessed, particularly those who are very satisfied: 13% say this compared to 8% of those who are dissatisfied with their GP.



Understanding of the way doctors are assessed is also low. Nearly half (46%) feel that there is some regular assessment of doctors, including 22% who feel this happens annually. Around one in three say they do not know how often doctors are assessed. Few (9%) think that assessments are made only if there are concerns about their ability.

Younger members of the public are more likely than older ones to think that regular checks are taking place every 1-5 years. Over half of those working full-time (52%) think that doctors are currently assessed every 1-5 years, compared to just 42% of those who are not working. There also seems to be an expectation of regular checks by patients using private medical care: 55% of these think they are taking place, compared to 46% of those only using the NHS.

Regional differences in this area are quite marked but few overall patterns emerge. For example, over half (53%) of those in the East Midlands think assessments currently take place every 1-5 years, compared to just two in five of those based in the North-West.

The quantitative findings are broadly in line with the qualitative work carried out among the general public. On the whole, respondents had little awareness of regulation.

> *I'm not sure to be honest. I'd like to think there will be some sort of regulations there (sic), but I couldn't honestly say, yes there is or no there isn't*
>
> Leeds, depth interview, younger male, ABC1, BME

Many simply assumed that regulation was in place:

> *They must be [regulated], they're professional people, they've got to be regulated haven't they? They can't just go willy-nilly and do what they like*
>
> Birmingham group, 55+, ABC1

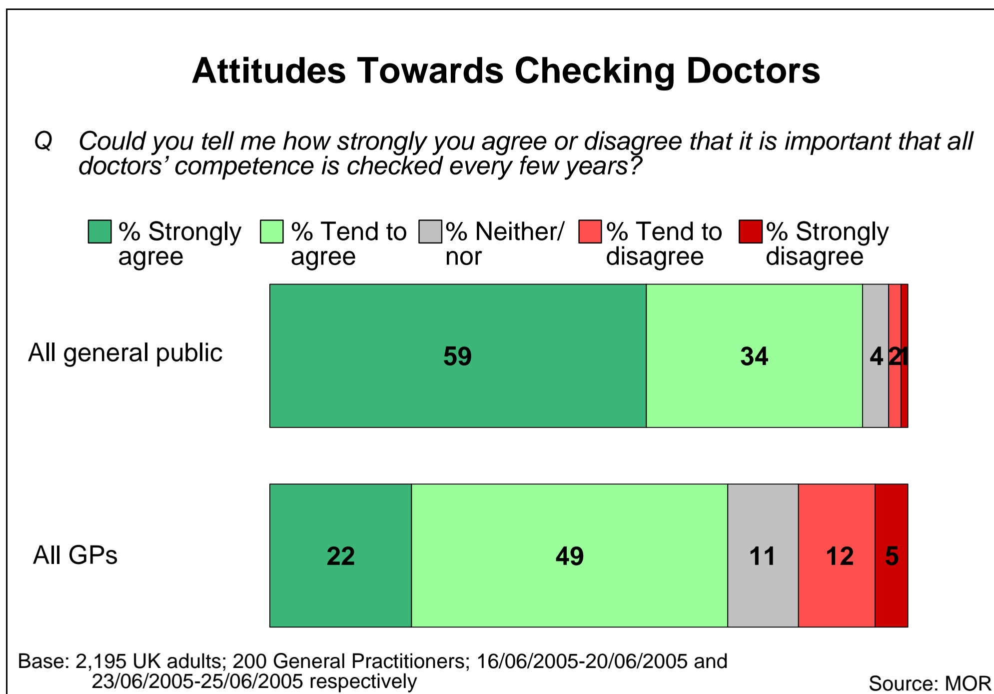
Only one group thought checks were only carried out once doctors qualify:

> *I would presume they're only checked when they go on the register, and then they go on until they die, and are never checked again*
>
> London group, 55+, C2DE

Attitudes Towards Assessments

There is widespread public support for the principle of testing doctors' abilities regularly. Around nine in ten (93%) agree that it is important that all doctors' competence is checked every few years, and three in five feel strongly about this.

Those living in the East Midlands are most likely to agree strongly that doctors' competence should be checked every few years. Seven in ten say this (71%), with 98% of people living in this area either strongly agreeing or tending to agree that it should be done. Those using private healthcare services are also more likely to agree strongly with the importance of checking doctors regularly – seven in ten strongly agree as compared to six in ten who only use NHS services (59%) and 56% of those who do not use any. The same is true of those who are dissatisfied with their GP: 72% strongly agree that all doctors' competence should be checked every few years, compared to 59% of those who are satisfied.



Levels of disagreement with the need for checking doctors' competence every few years are highest among broadsheet readers.

Support for regular assessments of doctors is much less widely and strongly felt among GPs. However, support remains strong: around seven in ten feel that all doctors' competence should be checked every few years – still a clear majority, but a much less widely held view than among the public. Around one in five of GPs feels strongly supportive of regular assessments.

Again, the qualitative findings are very much consistent with the findings from the quantitative work. Regulation and assessments were deemed to be necessary amongst the general public despite concern being voiced regarding the costs:

> *Well it's quite a critical job that they do, doctors. Dealing with life, death and disease, and everything basically. And if they're not checked on a regular basis, then firstly the doctor might not know where he's going wrong, and secondly there might be areas where he is going wrong, and he's following bad practices. If you haven't got a system in place, there's a greater scope for vulnerability, I think*
>
> Leeds, depth interview, younger male, ABC1, BME

The feelings amongst doctors were more mixed, with support for regulation and assessment very much anchored in the perceived loss of trust in the profession:

> *It'd be nice if it wasn't necessary, but I think because of Shipman and other things recently, there's a lot of mistrust in the medical profession. Perhaps if we were […] revalidated then that provides patients with a bit more trust*
>
> Depth interview, female, trainee GP

Even in the case of doctors who supported regulation, it was suggested that (although necessary) reassessment and revalidation would lead to the practice of more defensive medicine. There were also concerns that the processes would reward bad practice, by offering remedial help to those seen as failing/'dragging their feet', and not rewarding those striving for excellence:

> *If you drag your heels things do drop out of the sky, that's always happened […] If you're not forward thinking, people will have to do it for you, [but] if we're all going to meet a certain standard, then the Government always […] have to put extra money and extra effort in to the stragglers, really*
>
> Depth interview, male, rural GP/Partner

There was acknowledgment across the board that reporting colleagues' bad practice was a difficult thing to do in the current framework, despite increased pressure to do so - especially in the context of reporting on more senior colleagues or within small practices. According to some, being seen as a 'whistle blower' could severely impact on a doctor's career:

> *If you're working closely with a colleague and you suspect that their practice is not quite up to standard, it's a pretty difficult thing to approach, and I suppose there's a lot of the old fashioned 'protecting one's colleagues' rather than rocking the boat*
>
> Depth interview, female, trainee GP

> *You are […] under that pressure to come out […] with a good reference, and the point at which you report [bad practice] I think comes in your own personal conscience. [It] takes a lot of balls I think; a lot of guts to [do]*
>
> London group, junior doctor/medical student

However, it was also stressed that the general standards of care provided by doctors were very high, and it was only the cases of 'a few bad eggs' which caused concern. There was hope amongst some respondents, that reassessing or revalidating doctors might not only help pick out those bad eggs, but also raise morale in the profession.

> *I think it's about filtering out the bad eggs; and there are a few bad eggs. Out of thousands of doctors there might be the odd Shipman lurking around […] It's about picking out the oddities that are potentially dangerous to people and letting everyone else get on with it […] Everyone makes mistakes*
>
> London group, junior doctor/medical student

> *I think that doctors have never been better than they are now: they're better trained and have better conditions; they are more open and honest and off their pedestals. I think in the old days there was a problem with doctors [yet] at a time [in which] we are the best we've ever been, we're also seen […] in a worse light than ever. I think that […] doctors are somewhat demoralised […], and I whole heartedly welcome the idea of assessment and revalidation. If it's done properly it will help reassure patients and I hope that that will then help us to regain our morale.*
>
> Depth interview, male, rural GP/Partner

Whatever their overall stance on reassessments and revalidation, neither doctors nor the general public seem convinced that the introduction of assessments could prevent a recurrence of the Shipman case. This seemed especially true of those who knew more about it:

> *He was a good physician but he had a personality flaw that made him want to murder some of his patients; that could happen again*
>
> Depth interview, male, rural GP/Partner

> *If somebody's going to do that sort of thing no testing on earth is going to prove that they're not going to do it*
>
> Leeds, depth interview, older female, C2DE, disabled

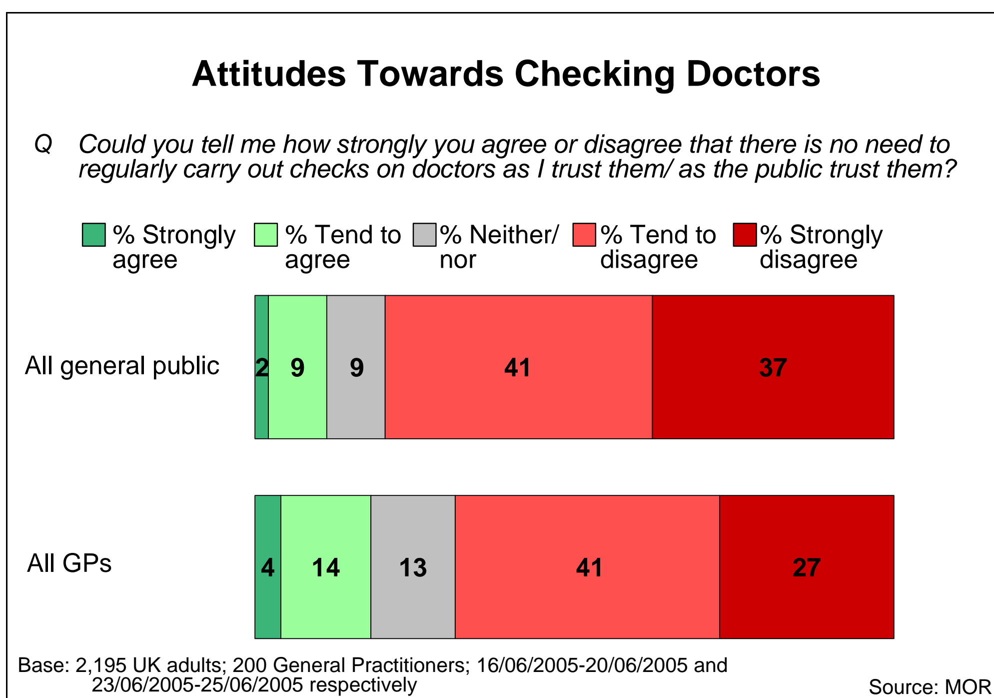
> *Unless mortality figures were particularly looked at, I don't think that problem would have been seen really, I mean it's such an unusual case […] Some things are just going to happen, aren't they? However much you try to stop them […]and that's just one of them. Unfortunately, it's had a fairly huge effect on patients' trust of doctors, but that's life*
>
> Depth interview, Female, trainee GP

Trust in Doctors

The public and GPs alike tend to agree that regular testing of doctors is needed, despite the high levels of public trust in the profession. This high level of trust has been demonstrated in other MORI surveys such as the annual research that MORI carries out on behalf of the BMA[5] comparing levels of public trust in doctors with trust in other professions, in which trust in doctors is consistently high. [6]

The public's trust in doctors does not override the need to carry out checks: only around one in ten (11%) agrees that there is no need to carry out checks regularly on doctors as they trust them. By contrast, nearly four in five (78%) disagree with this, saying that there is a need to carry out regular checks on them.

The groups in which the greatest proportion of people agrees that there is no need to carry out checks regularly with doctors, are the over 55 year olds (16%), and those without formal qualifications (17%). Over 55s are also more likely than those in other age groups to say that inspecting all doctors is a waste of time and money, which may reflect the fact that they are more likely to trust doctors. Those most likely to disagree with the statement (and feel that there is a need to regularly carry out checks on doctors) are those who are dissatisfied with their GP (86%) and those whose household income is in the highest income bracket (86%).



Two-thirds of GPs (68%) disagree that public trust in doctors means there is no need to carry out regular checks, lending fairly strong endorsement from GPs to the concept of revalidation.

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[5] Previously carried out on behalf of Cancer Research UK and *The Times*

[6] See: http://www.mori.com/polls/2004/bma.shtml

Levels of public trust in *individual* doctors (shown during the qualitative part of this research) often contrasted with the high levels of public trust in the profession as a whole shown in MORI's long-standing research comparing levels of public trust across different professions. [7] Although many said that they generally trusted doctors, most had had negative experiences with individuals, and even younger respondents voiced nostalgia for the quality of care once on offer.

Complaints were mostly aimed at GPs (patients' first port-of-call), often relating to the communication skills which both patients and doctors recognise as being so important. They included not being listened to, doctors not taking the time to talk to them, a lack of rapport being formed, insensitivity, and in the case of older patients, being treated 'like idiots'. These experiences stay with patients, and many wanted to share them:

> *I used to be a victim of domestic violence. When I told him [my doctor] about it, he said 'Oh well, you must have deserved it; being a woman you do get on men's nerves'*
>
> Leeds depth interview, older female, C2DE, disabled

In addition, there was heavy criticism relating to the systems of accessing doctors. These included receptionists and appointment booking systems, although they do not necessarily impact on trust in doctors themselves:

> *I think that doctors do a good job, a lot of times it's the receptionist that is not doing the job*
>
> Birmingham depth interview, older male, C2DE, elderly carer

> *You find the receptionists are ten times worse than the doctors, I have to say*
>
> Leeds group, 35-54, ABC1

Key attributes looked for in a doctor (and whose presence helps foster a relationship of trust) were seen as the ability to listen, the ability to understand, the ability to discuss and the ability to offer continuity of care.

[7] See: http://www.mori.com/polls/2004/bma.shtml

There was across the board disagreement that checking doctors implied a lack of trust and it was very much felt that if they were competent, doctors had nothing to fear:

> *If they're confident they're doing their job, they've got nothing to worry about, have they?*
>
> Birmingham, depth interview, older male, C2DE, elderly carer

Most doctors also recognised the importance of these attributes and of having a relationship of trust with their patients:

> *If you don't trust your doctor, then the doctor/patient relationship - there isn't one I don't think, because you're not going to believe a word they say, you won't believe the diagnosis, you're not going to take the tablets, you're not going to turn up for investigations or appointments, so it just doesn't work if there's no trust*
>
> London group, junior doctor/medical student

There was widespread acknowledgement amongst doctors of the importance of their communication skills in the impression that patients form of them and, in particular, a recognition of the importance of being able to listen to patients and of taking the time to do so. It was stressed however, that technical skills and medical knowledge need to go hand in hand with good communication:

> *The three very important attributes are knowledge, skills and attitudes, and all those three things are equally important*
>
> Depth interview, male, rural GP/Partner

Some felt that emphasis on communication skills in training could now be to the detriment of technical skills:

> *I feel there's a running joke whereby you're able to tell a patient that you haven't got a clue what's wrong with them in the nicest possible way*
>
> London group, junior doctor/Medical student

There was consensus amongst doctors that although they are still held in high regard by patients, perceptions of them are changing. In particular, they saw younger patients as less trusting and more willing to question their judgement:

> *I think the older generation are still very trusting of whatever you say, perhaps not correctly, and the younger generation are a bit more questioning and less trusting of what they hear. I think that's something that's across the board for all professions, probably as well, rather than just doctors*
>
> Depth interview, female, trainee GP

The impact of media stories was deemed to have had a noticeable effect on public opinion and on the public's trust in doctors - particularly negative stories such as the coverage of the Shipman case and the Alder Hey organ scandal:

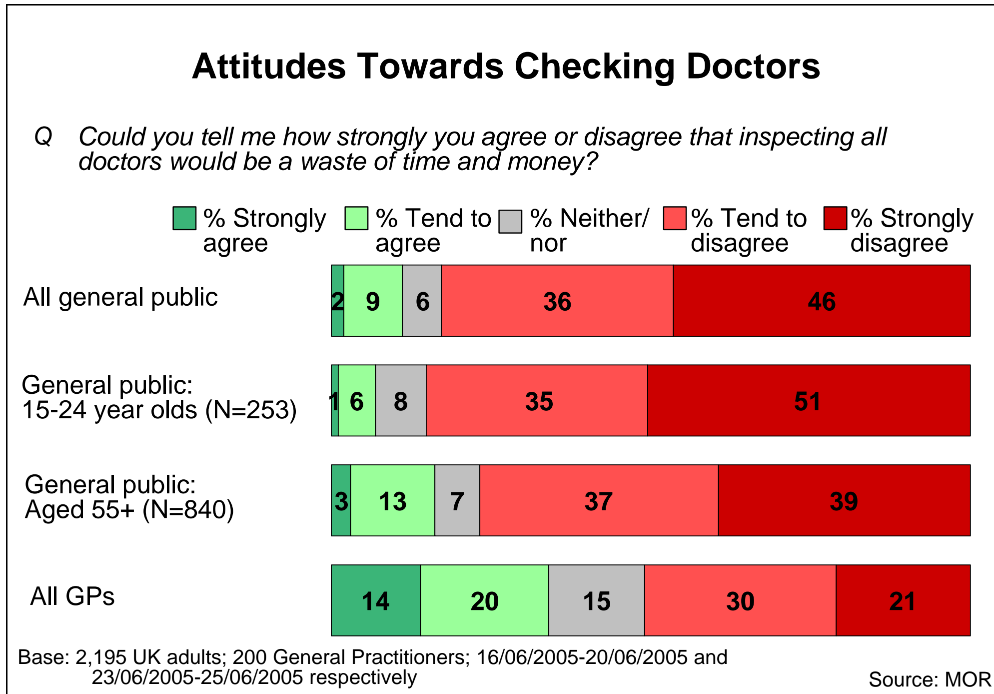
> *The media have undermined a lot of that trust I think, because Harold Shipman was the big sort of watershed of total trust in your GP*
>
> London group, hospital doctor/GP

Media coverage was also blamed for creating unrealistic expectations of doctors e.g. City Hospital not reporting on unsuccessful cases and ER showing high proportions surviving cardiac arrest:

> *[You've got] the ER perspective where 95% of people recover from cardiac arrest. You've [also] got City Hospital, Guy's and Tommy's, whereby they show a lot of very successful cases and there's been some feeling upset amongst the consultants [that] they've not shown cases that haven't got well post op… Patients believe that … this is the norm, this is all the patients, everything goes according to plan. So you either get the fantastic television or media perspective or you get the terrible things going on*
>
> London group, junior doctor/medical student

The Time and Cost Implications of Regular Checks

Any concern among the general public about the cost implications of regular mandatory checks for doctors is outweighed by the perceived need for them to take place. Only one in ten agrees that inspecting all doctors would be a waste of time and money.



Those most likely to disagree and think that inspecting all doctors is a worthwhile use of time and money are those with children in their household and those educated to GCSE level or equivalent (87% in both cases).

Although half of GPs disagree with the view that inspecting all doctors would be a waste of time and money, they are much more likely to think that it is a waste of time than the general public are (34% vs 11% respectively).

The qualitative work revealed that the general public appreciates that inspections are likely to have implications both in terms of time and money:

> *We perceive that the bulk of the money should go directly to patient care. Adding a layer of auditing feels wrong*
>
> Leeds group, 35-54, ABC1

On the whole however, it was felt that these were justified – not a waste:

> *It's time consuming, I'll appreciate it, but when you're dealing with people's lives time doesn't come into it, or money*
>
> Birmingham depth interview, C2DE, elderly male carer

There was a consensus amongst members of the public taking part in the qualitative research that all doctors should be checked, not just those who had had complaints levelled against them. Because the assumption is that doctors are being checked at the moment, there was no debate about what might happen if this doesn't occur. The feelings amongst doctors on this issue were more mixed: one respondent likened revalidation to the investment needed to ensure railway safety – necessary, but at a very high cost for the benefits generated:

> *I think sometimes you have to do these things in a civilised society. It's like having, making railways safe isn't it? It costs millions of pounds for each life you save*
>
> Depth interview, male, rural GP/Partner

Particular concerns were raised amongst doctors in relation to the extra paperwork that assessments and inspections would create, and it was argued that increased 'red tape' would result in less time being spent with patients:

> *It's a really difficult one because you want a system whereby you don't want to drain the whole system in paperwork and bureaucracy and at the same time it picks up the doctors that you don't want to go through the system*
>
> London group, junior doctor/medical student

However, not all doctors taking part in the qualitative research were opposed to every doctor being scrutinised:

> *I think that everyone should be open to scrutiny and we should all be reaching a certain standard. We all need to be assessed for that, we should all reach a certain standard and anyone falling below that standard should be assessed further*
>
> Depth interview, male, rural GP/Partner

There was concern both amongst the general public and amongst doctors that the increased pressure put on doctors by carrying out these assessments might have an adverse effect, and that they might either leave the profession or suffer psychologically as a result:

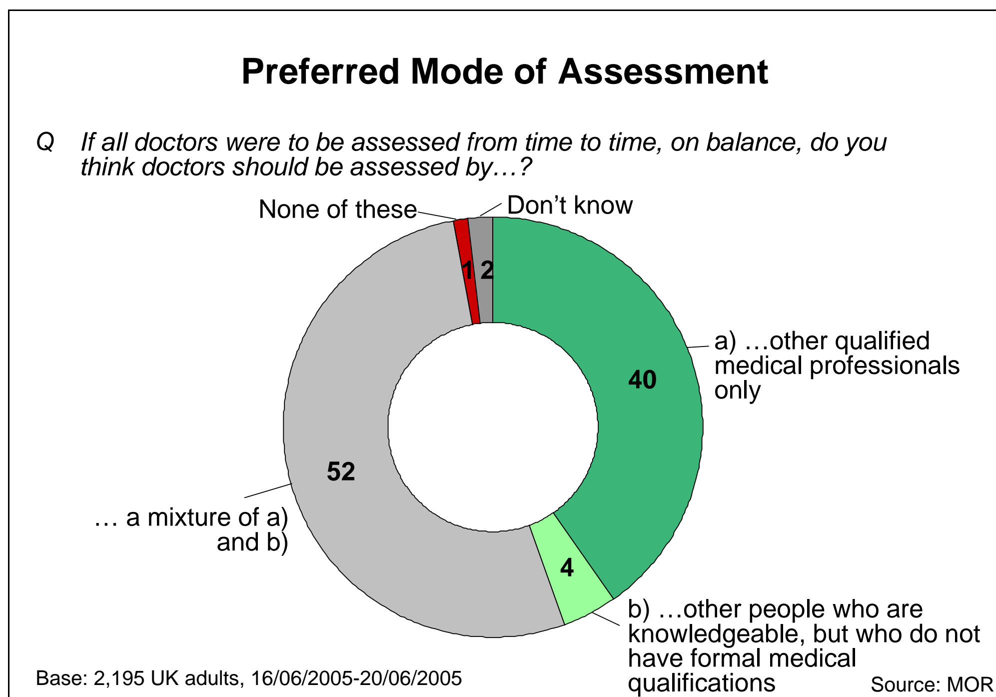
> *If it's not done properly […] it will upset some very good doctors and it won't necessarily get rid of the bad doctors. Whenever these things come in, generally, people that are already good put a lot of effort into things and make themselves even better, and they worry and lose sleep over it. There are psychological sequels from that and, the odd doctor ends up jumping off a cliff.*
>
> Depth interview, male, rural GP/Partner

Who Should Regulate and Assess Doctors

Compared with the general public, GPs are much more inclined to favour assessment by qualified medical professionals only, suggesting that most doctors feel medical professionals alone are best placed to assess their performance. Whilst two in five of the public feel that only qualified medical professionals should be involved, this rises to 58% of GPs.

Around half (52%) of the public is in favour of expert lay people also being involved, compared with 33% of GPs who support this. Only 4% of the public feel doctors should be assessed by expert lay people and none of the GPs favour this.

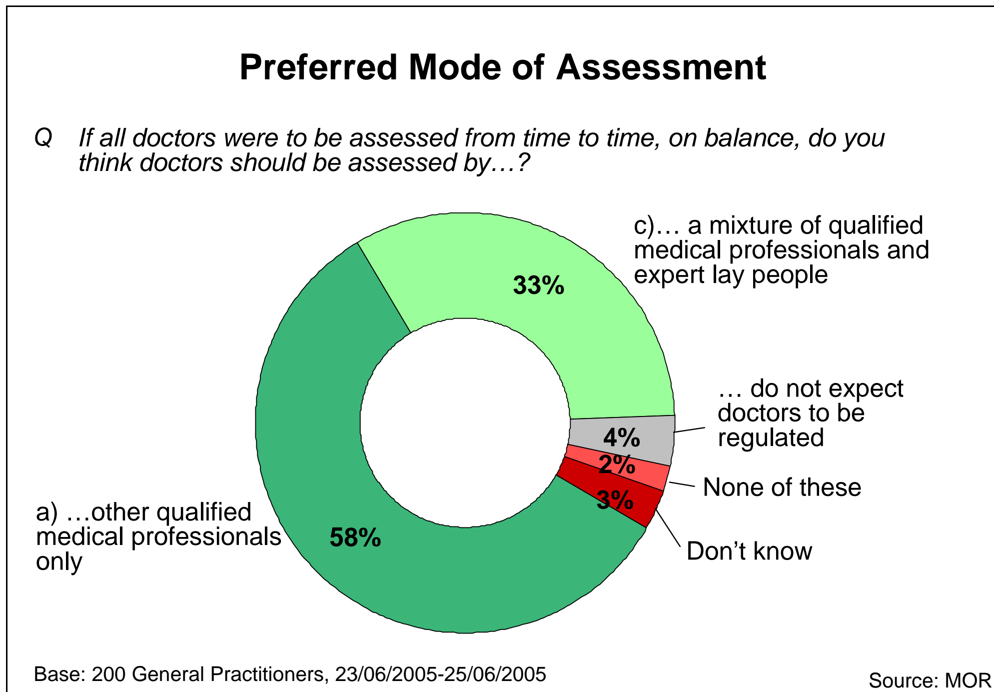
Opinions on who should assess doctors are fairly consistent by type of GP and type of practice.

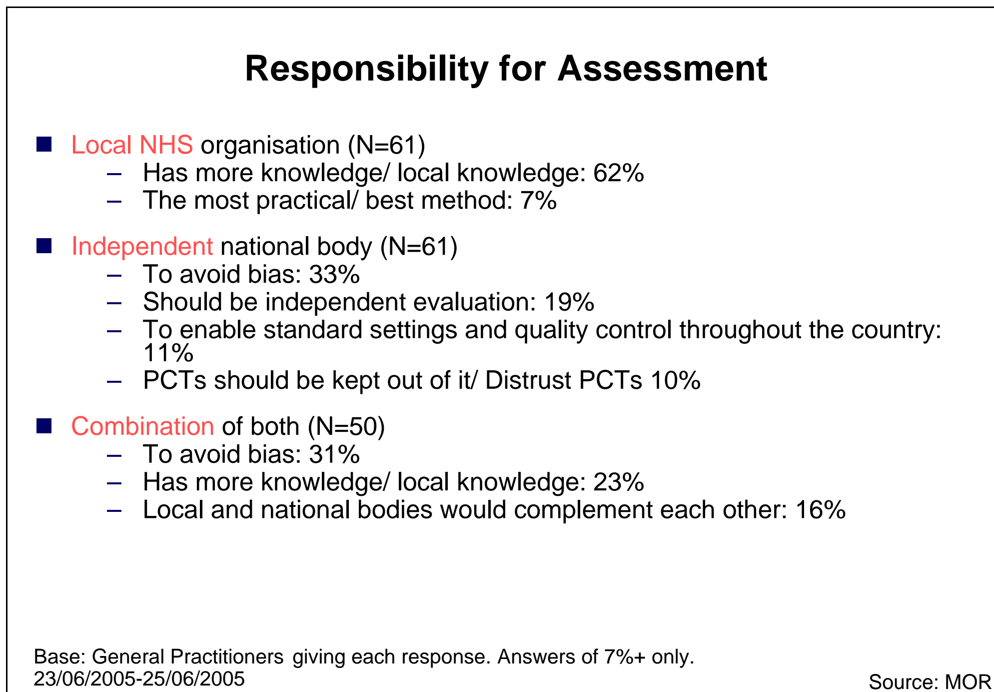


Within the general public, there are differences in preference according to demographic grouping. Slightly more 15-24 year olds favour assessment by qualified medical professionals only – going against the overall trend (46% favour this method versus 45% favouring a mixture of qualified medical professionals and people who are knowledgeable but have no formal medical qualifications).

GPs are divided on whether any system of regulation and assessment should involve local NHS organisations, an independent national body or a combination of both local NHS organisations and national bodies (see slide below). Three in ten GPs favour only local NHS organisations being involved, a similar proportion favours using an independent national body only, whilst 25% prefer a combination.

Using local NHS organisations for regulating and assessing doctors – whether solely or in combination with a national body – is seen to have one main advantage over independent national bodies: the provision of more local knowledge.[8]





[8] Mentioned by 37 of the 62 GPs saying only local NHS organisations should be used and by 11 of the 50 people who feel that a combination of local NHS organisations and national bodies should be used. Please note that caution is needed in drawing conclusions from these apparent differences due to the small sub-group sizes in question.

The main perceived advantages of using an independent national body – either solely or in combination with a local NHS organisation – is that this is seen as likely to avoid bias[9] and for independent evaluation[10].

General Public Views of Regulatory Responsibility

Although this was not covered by the quantitative research, there was agreement amongst the general public participating in the qualitative research that a national standard for regulation is necessary:

> *It should be on a national level. Primarily because obviously doctors could move around from region to region and there should be a way of looking at all the history together*
>
> Leeds, depth interview, younger male, ABC1, BME

The questions of who *is* responsible for regulation and who *should be* responsible for regulation however, created difficulties.

In a few instances there was spontaneous awareness of self-regulation. This received mixed feedback; on the one hand there was a feeling that only other doctors have the knowledge necessary to understand the technicalities of their colleagues' work:

> *A man in a suit who's never picked up a stethoscope: how can he go and assess what the doctor's doing?*
>
> Birmingham group, 35-54, C2DE

> *It's difficult to see how they could be externally regulated rather than self-regulated because it would take another doctor to know whether they were doing it right or not*
>
> Leeds group, 35-54, ABC1

[9] Mentioned by 20 of the 60 GPs who favour using an independent national body only and by 16 of the 50 who prefer a combination.
[10] Mentioned by 12 of the 60 GPs who favour using an independent national body only. Due to the small sub-group sizes, findings should be interpreted with caution.

On the other hand, there was underlying suspicion of self-regulation due to the vested interest that doctors were seen as having in protecting their own:

> *That [self-regulation] is all right to a certain extent but it's a bit like the Police Federation doing checks on police; it's a bit of a closed book*
>
> London, depth interview, younger woman, carer

> *They should be independent to some degree, so it's got no conflict of interest basically*
>
> Leeds, depth interview, younger male, ABC1, BME

> *Well, if there's a complaint about a doctor I reckon they should have an independent body to complain to instead of more doctors. Doctors won't really complain about one another so I think you've got to have an independent body to go to and explain your case to them*
>
> Birmingham, depth interview, elderly male carer, C2DE

> *You can't just regulate GPs by the same people in the practice, it has got to be a panel of external people as well*
>
> London, depth interview, younger woman, carer

Where respondents did comment on who should be responsible for regulation and assessments, they felt the ideal body should be independent, but have input from people with medical knowledge. Retired doctors were given as examples by a few respondents of people who might be able to provide this input. They also thought that outside interests should be taken into consideration:

> *[It should be] people in the same profession as they (sic), not outsiders. It's got to be […] other doctors: ex-doctors, the retired ones, them type of people [it] should be (sic). I don't think it should be politicians anyway*
>
> London, depth interview, older man, ABC1, BME

> *Yeah, I don't think it matters too much who does it as long as it's a representation of everyone with an interest and not just a closed book with the doctors and the BMA*
>
> London, depth interview, younger women, carer

This ties in relatively well with the quantitative research, which shows most preferring a mixture of medical professionals and lay people being responsible for assessments.

In the few cases where respondents were aware of the GMC, the organisation was generally seen in a negative light:

> *Fat cats*
>
> Birmingham group, 35-54, C2DE
>
> *General Medical Council can sit in an office and get told something and then they don't get round to seeing and dealing with it for weeks… They're too slow and they like to look after their own if you know what I mean. If the doctor makes a mistake, he gets a slap on the wrist and told not to be a naughty boy and he's back again and they can keep making the same mistakes*
>
> Leeds, depth interview, older disabled female, C2DE
>
> *The GMC […] it's a reactive type of regulation, isn't it? It comes in when they're all in front of a disciplinary committee, but they don't seem to [do] any[thing] proactive*
>
> Birmingham group, 55+, ABC1

Trusts were also criticised however, and were not seen as suitable for taking over regulatory responsibilities from the GMC:

> *How can they regulate something when they don't know what they're doing?*
>
> London group, 55+, C2DE

Doctors' Views of Regulatory Responsibility

There was consensus amongst doctors that they need input into any system introduced. As with the general public, they felt that only medical professionals are in a position to judge the entirety of a doctor's performance:

> *I think we do need doctors [to be involved] because only they can appreciate what other doctors are doing*
>
> London group, junior doctor/medical student

It was stressed that care needed to be taken in the selection of the doctors involved however, as the doctors in question needed to be 'close to the coalface' rather than the type of doctor often sitting on committees:

> *We need doctors who aren't the committee sitting doctors [though], but doctors who actually work at the coalface to regulate the other doctors*
>
> London group, junior doctor/medical student

Doctors agreed that any systems put in place needed to conform to a national framework, and, in one group, it was suggested that it could conform to international norms. This is not to say that doctors taking part in the qualitative research did not see scope for involvement at a local level reflecting the views of those taking part in the quantitative research. Many in fact thought that implementation should be done at this level:

> *I think it has to be at a local level to start with because they will be both your eyes and ears, picking up the things and they can pass it upwards to try and lose the local personal relationship, so it could be used more objectively as it moves up*
>
> London group, junior doctor/medical student

> *I think it has to be […] a nationally uniform process because doctors move around heaps and to make it as easy a system to work with [as possible]. It should be a nationally based process. It's probably better to be assessed by local people in the area that you work [though] and they can perhaps help with improvements that you can make, rather than somebody from the opposite end of the country trying to tell you what to do.*
>
> Depth interview, female, trainee GP

There was concern, particularly in one group, that any assessments or regulation needed to be tailored to the different specialisms, as a 'catch all' system would be ineffective.

Practical Steps Needed to Ensure Success

It was stressed by doctors that any system adopted needed to have positive repercussions for those being assessed:

> *It has to be a positive thing because if it's not, you imagine people are going to be petrified of going towards it*
>
> London group, junior doctor/medical student

Enabling access to training was given as an example of how this might be done, but it was emphasised that facilities to do this needed to be in place from the onset of the process being introduced:

> *[It] requires money and facilities there from the offset, not after everyone's been shown to be poor*
>
> London group, junior doctor/medical student

The need for 360º colleague feedback to feed into any assessment process was voiced, especially in the case of assessing higher doctor grades:

> *But the regulation, does it happen […] down, up, 360 degrees? There's so many levels of regulation but the processes all seem to be in one place from the top down*
>
> London group, junior doctor/medical student

Examples of assessment procedures already in use were given, which, it was felt, might be able to help shape any new systems being put into place. The QOF system was given as one example, another was the system of checks and assessments that are undertaken in practices and departments involved in training doctors:

> *Certainly the Royal Colleges set standards and if you're involved in teaching and education [...] there are [...] visits to departments to check that the educational environment is up to speed. But of course that's not necessarily true for the district hospitals that are not involved in teaching because they wouldn't get the visiting. The model is there in the teaching and educational processes to see that standards are being achieved by practitioners in the department*
>
> London group, hospital doctor/GP

There was agreement both amongst doctors and the general public that emphasis needed to be placed on retraining doctors, rather than on taking punitive action:

> *I think the big concern that everyone has is that it's a fair system and 'fair' means you'd be judged by your peers […] and [that] there's also an approach and a pathway [so] that if you do make mistakes there are pathways by which you can retrain and show that you've corrected those mistakes and that you're going to carry on working. The worst thing that everybody wants [to avoid] is a whole process of testing, testing, testing without it being fair*
>
> London group, junior doctor/medical student

> *[They should get] more training, yes. Unless it's really serious*
>
> London, depth interview, younger woman, carer

Doctors were generally negative about the GMC. There was some confusion about changes in its role, and many spoke of the criticism that has been levelled against the organisation recently:

> *The GMC's under massive criticism, and probably rightly so. Their system needs to change in some way*
>
> Depth interview, female, trainee GP

Whether or not there is any scope for self-regulation caused disagreement however, as did the type of regulatory body needed. Some felt that having lay people in the GMC would be enough to reassure the public:

> *There's a lot of lay people in the GMC today and that's a change I think that should give the public more confidence*
>
> London group, hospital doctor/GP

There was also the suggestion that the current GMC set-up could be combined with some kind of judiciary to create a more impartial organisation (albeit one benefiting from medical expertise):

> *As you have said, if we are seen to be regulating ourselves then we might be covering up for bad doctors. [But there's] the difficulty of knowing what the profession entails. [What's needed is] something like the GMC but [with] a judiciary overlooking it, a respectable judiciary, seeing how processes and how rulings are taken in difficult cases*
>
> London group, junior doctor/medical student

Others, however, held the view that the body responsible for regulation needed to be as independent as possible and that there was no room for self-regulation:

> *Go [with] a more independent, public governing body rather than the GMC*
>
> London group, junior doctor/medical student

How Doctors Should Be Regulated and Assessed

There is some consistency between GPs and the public in their views on the factors that are seen as most important for assessing doctors to ensure that everybody has a good doctor. The most important factors for GPs and the public is evidence that the doctor is keeping up-to-date with medical developments (81% for GPs, 67% for the general public). Receiving high ratings from patients also tends to be important for both groups (36% and 43% respectively).

Giving Feedback on Doctors

Q *If all doctors were to be assessed from time to time, which, if any, of the following do you think would be most important to ensure that everybody has a good doctor?*

	% Public	% GPs
Evidence that the doctor is keeping up-to-date with medical developments	67	81
Monitoring the success rates of the doctors' treatments	44	14
Receiving high ratings from their patients	43	36
Re-checking of doctors' qualification from time to time	33	15
Demonstrations of technical skills	31	23
Passing a written test of medical knowledge from time to time	30	20
Receiving high ratings from nurses	19	19
Receiving high ratings from other doctors	18	30

Base: 2,195 UK adults; 200 General Practitioners; 16/06/2005-20/06/2005 and 23/06/2005-25/06/2005 respectively

Source: MORI

[11]

However, there are a number of areas that tend to be seen as more important by the public than GPs. These include:

- monitoring of success rates (44% for the general public vs 14% for GPs);
- Re-checking of doctors' qualification from time to time (33% vs 15%);
- Passing a written test of medical knowledge from time to time (30% vs 20%).

By contrast, GPs are more likely to view peer review as important, with 30% saying ratings from other doctors would be important to ensure everybody has a good doctor (compared with 18% for the general public).

[11] Categories based on research carried out by The Gallup Organization for The American Board of Internal Medicine, August 2003

Within the general public, there are demographic differences in the extent of importance allocated to each element. Only half (51%) of 15-24 year olds feel that evidence that a doctor is keeping up-to-date with medical developments is particularly important for example, compared to around two-thirds (67%) overall, and seven in ten of those in the older age groups. Almost four-fifths of those in Wales (78%) feel this element is of particular importance – significantly higher than for those based everywhere else bar Eastern England. However, *across* demographic groupings, evidence that a doctor is keeping up-to-date with medical developments is seen as the most important, and the other potential elements of assessments hold positions roughly in line with overall importance ratings.

There is a wide range of skills and professional behaviour that people would want to comment on if asked to give feedback on their doctor. This is particularly true of communication skills, with just over half (53%) saying they would want to comment on this.

Giving Feedback on Doctors

Q *If you were asked to give feedback on your doctor, what, if anything, would you want to comment on?*

	% Respondents
His/ Her communication skills	53
How up-to-date he/she is with new developments	36
How much he/she involves patients in treatment decisions	36
The amount of dignity and respect he/she gives to patients	35
His/ her knowledge/ technical ability	33
Success rates of his/ her treatments	26
I would not expect doctors to be assessed	1
None of these	10

Base: 2,195 UK adults, 16/06/2005-20/06/2005

Source: MORI

Success rates are seen as less important than communication skills and softer, interpersonal skills, such as the amount of dignity and respect a doctor gives to patients (26% compared with 35% respectively). This possibly reflects the fact that people are unlikely to be aware of the success rates of doctors' treatments.

ABs express more desire to comment on each aspect of a doctor's ability than C2DEs. Those defined as socio-political activists (i.e. who have done 5 or more of the things listed in the table overleaf) are also more likely to want to give feedback on each monitored aspect of their doctor's skills and professional

behaviour than non-activists (i.e. having done less than three of the things listed below).[12]

A) Presented my views to a local councillor or MP
B) Written a letter to an editor
C) Urged someone outside my family to vote
D) Urged someone to get in touch with a local councillor or MP
E) Made a speech before an organised group
F) Been an officer of an organisation or club
G) Stood for public office
H) Taken an active part in a political campaign
I) Helped on fund raising drives
J) Voted in the last general election

More of those using private healthcare services are interested in commenting on how much their doctor involves patients in treatment decisions and in rating the success rate of their treatments, than those only using NHS services (42% say they would want to comment on how much their doctor involves patients in treatment decisions, compared to 36% of those only using NHS services, and 36% would want to comment on the success rates of their treatments, versus 25% of NHS-only patients).

Perhaps surprisingly, those saying that they are very satisfied with their GPs are more likely to want to comment on all monitored aspects of their doctor's ability than those who are only fairly satisfied.

The element seen as the most important possible component of regulation during the qualitative research amongst the general public was doctors being re-evaluated on their qualifications every so many years. Respondents also perceived a folder of evidence that a doctor has kept up-to-date with medical developments as important, along with the periodic passing of a written test of medical knowledge.

Involving patient feedback in any assessment process was broadly welcomed amongst members of the public, especially on issues of communication. Questionnaires were welcomed as a means of doing this, and many had already given feedback in this way at their local surgery. Some queried how seriously questionnaires are taken however, and issues with this methodology were raised:

> *I think it would be good [for questionnaires to go] through the post […] because then it's more confidential and you don't feel like you're being watched when you're writing out the questionnaire*
>
> Birmingham, depth interview, younger BME, female, ABC1, disabled son

[12] Socio-political activists are more likely to be ABs and therefore, this finding reflects the correlation between the two.

It's got to be pretty simple or people won't bother filling it in will they? But they've got to be meaningful questions

London, depth interview, younger woman, carer

Although some members of the public thought they themselves should be at the centre of doctor assessments, there was recognition by others that popular doctors are not necessarily the best, implying that doctors should not only be judged in this way:

There's a practice near me […] all they're capable of is doing a dole sheet […] I doubt if they've done a prescription in years […] but the patients think they're wonderful

London group, 55+, C2DE

Respondents felt uneasy about judging the technical ability of a doctor, unless they had had dealings with other doctors concerning the same issue, as this gave them means of comparison.

Patient confidentiality being jeopardised through giving feedback was not seen as being a problem. In fact, some already had suspicions regarding the confidentiality of their computer records:

I don't think there's any confidentiality even now. You see, you've only got to get onto a compute; they know everything about you

Birmingham, depth interview, older male carer, C2DE

Be it within a formal or informal assessment system, doctors also welcomed the opportunity for patients to give feedback:

It would be interesting to audit a percentage of patients randomly from different people to say what their experience was like, because certainly it's amazing once you're on the other side and become a patient, what a big difference it is

London group, junior doctor/medical student

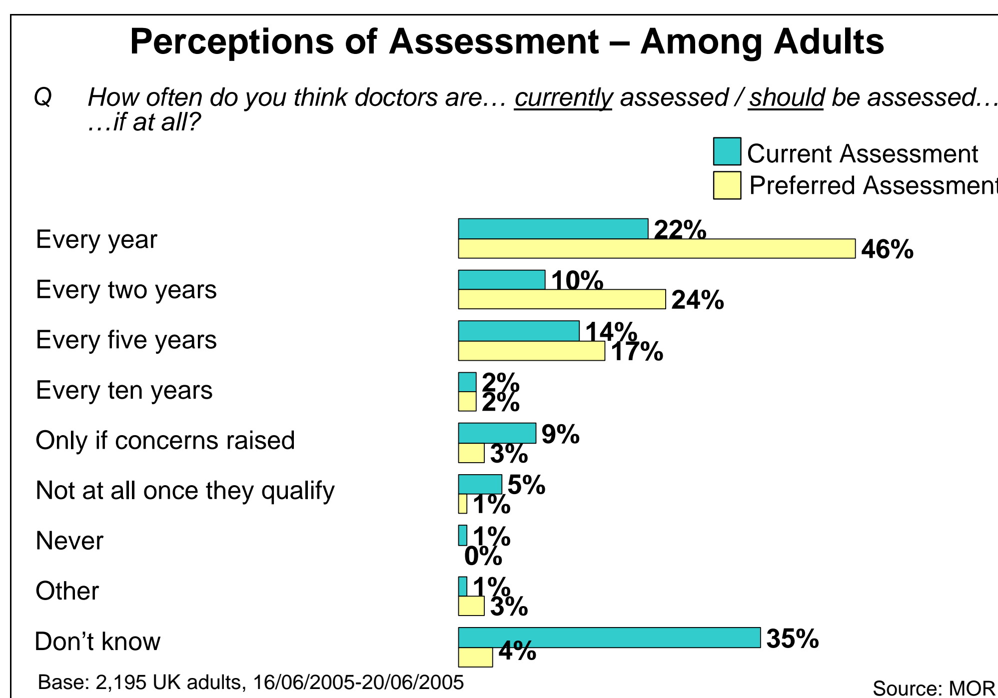
How their manners were, the communication, whether they listened or not. These are the areas which the patients can tell you very well

London group, junior doctor/medical student

Certain caveats were given. There was recognition that patients may not be able to judge the technical ability of doctors, which is broadly in line with the views of the general public. There was also concern about how patients' views are elicited to ensure that all types of feedback are received, not simply a series of complaints which may result from patients self-selecting to take part.

Frequency of assessment

There is strong demand amongst the public for doctors to be assessed frequently, contrasting with how often people feel they are *currently* assessed. Nearly half say assessments should be made every year (46%), yet only one in five (22%) feels this is currently the case. (Please see chart below). The most commonly mentioned option among GPs is that doctors should be assessed every 5 years (43%).



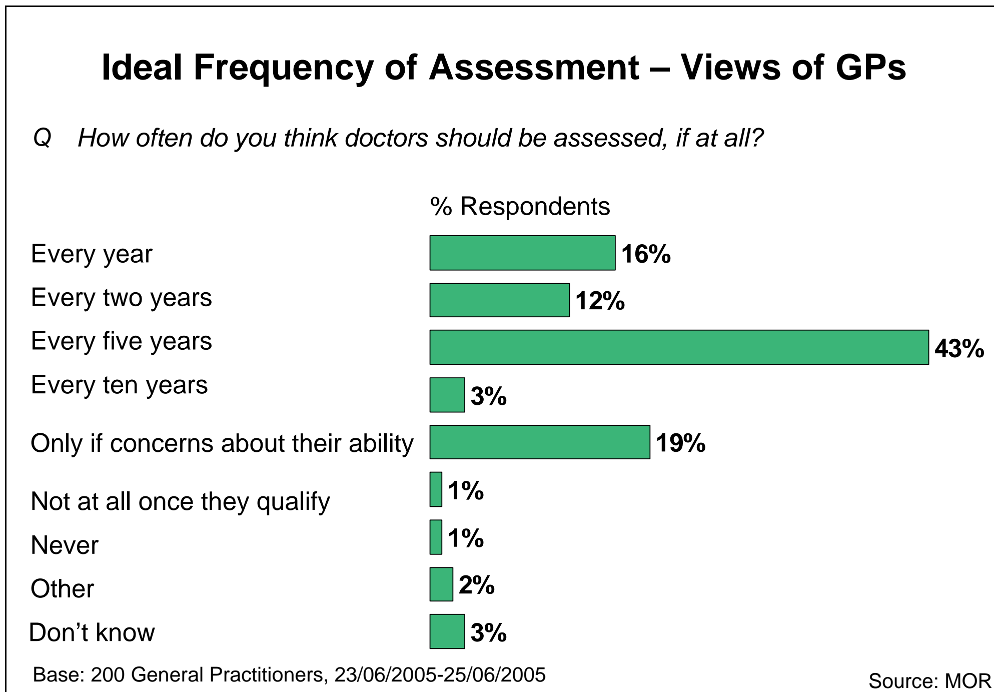
There is almost unanimous agreement that doctors should be assessed, with only 1% feeling that they should not be assessed once they qualify. For the vast majority, such testing should be regular and mandatory. A tiny proportion (3%) feels that testing once concerns are raised is sufficient.

Agreement for frequent assessments is strong across the board, with between 80% and just over 90% of respondents in the sub-groups looked at, agreeing that they should be assessed every 1-5 years.

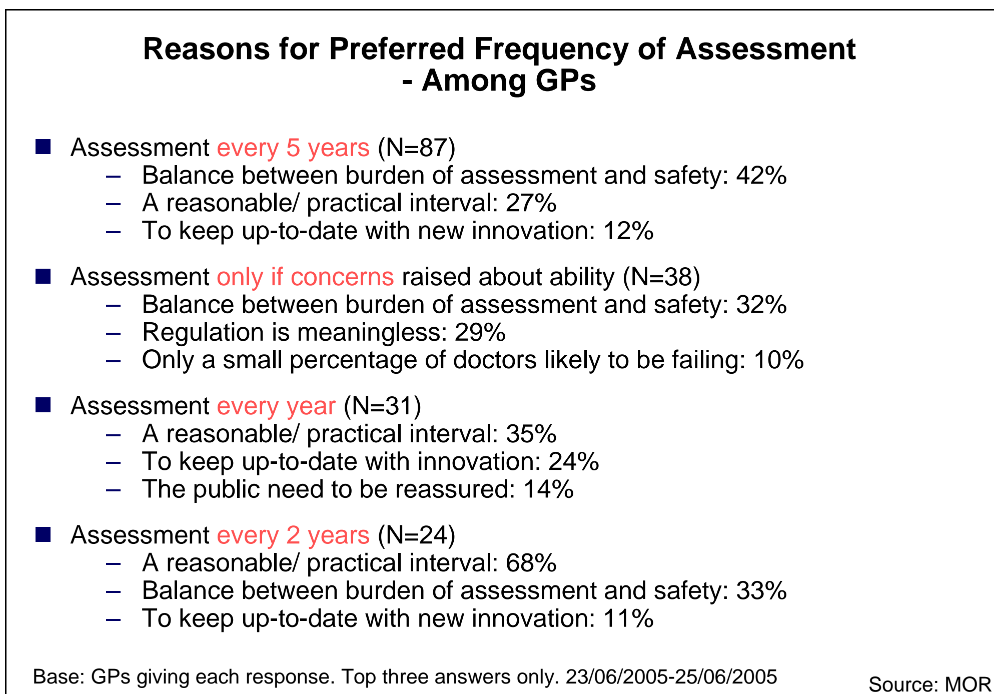
Younger respondents however, are more likely to feel that doctors should be assessed every year, and less inclined to feel that they should be assessed every five years.

The same is true of those in the lower socio-economic groups: around half (51%) of DEs feel doctors should be assessed every year, compared to four in ten (41%) of ABs. Conversely, more ABs feel that they should be assessed every five years (21%) than DEs (13%). Newspaper readership follows a similar pattern to that of class, with a greater proportion of tabloid than broadsheet readers wanting assessments on an annual basis (48% and 39% respectively), and a

greater proportion of broadsheet than tabloid readers wanting assessments to take place every 5 years (22% and 15% respectively).



GPs tend to favour less frequent assessment of doctors than the public do, although there is a wide range of views on how often doctors should be assessed. The most common preference is for assessment every five years (43%), whilst one in five feel doctors should be assessed only if there are concerns about their ability, and 12% express preferences for assessment every two years.



Around half (48%) of those favouring assessments every year or every two years feel this represents a reasonable/practical interval. For those favouring assessments every five years, this is often seen as providing a balance between a burden of assessment and safety (42%).[13]

There was little consensus of opinion amongst the public in the qualitative research on how often assessments should be undertaken. Responses varied from every six months, to every three – five years. However the general public and doctors alike agreed that the frequency of assessments or the extent of monitoring could be varied according to the individual doctors:

> *If there's any cause of concern, then obviously it should be monitored more closely*
>
> Leeds, depth interview, younger male, ABC1, BME

> *People that have been highlighted as having concerns, they should be [more] heavily investigated*
>
> London group, junior doctor/medical student

> *Once it's up and running if everything's in an order maybe every five years then if there were some slight concerns every three years and if there were major concerns you're assessed in a year, that sort of thing. A bit like your fitness to drive. If you're sailing through then we'll see you in five years and if you had a problem we'll see you in a year*
>
> Depth interview, male, rural GP/Partner

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Michele Corrado

Anna Carluccio

Corinne Wilkins

Andrew Norton

[13] This was mentioned by 36 of the 87 GPs who favour assessment every five years.

Appendices

Technical Details

General Public Omnibus Design

The sample design is a constituency based quota sample. There are 641 parliamentary constituencies covering Great Britain. From these, we select one in three (210) to be used as the main sampling points on the MORI Omnibus. These points are specially selected to be representative of the whole country by region, social grade, working status, MOSAIC rurality, tenure, ethnicity and car ownership. Within each constituency, one local government ward is chosen which is representative of the constituency.

Within each ward or sampling point, we interview ten respondents whose profile matches the quota. The total sample therefore is around 2,100 (10 interviews multiplied by 210 sampling points).

Gender:	Male; Female
Household Tenure:	Owner occupied; Council Tenant/HAT; Other
Age:	15 to 24; 25 to 44; 45+
Working Status	Full-time; part time/not working

These quotas reflect the socio-demographic makeup of that area, and are devised from an analysis of the 2001 Census. Overall, quotas are a cost-effective means of ensuring that the demographic profile of the sample matches the actual profile of GB as a whole, and is representative of all adults in Great Britain aged 15 and over.

Fieldwork

Fieldwork is carried out by MORI using CAPI (Computer Assisted Personal Interviewing). All interviews are conducted face to face, in the home – one interview per household. No incentives are offered to respondents.

Weighting and Data Processing

Data entry and analysis are carried out by an approved and quality-assured data processing company. The data are weighted using 6 sets of simple and interlocking rim weights for social grade, standard region, unemployment within region, cars in household, and age and working status within gender. This is to adjust for any variance in the quotas or coverage of individual sampling points so that the sample is representative of the GB adult population.

Statistical Reliability

Because a sample, rather than the entire population, was interviewed the percentage results are subject to sampling tolerances – which vary with the size of the sample and the percentage figure concerned. For example, for a question where 50% of the people in a (weighted) sample of (2,195) respond with a particular answer, the chances are 95 in 100 that this result would not vary more than (2) percentage points, plus or minus, from the result that would have been obtained from a census of the entire population (using the same procedures). The tolerances that may apply in this report are given in the table below.

Approximate sampling tolerances applicable to percentages at or near these levels (at the 95% confidence level)

Size of sample or sub-group on which survey result is based	**10% or 90%** ±	**30% or 70%** ±	**50%** ±
2,195 UK adults aged 15+	1	2	2
2,085 GB adults	1	2	2
110 adults in Northern Ireland	6	9	9
200 GPs	4	6	7

Source: MORI

Tolerances are also involved in the comparison of results between different elements of the sample. A difference must be of at least a certain size to be statistically significant. The following table is a guide to the sampling tolerances applicable to comparisons between sub-groups.

Differences required for significance at the 95% confidence level at or near these percentages

	10% or 90%	**30% or 70%**	**50%**
Size of sample on which survey result is based			
General public (2,195) vs GPs (200)	4	7	7
Men (1,026) vs Women (1,169)	3	4	4
ABs (450) vs DEs (640)	4	6	6
GB (2,085) vs Northern Ireland (110)	6	9	10

Source: MORI

Definition of Social Grades

The grades detailed below are the social class definitions as used by the Institute of Practitioners in Advertising, and are standard on all surveys carried out by MORI (Market & Opinion Research International Limited).

Social Grades			
	Social Class	**Occupation of Chief Income Earner**	**Percentage of Population**
A	Upper Middle Class	Higher managerial, administrative or professional	2.9
B	Middle Class	Intermediate managerial, administrative or professional	18.9
C1	Lower Middle Class	Supervisor or clerical and junior managerial, administrative or professional	27.0
C2	Skilled Working Class	Skilled manual workers	22.6
D	Working Class	Semi and unskilled manual workers	16.9
E	Those at the lowest levels of subsistence	State pensioners, etc, with no other earnings	11.7

Topic Guide and Questionnaires

Public attitudes to medical regulation and revalidation of doctors

General Public Topic Guide: Final (24/05/05)

Core objectives

1. Explore general public perceptions of how doctors are regulated and how they should be regulated
2. Gauge awareness of the regulation process
3. Examine attitudes towards regulation of doctors

Outline of the research programme

- 6 X 1 ½ hour focus groups with members of the general public
- Groups to be held 24 - 26 May
- 10 respondents recruited for 8 to participate
- Quota information

	Age	Social Class	Gender	Family Roles	Services used
Group 1 (Leeds, North)	55+	C2DE	Good mixture	Some grandparents	½ or more to have been inpatients/ outpatients in the last year, or to have visited someone in hospital, or to have visited their GP/ practice nurse
Group 2 (Leeds, North)	35-54	ABC1	Good mixture	*½ or more to have children *1 or 2 to be carers of elderly people or people with disabilities	Some to have been inpatients/ outpatients in the last year, or to have visited someone in hospital, or to have visited their GP/ practice nurse
Group 3 (B'ham, Midlands)	55+	ABC1	Good mixture	Some grandparents	½ or more to have been inpatients/ outpatients in the last year, or to have visited someone in hospital, or to have visited their GP/ practice nurse
Group 4 (B'ham, Midlands)	35-54	C2DE	Good mixture	*½ or more to have children *1 or 2 to be carers of elderly people or people with disabilities	Some to have been inpatients/ outpatients in the last year, or to have visited someone in hospital, or to have visited their GP/ practice nurse
Group 5 (London)	18-34	ABC1	Good mixture		Some to have been inpatients/ outpatients in the last year, or to have visited someone in hospital, or to have visited their GP/ practice nurse
Group 6 (London)	55+	C2DE	Good mixture	Some grandparents	½ or more to have been inpatients/ outpatients in the last year, or to have visited someone in hospital, or visited their GP/ practice nurse

Interview sections	Notes	Approx timing
1. Introduction	Sets the scene	15 mins
2. Regulation awareness	Spontaneous awareness of regulation	15 mins
3. Regulation requirements	Looks at what regulations general public would like to see	55 mins
4. Conclusion and key message	Summary and key messages	5 mins

<table>
<tr><th>Key Questions</th><th>Notes/approx timing</th></tr>
<tr><td>1. Introductions</td><td>15 minutes</td></tr>
<tr><td>1.1 Scene-setting:
Thank interviewee for taking part
Introduce self, MORI and explain the aim of the discussion
Role of MORI – research organisation, gather all opinions: all opinions valid, disagreements OK
Confidentiality: reassure all responses anonymous and that information about individual cases will not be passed on to any third party (eg Department of Health)
Get permission to tape record – transcribe for quotes, no detailed attribution.
First name
Where you live? Who with? (household details)
1.2 Introduction:

Just to start with, can you tell us a bit about your experiences with doctors/the medical profession in general? Have they generally been good/bad? Why is that?
What makes a good/bad doctor?
Moderator: ask respondents about their OWN doctors vs. OTHER doctors

PROBE: Overall level of satisfaction with the way doctors do their job? Why?
What is your relationship like with your GP?
Explore:
Level of confidence in GPs to do their job? Why do you say that?
What gives you that confidence?
How do you know if your doctor is doing a good job? What makes doctors trustworthy? DO NOT PROMPT WITH REGULATION
On what sort of things do they make a judgement? ALLOW SPONTANEOUS THEN PROBE
Communication skills/How well they explain things?
Bedside manner?
Involving you in treatment decisions
Privacy/respecting dignity?
Technical ability?</td><td>Welcome: orientates interviewee, gets them prepared to take part in the discussion

Outlines the ‘rules’ of the interview (including those we are required to tell them about under MRS and Data Protection Act guidelines)

No detail about specifics (e.g. the regulation or revalidation) at this stage. This ensures that spontaneity is retained for initial discussions and that the interviewee is not over-whelmed with information

Introduction: provides contextual background information about the interviewee (which can then be used in the analysis)</td></tr>
<tr><td>2. Regulation awareness</td><td>15 minutes</td></tr>
<tr><td>Have you heard anything in the news about regulating doctors?

When I say regulation, what springs to mind?</td><td>This section establishes awareness of regulation.</td></tr>
</table>

Moderator: If participants unclear what regulation means "making sure doctors can do their job well" Do you think doctors are regulated at the moment? *Explore:* • Do you know how? What processes could there be? *COVER FREQUENCY OF POSSIBLE CHECKS AND POSSIBLY EXTENT OF CHECKS.* • Do you know if there is an appraisal system for doctors? IT MAY BE NECESSARY TO DEFINE APPRAISAL • How frequently do you think they are appraised? • Who do you think is responsible for undertaking this regulation • If we trust doctors so much, why do they need to be regulated?	
3. Regulation requirements	55 minutes
3.1 Processes *Moderator: "Now I'd like to talk about the process in a little more detail"* *Explore:* • What do you think is currently done? • Who should be regulating them? *Check attitudes towards self-regulation?* • How often should doctors be assessed? • *Assessment* – Should all doctors be assessed or just those where concerns about their abilities have been raised? • *Assessment* – who should be included? Patients? Colleagues? • *If they want to include patients' feedback* "What kind of information would you like to give about your doctor?" • How would you as patients like to give your feedback? *Questionnaire as they leave the surgery that they send to someone else? Postal questionnaire? Telephone interview?* • *Patient feedback publicity* How could patients' be made aware that they can give information about their doctor? • *What about confidentiality – would they be worried about who contacts them and what information they hold about them?* • What should happen if a doctor fails an assessment? *Does it depend on the severity of the failure/risk to patient safety?* *Moderator: Hand out agree/disagree statements* "Could you write next to each statement whether you agree or disagree with it". Agree/disagree statements: a) Pilots and doctors work in 'life or death' professions. It is vital they are assessed regularly. b) Regulation can be unnecessarily expensive and time consuming. c) Inspecting all doctors regularly would be a waste of money. d) It is important that all doctors' competence is checked	**Moderator: this is the KEY SECTION** This section explores awareness of regulatory bodies and their role, specifically looking at local vs. national responsibility. Additionally, it looks at what assurances respondents feel they need and giving feedback on doctors for their assessments. It allows the group to discuss regulatory requirements without having to have prior knowledge of processes and procedures.

every few years e) Doctors often say that if you check on them, you don't trust them. What do you think? f) Not even the best system of regulation could have detected a problem doctor like the mass murderer Dr Harold Shipman? *Explore:* *Probe fully* *Why did they agree/disagree with each?* What could have prevented Shipman? What do you think are the most important things the NHS needs to do over the next 5 years? *Moderator: record each item on flipchart paper including "checking doctors ability to practice" or similar, and hand out stickers.* Each of you has three stickers, I want you to come up to the board and stick your stickers next to your top three most important things. Discuss priorities in detail. Probe fully. **3.2 Identifying regulatory responsibility** "I'm going to spread out some cards and I want you to tell me who's responsible for regulating doctors" *(GMC logo will be included with a number of other medical/official bodies – Healthcare Commission, NICE, NHS, DH, Police, BMA, the EU, local PCT, local SHA, LA, Academy of Medical Royal Colleges).* *Explore fully why they made their choices**, including the local and national aspect –*** ie should there be a national database of doctors? What should it contain? • Who should be responsible for ensuring doctors' work is good? *Explore who should have responsibility for ensuring standards are maintained ALLOW SPONTANEOUS THEN PROBE* • Should doctors be assessed by local NHS organisations or at a national level? PROBE FOR o NHS? o GP surgery? o Hospital? o Medical profession? IF SAY LOCALLY PROBE FOR: should any misconduct be escalated to a national level if they need to be struck off? *And who should deal with professional development?* What role should bodies, such as the General Medical Council, or Medical colleges/universities have?	

Moderator: If group show a good understanding the GMC hand out bubble drawings, otherwise continue exploration of regulation.

"Here are some drawings. I want you to pretend you are the stick person and write in the thought bubble what springs to mind when you think of the General Medical Council, what personifies the GMC."

Explore: what their perceptions are; where they got them from etc.

Moderator: "To what extent can regulation ensure everyone has a good doctor?"

Do you think there is a system to ensure everyone has a good doctor?

What checks should be made? What key things would you want to know have been checked?

How do you think these would be demonstrated?

What attributes (knowledge & skills) would doctors have to demonstrate to maintain their registration?

How frequently should these appraisals/checks be made?

3.3 Key components

Moderator: Hand out list of pre-printed possible options.

"Now on the pieces of paper I've just given you I'd like you to give each bullet point a number from one to eight, with one being the most important and eight being the least important."

List of possible components of regulation:

- Periodically passing a written test of medical knowledge
- Receiving high ratings from other doctors they work with
- Receiving high ratings from nurses they work with
- Receiving high ratings from their patients
- Practicing their technical skills in simulated situation
- A doctor having high success rates for disease or conditions they treat most often
- Being re-evaluated on their qualifications every so many years
- A folder of evidence that a doctor has kept up-to-date with medical developments

Discuss ranking in detail, probe fully.

<table>
<tr><td></td><td></td></tr>
<tr><td>4. Conclusion and key message</td><td>5 minutes</td></tr>
<tr><td>Finally, just to conclude, can you summarise for me what you think about the regulation of doctors at the moment?
Prompt where necessary:
Is there anything else you’d like to say about doctors today?
What would be your Number one improvement to the current system for assessing doctors?
Is there any key message you would like us to feed back to Department of Health?

Thank respondents, explain the next steps (eg what DH will do with the findings) and close</td><td>Formally ends the discussion and provides reassurance that the findings will be both appreciated by and useful to DH</td></tr>
</table>

Doctors' groups and teledepths Topic Guide: Final (02/05/05)

Core objectives

1. Explore doctors perceptions of how doctors are regulated and how they should be regulated
2. Gauge awareness/attitudes towards the regulation process
3. Examine attitudes towards regulation of doctors

Outline of the research programme

- 2 X 1 ½ hour focus groups with doctors
- Groups to be held 7 - 8 June
- 8 respondents recruited for 6 to participate
- Quota information

Group: 1	Date:	8th June 2005	Code:
	Time:	18.45	1
		Hospital Doctors and GPs **(3 or each or 2 and 4)** Good mix of gender No two doctors from same hospital department/ surgery All working full time	
	Venue Details:	Hilton, Croydon	
	Moderator:	Caroline Webb	

Group 2	Date:	7th June 2005	Code:
	Time:	18.30	2
		Junior Doctors (recently qualified) and Medical Students **(4 junior doctors and 2 medical students)** Good mix of gender No two doctors from same hospital department/ surgery All working full time	
	Venue Details:	London	
	Moderator:	Neil Reynolds	

Interview sections	Notes	Approx timing
1. Introductions	**Sets the scene**	15 mins
2. Attitudes towards regulation	**Establishing attitudes towards regulation and an overview**	15 mins
3. Possible future regulatory developments	**Looks at what regulations doctors think should be in place**	55 mins
4. Conclusion and key message	**Summary and key messages**	5 mins

Key Questions	Notes/approx timing
1. Introductions	15 minutes
1.1 Scene-setting: • Thank interviewee for taking part • Introduce self, MORI and explain the aim of the discussion • Role of MORI – research organisation, gather all opinions: all opinions valid, disagreements OK • Confidentiality: reassure all responses anonymous and that information about individual cases will not be passed on to any third party (eg Department of Health) • Get permission to tape record – transcribe for quotes, no detailed attribution. • First name • Job title/role? Length of time as a doctor/in particular role **1.2 Introduction:** In general what do you think patients' perceptions of doctors are? *If say trustworthy:* Why do you think patients feel doctors are trustworthy? • What is your relationship like with your patients? How do doctors build patients' confidence in their ability? *Explore:* • *What gives them that confidence?* • *On what sort of things do patients make a judgement, do you think?* *ALLOW SPONTANEOUS THEN PROBE* o *Communication skills/How well they explain things?* o *Bedside manner?* o *Involving patients in treatment decisions* o *Privacy/respecting dignity?* o *Technical ability?*	**Welcome**: orientates interviewee, gets them prepared to take part in the discussion Outlines the 'rules' of the interview (including those we are required to tell them about under MRS and Data Protection Act guidelines) No detail about specifics (e.g. the regulation or revalidation) at this stage. This ensures that spontaneity is retained for initial discussions and that the interviewee is not over-whelmed with information **Introduction**: provides contextual background information about the interviewee (which can then be used in the analysis)
2. Attitudes towards regulation	15 minutes
Have you heard anything recently *(use "in the news" if needed)* about regulating doctors? When I say regulation, what springs to mind? Can you tell me a bit about how regulating doctors works? • Are you assessed regularly? *If yes establish how frequently and what assessment covers* • Is your appraisal separate to any assessment to maintain standards/protect patients?	This section establishes attitudes towards regulation.

3. Possible future regulatory developments	55 minutes
3.1 Processes *Moderator: "Now I'd like to talk about the process in a little more detail"* *Explore:* • How do you feel about doctors being regulated? • How should doctors be regulated? • How should the standard of professional conduct be monitored/maintained? • *Check attitudes towards self-regulation – how is this seen by the general public? Reliable?* • How often should doctors be assessed? • *Assessment* – Should all doctors be assessed or just those where concerns about their abilities have been raised? • *Assessment* – who should be included? Patients? Colleagues? • *If they want to include patients' feedback* "What kind of information could patients feedback on?" • How should patients give feedback? *(Questionnaire with every visit – self-selection issues, telephone interview, postal survey? – issues of confidentiality?)* • *Patient feedback* ***publicity*** How could patients' be made aware that they can give information about their doctor? • What should happen if a doctor fails an assessment? *Does it depend on the severity of the failure/risk to patient safety?* *Moderator: If revalidation comes up fully explore doctors understanding of it and attitudes towards it.* The Shipman inquiry's 5th report made recommendations for the future regulation of doctors. Could a system of regulation be developed that would detect a problem doctor like the mass murderer Dr Harold Shipman? *Explore:* *Probe fully* *'Life 'or' death' professions like pilots – need regular assessment?* *Doctors' competence needs to be checked every few years?* *Worthwhile expense? 'Unnecessary and time consuming'?* *Trust – assessment suggests doctors are not trusted?* Thinking about NHS priorities over the next few years where does regulation/revalidation fit into this? Discuss priorities in detail. Probe fully. **3.2 Allocating regulatory responsibility** Who should be responsible for regulating doctors/ maintaining standards/ doctors professional development? What role should different bodies play?	**Moderator: this is the KEY SECTION** This section explores the role of regulatory bodies, specifically looking at local vs. national responsibility.

(GMC, Healthcare Commission, NICE, NHS, DH, Police, BMA, the EU, local PCT, local SHA, LA, Academy of Medical Royal Colleges). Should the GMC's register include more information about doctors to reassure patients? What information should it contain *(cover issues of confidentiality/putting issues behind them once they've been dealt with)*? • Should doctors be assessed/ professionally developed by **local** organisations or at a **national** level? ALLOW SPONTANEOUS AND THEN PROBE FOR o PCT/Trust (if hospital doctor)? o SHA? o GP surgery? o Hospital? o Medical profession/body? o Royal colleges? IF SAY LOCALLY PROBE FOR: should any misconduct be escalated to a national level if they need to be struck off? What role should bodies, such as the General Medical Council, or Medical colleges/universities have? **3.3 Key components** *Moderator: "To what extent can regulation ensure everyone has a good doctor?"* Do you think there is a system to ensure everyone has a good doctor? What checks should be made? What key things do you think would reassure patients? How could these be demonstrated? Should doctors' knowledge & skills be regularly assessed? What attributes should doctors demonstrate to maintain their registration? Probe fully.	
4. Conclusion and key message	5 minutes
Finally, just to conclude, can you summarise for me what you think about the regulation of doctors at the moment? *Prompt where necessary:* • *Is there anything else you'd like to say about regulation that we haven't covered today?* • *What would be your main improvement to the current system for assessing doctors?* Is there any key message you would like us to feed back to Department of Health? Thank respondents, explain the next steps (eg what DH will do with the findings) and close	Formally ends the discussion and provides reassurance that the findings will be both appreciated by and useful to DH

Toplines

Public attitudes to medical regulation and revalidation of doctors – General public Final Topline Results, 14/07/2005

- MORI interviewed a representative quota sample of 2,195 UK adults aged 16+. 2,085 of these were in Great Britain and 110 in Northern Ireland.
- Interviews were carried out face-to-face with the aid of CAPI terminals in Great Britain and on paper in Northern Ireland.
- The fieldwork period was 16 – 20 June 2005.
- Data have been weighted to the known population profile.
- Where figures do not sum to 100 per cent, this may be due to computer rounding, multiple codes or the exclusion of 'Don't know'
- * represents a percentage of greater than zero, but less than 0.5%

I would now like to ask you a number of questions relating to health issues.

Q1. **Which of the following services, if any, have you personally used within the last year or so? Please read out the letter or letters which apply**.

		%
A	Visited an NHS GP	76
B	Attended an NHS hospital as an outpatient	33
C	Visited an accident and emergency (A&E) department	20
D	Been an inpatient at an NHS hospital	14
E	Had medical treatment as a private patient	7
F	NHS Direct	14
G	Walk in Clinics	9
	None of these	15
	Don't know/ refused	*

Q2. **Thinking about the last time you visited your local doctor or GP, overall, how satisfied or dissatisfied were you with this last visit as a patient?**

	%
Very satisfied	49
Fairly satisfied	36
Neither satisfied nor dissatisfied	5
Fairly dissatisfied	5
Very dissatisfied	3
Not applicable/haven't been	2
Don't know	*

Q3. **How much, if anything, do you know about the way doctors are assessed to check that they are doing a good job? Would you say a great deal, a fair amount, not very much or nothing at all?**

	%
A great deal	3
A fair amount	10
Not very much	25
Nothing at all	56
Don't know	7

Q4. **How often do you think doctors are currently assessed, if at all? Please read out the letter that applies.**

		%
A	Every year	22
B	Every two years	10
C	Every five years	14
D	Every ten years	2
E	Only if there are concerns about their ability	9
F	Not at all once they qualify	5
	Never	1
	Other	1
	Don't know	35

Q5. **How often do you think doctors <u>should</u> be assessed, if at all? Please read out the letter that applies.**

		%
A	Every year	46
B	Every two years	24
C	Every five years	17
D	Every ten years	2
E	Only if there are concerns about their ability	3
F	Not at all once they qualify	1
	Never	*
	Other	3
	Don't know	4

Q6. **If you were asked to give feedback on your doctor, what, if anything, would you want to comment on? Please read out the letter or letters which apply.**

		%
A	His/her communication skills/ How well he/she explains things	53
B	How up-to-date he/she is with new developments in medicine	36
C	His/her knowledge/technical ability	33
D	How much he/she involves patients in treatment decisions	36
E	The amount of dignity and respect he/she gives to patients	35
F	Success rates of his/her treatments	26
	I would not expect doctors to be assessed	1
	Other	2
	None of these	10
	Don't know	4

Q7. **Could you tell me how strongly you agree or disagree with the following statements**

			Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	No opinion
A	**Inspecting all doctors would be a waste of time and money**	%	2	9	6	36	46	1
B	**There is no need to regularly carry out checks on doctors as I trust them**	%	2	9	9	41	37	1
C	**It is important that all doctors' competence is checked every few years**	%	59	34	4	2	1	*

Q8. **If all doctors were to be assessed from time to time which, if any, of the following do you think would be most important to ensure that everybody has a good doctor? Please read out the letter or letters that apply.**

		%
A	Demonstrations of technical skills	31
B	Evidence that the doctor is keeping up to date with medical developments	67
C	Monitoring the success rate of the doctor's treatments	44
D	Passing a written test of medical knowledge from time to time	30
E	Re-checking of doctors' qualifications from time to time	33
F	Receiving high ratings from other doctors	18
G	Receiving high ratings from nurses	19
H	Receiving high ratings from their patients	43
	None of these	2
	Don't know	2

Q9. **If all doctors were to be assessed from time to time, on balance, do you think doctors should be assessed by……….?**

		%
A	**…other qualified medical professionals only**	40
B	**…other people who are knowledgeable, but who do not have formal medical qualifications**	4
C	**…a mixture of qualified medical professionals and people who are knowledgeable but have no formal medical qualifications**	52
	Do not expect doctors to be regulated	*
	None of these	1
	Don't know	2

Attitudes to medical regulation and revalidation of doctors – GP Omnibus Topline Results, 14/07/2005

- MORI placed a number of questions on a General Practitioner omnibus.
- Interviews were carried out with GPs via the internet.
- 200 interviews were conducted with GPs based throughout the UK.
- The fieldwork period was 23-25 June 2005.
- Data have been weighted to the known population profile.
- Where figures do not sum to 100 per cent, this may be due to computer rounding, multiple codes or the exclusion of 'Don't know'
- * represents a percentage of greater than zero, but less than 0.5%

I would now like to ask you a number of questions relating to regulation of doctors.

Q1 **How often do you think doctors <u>should</u> be assessed, if at all?**

		%
A	Every year	16
B	Every two years	12
C	Every five years	43
D	Every ten years	3
E	Only if there are concerns about their ability	19
F	Not at all once they qualify	1
	Every 5 years or sooner if concerns	1
	Every three years	1
	Every 7 years	*
	Never	1
	Other	0
	Don't know	3

Q2 **Why do you say that that?**
(Responses over 1% included)

	%
Balance between burden of assessment and safety	31
A reasonable/practical interval	26
To keep up to date with new innovations and patient management	12
Regulation is meaningless	6
More frequent assessment would be too expensive	6
The public need to be reassured	5
Only a small percentage of doctors are likely to be failing	4
Need to balance continuing education with exams and burden of good clinical practice	3
Appraisal is helpful and motivating	3
To maintain clinical quality	2
More often is of no more value	2
Other professions are assessed so why not doctors	2
Administrative issues	2
Regular assessments will discover any underperformers	2
Annual appraisals with more formal appraisals every 5 years	2
Change does not usually take place very quickly	2
Don't know	3

Q3 **Could you tell me how strongly you agree or disagree with the following statements?**

			Stron-gly agree	Tend to agree	Neither agree nor dis-agree	Tend to dis-agree	Stron-gly dis-agree	No opinion
A	**Inspecting all doctors would be a waste of time and money**	%	14	20	15	30	21	0
B	**There is no need to regularly carry out checks on doctors as the public trust doctors**	%	4	14	13	41	27	1
C	**It is important that all doctors' competence is checked every few years**	%	22	49	11	12	5	*

Q4 **If all doctors were to be assessed from time to time which, if any, of the following do you think would be most important to ensure that everybody has a good doctor? Please read out the letter or letters that apply.**

		%
A	Demonstrations of technical skills	23
B	Evidence that the doctor is keeping up to date with medical developments	81
C	Monitoring the success rate of the doctor's treatments	14
D	Passing a written test of medical knowledge from time to time	20
E	Re-checking of doctors' qualifications from time to time	15
F	Receiving high ratings from other doctors	30
G	Receiving high ratings from nurses	19
H	Receiving high ratings from their patients	36
	None of these	5
	Don't know	4

Q5 **If all doctors were to be assessed from time to time, on balance, do you think doctors should be assessed by……….?**

		%
A	**…other qualified medical professionals only**	58
B	**…other expert lay people, who do not have formal medical qualifications**	0
C	**…a mixture of qualified medical professionals and expert lay people**	33
	Do not expect doctors to be regulated	4
	None of these	2
	Don't know	3

Q6 **And if a system of regulation and assessment were to be introduced, in your view, should a local NHS organisation, an independent national body or a combination of both be responsible for assessing doctors?**

		%
A	**Local NHS organisation**	30
B	**Independent national body**	30
C	**Combination of both local NHS organisation and independent national body**	25
	None of these	5
	Don't know	9

Q7 **Why do you say that?**
(Responses over 1% included)

	%
More knowledge/local knowledge	25
To avoid bias	18
Should be independent evaluation	8
Local and national bodies should compliment each other	6
To enable standard setting and quality control throughout country	6
Most practical/best method	3
PCT's should be kept out of it/distrust PCT	3
Combines national standards with local convenience and flexibility	2
Peer review is the least offensive option	2
For patient and doctor reassurance	2
Keep politics out of it	2
Assessors should be involved with doctors they are assessing	2

Attitudes to Medical Regulation and Revalidation of Doctors

Research among Hospital Doctors

Research Study Conducted for Department of Health

December 2005

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Introduction

This report presents the findings of research conducted among hospital doctors by Ipsos MORI Social Research Institute on behalf of the Department of Health. The research assesses attitudes among hospital doctors towards the regulation and assessment of doctors.

This research among hospital doctors follows qualitative and quantitative research among both the general public and doctors, and quantitative work among the general public and GPs, which examined similar issues. These previous studies have already been reported on. The purpose of this study was to provide quantitative research among hospital doctors, as their views have previously only been explored qualitatively.

The context for the research is the Government's review of the GMC's proposed new system of doctor revalidation, following Dame Janet Smith's report on the Shipman case. As part of this review, the GMC, the medical profession and other interested parties are being consulted.

The main aims of the review are to:

- strengthen procedures for assuring the safety of patients in situations where a doctor's performance or conduct poses a risk to patient safety or the effective functioning of services;
- ensure the operation of an effective system of revalidation; and to
- modify the role, structure and functions of the GMC.

The findings will inform the Consultation Advisory Group being chaired by Professor Sir Liam Donaldson, which is deliberating on the future of medical regulation.

Methodology: The findings are based on a stratified random sample of 100 interviews with hospital doctors in Great Britain, carried out by telephone between 3 November and 1 December 2005. Quotas were set on region/country and grade.

The survey questions are based on the MORI/DH questionnaire that was used for research among GPs and the general public. [14]

[14] 200 UK GPs were interviewed using a GP Omnibus survey, conducted via the Internet between 23 and 25 of June 2005; 2,195 UK adults aged 15+ were interviewed on the MORI Omnibus (with a booster in Northern Ireland), face-to-face, in-home, from 16-20 June 2005.

In the short fieldwork period, it was not possible to carry out any interviews with hospital doctors in Northern Ireland. Some were contacted, but were too busy to take part. However, the comparison of a UK survey of GPs with a GB survey of hospital doctors is still valid.

It is not possible to draw firm conclusions on the differences of opinion among hospital doctors – by gender, date of qualification, grade or region/country – as the sub-group sizes are not sufficient to provide robust statistical findings. Further detailed research would be required to prove conclusively whether any apparent differences between these sub-groups highlighted by the research represent 'real' differences.[15]

Reporting: The survey findings presented in this report have been weighted (to adjust for minor discrepancies in the profile obtained) according to grade[16] and region of the UK.[17] The impact of the weighting on the data has been minimal The In the graphs and tables, the figures quoted are percentages. The size of the sample from which each percentage is derived is indicated. Note that the base may vary – the percentage is not always based on the total sample. Caution is advised when comparing responses between small sample sizes.

Please note that the percentage figures for the various sub-samples or groups need to differ by a certain number of percentage points for the difference to be statistically significant. This number will depend on the size of the sub-group and the percentage finding itself - as noted in the appendices.

Where an asterisk (*) appears, it indicates a percentage of less than half, but greater than zero. Where percentages do not add up to 100% this can be due to a variety of factors – such as the exclusion of 'Don't know' or 'Other' responses, multiple responses or computer rounding.

Publication of Data: Our standard Terms and Conditions apply to this, as to all studies we carry out. Compliance with the MRS Code of Conduct and our clearing is necessary on any copy or data for publication, web-siting or press releases which contain any data derived from Ipsos MORI research.[18] This is to protect our client's reputation and integrity as much as our own. We recognise that it is in no-one's best interests to have survey findings published which could be misinterpreted, or could appear to be inaccurately, or misleadingly, presented.

[15] Some of the differences between GPs and hospital doctors could be methodological. On (prompted) questions with options, GPs would have seen all the options (on the internet); with hospital doctors (conducted by telephone), the respondents would have heard the options.

[16] According to the Department of Health 2005; *Hospital, Public Health Medicine and Community Health Services Medical and Dental staff in England: 1994-2004*

[17] Drawn from the Profile of Binley's GB Database

[18] MORI merged with Ipsos in October 2005 to become Ipsos MORI

Executive Summary

Overall, hospital doctors support regular assessment of themselves and their counterparts, sometimes considerably more so than GPs, and they respond much more positively to suggestions that a combination of a national independent body and a local NHS organisation should be responsible for assessing doctors. In line with this, hospital doctors are less inclined to select a local NHS organisation as the sole fulfiller of this role.

Not only do most hospital doctors believe that regular checks on doctors are worthwhile and necessary, despite the public's faith in doctors, they are also significantly more likely than their GP counterparts to think assessments should take place every two years.

Many hospital doctors also disagree that inspecting all doctors would be a waste of time and money. Whereas hospital doctors and GPs are both very likely to consider evidence that a doctor is keeping up-to-date with medical developments an important gauge of competence, hospital doctors are significantly more likely to rate other measures of performance highly, such as demonstrating technical skills, monitoring treatment success rates, re-checking qualifications and passing a written test of knowledge.

Similarly, receiving high ratings from patients, nurses and other doctors is seemingly more important to hospital doctors than GPs. However, some of these differences could be methodological, as noted in the introduction.

Although only a minority of hospital doctors would like to see any involvement of lay people in the assessment process, where this has been selected, it is as part of a mixture with qualified medical professionals too.

However, the bodies hospital doctors think are most responsible for ensuring doctors are competent – the General Medical Council and the Department of Health– are also the medical institutions they are most inclined to distrust. However, a majority does trust both the GMC (66%) and the Department of Health (53%).

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December 2005

Michele Corrado

Andrew Norton

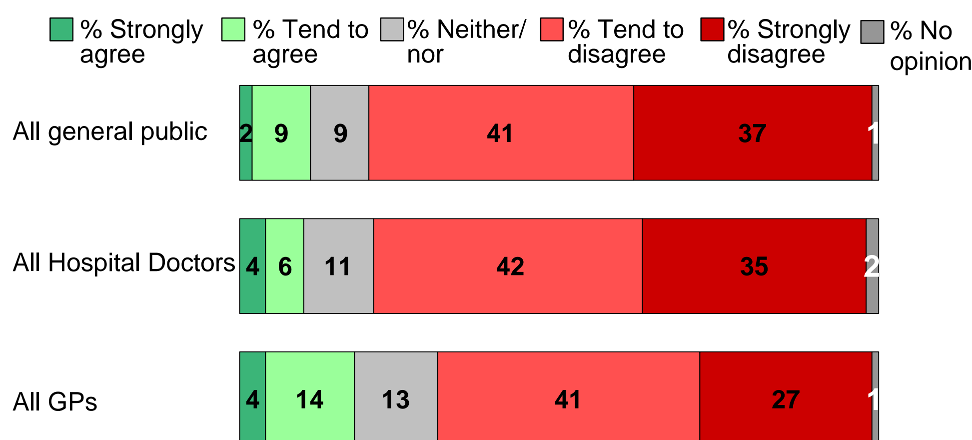
Luke Daxon

Summary of Findings

Trust in Doctors

As with the public and GPs, hospital doctors tend to agree that regular checks on doctors is needed, despite the very high levels of public trust in the profession.[19] Only one in ten agrees that there is no need to carry out checks regularly on doctors as they trust them, (see Figure 1 below). By contrast, over three-quarters (77%) disagree with this, saying that there is a need to carry out regular checks on them, suggesting fairly strong endorsement from hospital doctors of the concept of revalidation.

Figure 1



19 MORI/BMA Trust in Doctors study; 2,133 people interviewed from 17-21 February 2005. 90% of people in the UK trust doctors to tell the truth. MORI has trends going back to 1983 on this, and doctors have always come top or (in one case) joint first (with teachers).

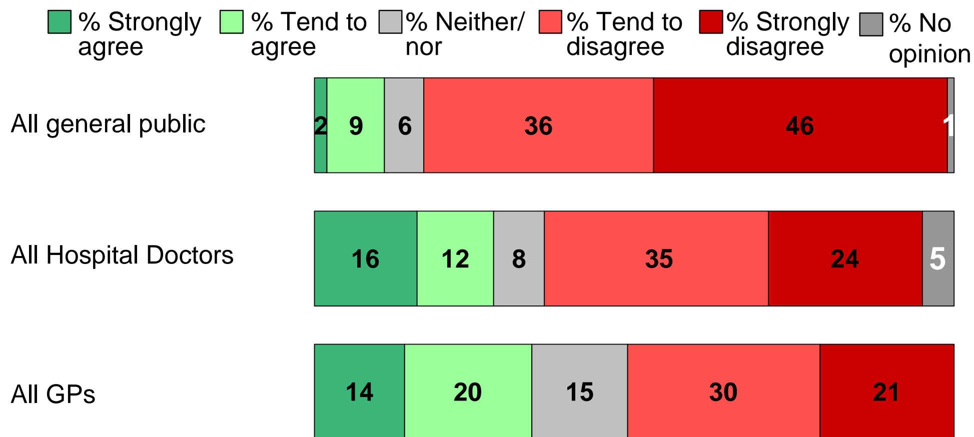
The Time and Cost Implications of Regular Checks

Most hospital doctors and GPs disagree with the view that inspecting all doctors would be a waste of time and money. However, a sizeable minority: 28% of hospital doctors and 35% of GPs – agree that universal inspection <u>would</u> be a waste of time and money. By comparison, the general public is much less likely to doubt the value for money of inspections (11%).

Figure 2

Attitudes Towards Checking Doctors

Q *Could you tell me how strongly you agree or disagree that inspecting all doctors would be a waste of time and money?*



Base: 2,195 UK adults; 200 UK General Practitioners; and 100 GB hospital doctors;16/06/2005-20/06/2005; 23/06/2005-25/06/2005; and 3/11/05-1/12/05 respectively

Source: MORI

Monitoring Doctors' competence

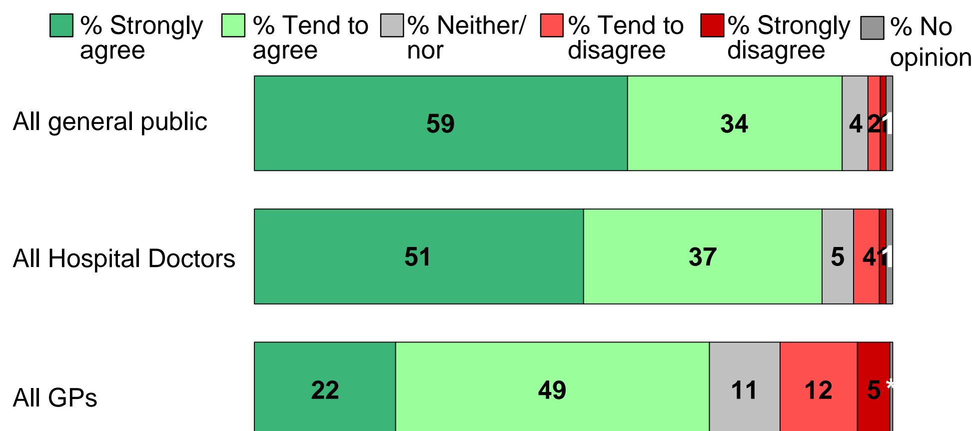
When asked about checking doctors' competence every few years, the great majority of hospital doctors consider it important (89%). In this respect, they are more closely in line with public opinion (93% of the public think it important). However, there is a significant difference of opinion with GPs, only 71% of whom consider it important to check the aptitude of doctors every few years.

This difference is even greater between hospital doctors and GPs who *strongly* agree it is important to monitor competence. Just over half of hospital doctors strongly agree it is important, compared to only about one fifth of GPs.

Figure 3

Attitudes Towards Checking Doctors

Q Could you tell me how strongly you agree or disagree that it is important that all doctors' competence is checked every few years?



Base: 2,195 UK adults; 200 UK General Practitioners; and 100 GB hospital doctors;16/06/2005-20/06/2005; 23/06/2005-25/06/2005; and 3/11/05-1/12/05 respectively

Source: MORI

Feedback on Doctors

When asked what is most important in ensuring everybody has a good doctor, over four in five hospital doctors and GPs mention evidence that a doctor is keeping up-to-date with medical developments (see Figure 4 below).

However, hospital doctors are significantly more likely than GPs to mention practical methods of assessing doctors' performance. For example, almost three in four suggest demonstrations of technical skills, compared to less than one in four GPs. Similarly, over half of hospital doctors mention monitoring the success rates of doctor's treatments, in comparison with only one in seven GPs.

Hospital doctors are also more likely to favour academic means of revalidation, with over a third of them suggesting that doctors have their qualifications rechecked periodically, and that they sit occasional written tests of medical knowledge, compared to only one in seven and one in five GPs respectively. This also places hospital doctors more closely in line with general public opinion: 30% of whom believe doctors should pass written tests, and 33% of whom think qualifications ought to be re-checked.[20]

Figure 4

Giving Feedback on Doctors

Q *If all doctors were to be assessed from time to time, which, if any, of the following do you think would be most important to ensure that everybody has a good doctor?*

	% Hospital doctors	% GPs	% General Public
Evidence that the doctor is keeping up-to-date with medical developments	85	81	67
Demonstrations of technical skills	74	23	31
Receiving high ratings from their patients	74	36	43
Receiving high ratings from other doctors	60	30	18
Receiving high ratings from nurses	56	19	19
Monitoring the success rate of the doctor's treatments	54	14	44
Re-checking of doctors' qualifications from time to time	36	15	33
Passing a written test of medical knowledge from time to time	35	20	30

Base: 200 UK General Practitioners; and 100 GB hospital doctors; 23/06/2005 25/06/2005; and 3/11/05-1/12/05 respectively

Source: MORI

[20] MORI/DH, Attitudes to Medical Regulation and the Revalidation of Doctors; 2,195 members of the public in the UK interviewed from 16-20 June 2005.

Who Should Regulate and Assess Doctors

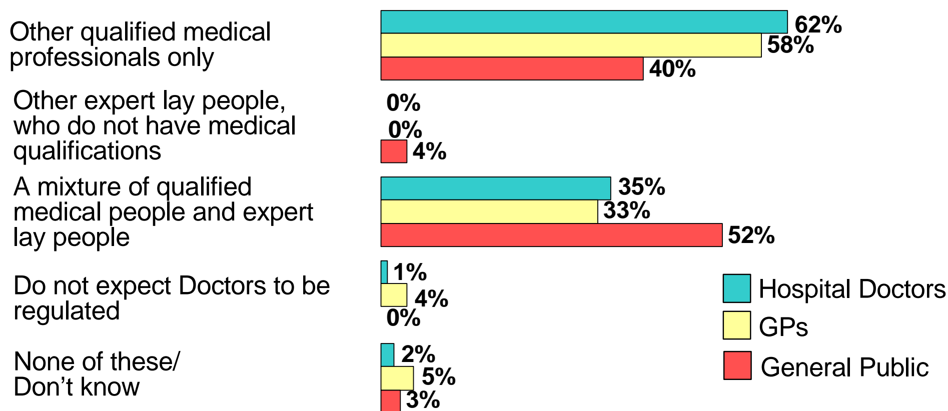
Most hospital doctors and GPs alike feel assessment of doctors should be carried out solely by other qualified medical professionals (62% and 58% think this respectively). However, a minority support assessment of doctors by a mixture of qualified medical professionals and expert lay people (35% and 33% respectively).

Compared with the public, doctors are much more inclined to favour assessment by qualified medical professionals alone. Figure 5 below shows that around half (52%) the public is in favour of expert lay people also being involved, compared with only 35% of hospital doctors who support this. None of the hospital doctors interviewed felt that assessment should only be carried out by expert lay people.

Figure 5

Preferred Mode of Assessment

Q If all doctors were to be assessed from time to time, on balance, do you think doctors should be assessed by…



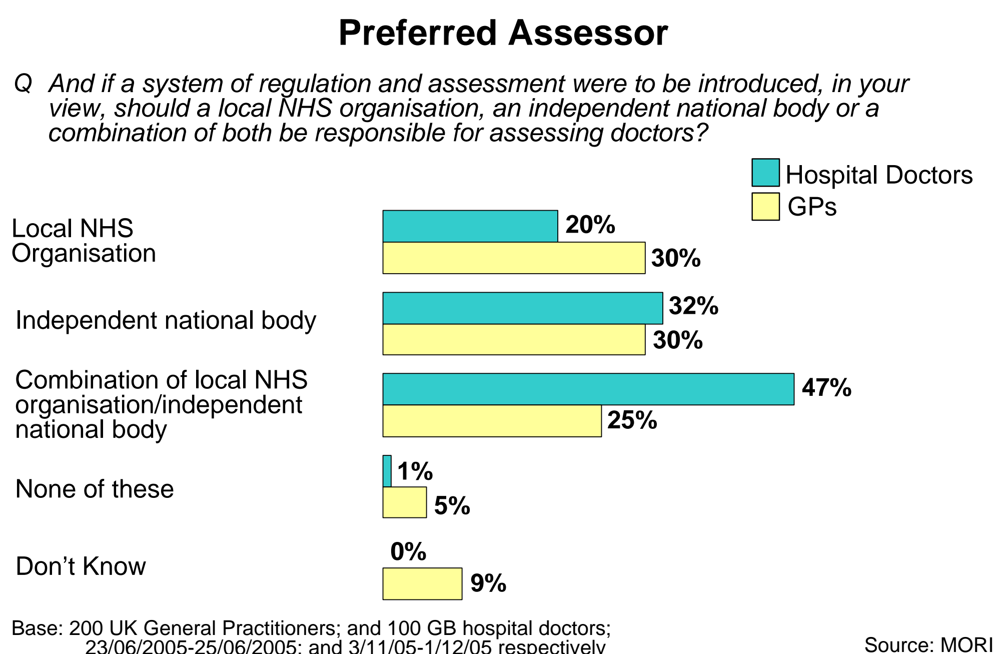
Base: 2,195 UK adults; 200 UK General Practitioners; and 100 GB hospital doctors;16/06/2005-20/06/2005; 23/06/2005-25/06/2005; and 3/11/05-1/12/05 respectively

Source: MORI

Hospital doctors are divided on whether any system of regulation and assessment should involve local NHS organisations, an independent national body or a combination of both local NHS organisations and national bodies (see Figure 6 below). One in five favours only local NHS organisations being involved, whilst around one in three favours using an independent national body only. However nearly half (47%) prefer a combination. This is significantly more than among GPs, only 25% of whom would prefer a mixture of local NHS and national institutional assessment.

All told, 79% of hospital doctors think an independent body should have at least some role in assessment and regulation, in contrast to only 55% of GPs.

Figure 6



A number of factors stand out in hospital doctors' reasons for choosing a regulation and assessment system. They are:

- Avoidance of bias (26%);
- Better to have independent/outside input (21%);
- Combining national standards with local convenience and flexibility (16%);
- More knowledge/Local knowledge (15%).

When hospital doctors are compared with GPs, they say more often that there is a need to combine national standards with local flexibility (16%, compared to 2% of GPs). This might well explain their greater preference for a mixture of local and national assessment. They are significantly less likely than GPs to say that more knowledge and local knowledge is a factor in choosing their type of assessor (15%, compared to 25% of GPs).

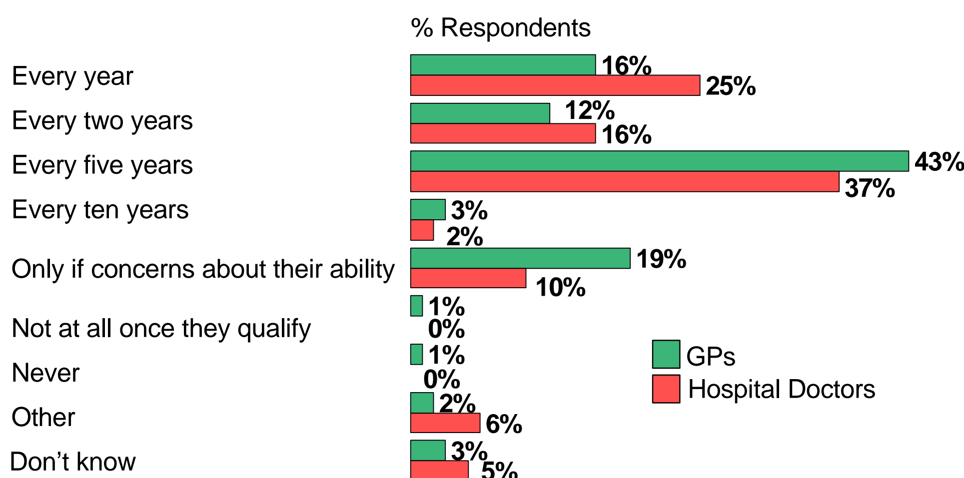
Frequency of Assessment

There is widespread support among hospital doctors for regular assessment, and approaching four-fifths (79%) feel this should occur at least every five years.

They are also significantly more likely than GPs to support an even greater frequency of assessment, with 41% believing it should occur at least every two years, compared to 28% of general practitioners.

A small minority (10%) prefers assessment only if concerns are raised about a doctor's ability, significantly fewer than among their GP counterparts (19%). No hospital doctor interviewed felt that doctors should never be assessed after qualification.

Figure 7



When asked to explain their preferred frequency of assessment (without being prompted), the reason hospital doctors give most often is keeping up-to-date with new innovations and patient management (30%), something they indicated significantly more often than GPs (12%). A reasonable or practical interval is also mentioned by over a quarter of hospital doctors and GPs (27% and 26% respectively).

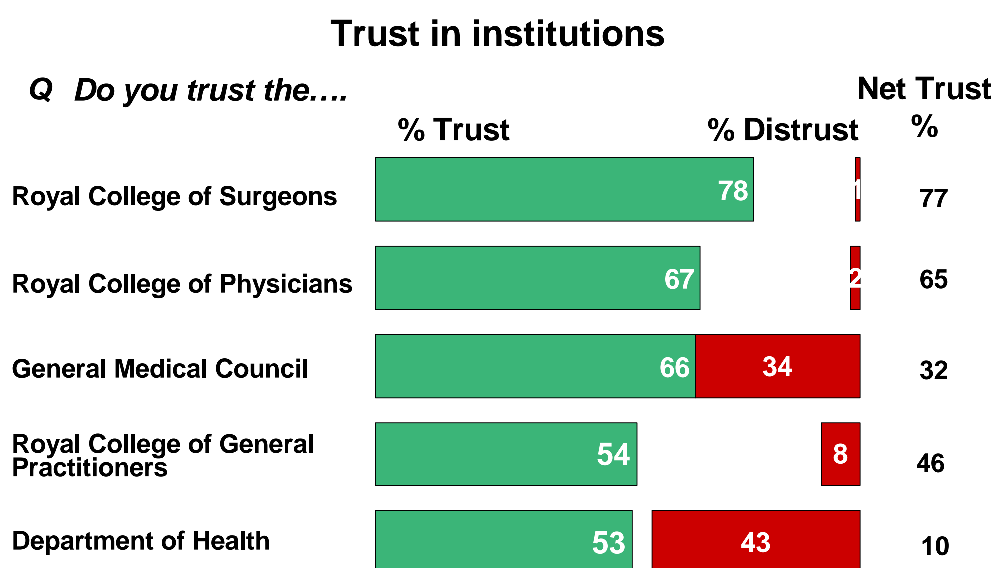
However, hospital doctors are far less likely to mention the balance between the burden of assessment and safety (only 2%, compared with 31% of GPs)

Other reasons hospital doctors offer for their preferred frequency of assessment are: discovering underperformers (10%), the need to balance continuing education with exams and the burden of good clinical practice (8%), that assessment every 1 or 2 years is too often (8%) and the need to maintain clinical quality (7%).

Perceptions of Professional Bodies

The body most trusted by hospital doctors is the Royal College of Surgeons (78%) with a net trust figure of +77.[21] The Royal College of Physicians comes second (with +65), followed some way behind by the Royal College of Practitioners (+46). Looking at the other net trust figures, the General Medical Council is next (+32) and the Department of Health is last (+10).

Figure 8



In the case of the RCP and RCGP, few hospital doctors actively distrust them (and perhaps many know little about them in detail). In contrast, a significant minority of hospital doctors actively distrusts the Department of Health (43%) and the General Medical Council (34%). This might be considered notable because these are the bodies hospital doctors consider as having most responsibility for ensuring everybody has a good doctor (24% say the DH and 63% say this for the GMC).

[21] 'Net Trust' is the proportion that trusts, minus the proportion that does not.

Appendices

Statistical Reliability

Because a sample, rather than the entire population of hospital doctors, was interviewed the percentage results are subject to sampling tolerances – which vary with the size of the sample and the percentage figure concerned. For example, for a question where 50% of the hospital doctors in a sample of (100) respond with a particular answer, the chances are 95 in 100 that this result would not vary by more than (10) percentage points, plus or minus, from the result that would have been obtained from a census of the entire hospital doctor population (using the same procedures). The tolerances that may apply in this report are given in the table below.

Approximate sampling tolerances applicable to percentages at or near these levels (at the 95% confidence level)

Size of sample or sub-group on which survey result is based	**10% or 90%** ±	**30% or 70%** ±	**50%** ±
100 hospital doctors	6	9	10

Source: MORI

Tolerances are also involved in the comparison of results between different elements of the sample. A difference must be of at least a certain size to be statistically significant. The following table is a guide to the sampling tolerances applicable to comparisons between sub-groups.

Differences required for significance at the 95% confidence level at or near these percentages

	10% or 90%	**30% or 70%**	**50%**
Size of sample on which survey result is based			
General public (2,195) vs. hospital doctors (100)	6	9	10
GPs (200) vs. hospital doctors (100)	7	11	12

Source: MORI

Quotas

Hospital Doctors Survey

Quotas (27/10/05)

We need interviews with **100** hospital doctors.

There are two quotas, on region and grade:

Region

	QUOTA
West Midlands, East Midlands, Eastern	At least 18
London	At least 14
Yorkshire & Humber, North West, North East	At least 20
Northern Ireland	At least 5, max 6
Scotland	At least 10, max 12
South West, South East	At least 16
Wales	At least 5, max 4

Grade

Career Grade	QUOTA
Consultant Associate Specialist Staff Grade Hospital Practitioner/Clinical Assistant	Aim for 50 to 75
Training Grade Registrar/Specialist Registrar/Senior Registrar Senior House Officer/SHO House Officer	Aim for as many as possible, max 50

Topline

MORI/26468/AN/MC

Hospital Doctors Survey
Final Topline Results (22/12/05)

- Results are based on a random sample of 100 hospital doctors in Great Britain, conducted by telephone for the Department of Health.
- Interviews were carried out by telephone between 3 November and 1 December 2005.
- For comparison, results are given for interviews among:
  - 200 UK GPs, conducted from 23-25 June 2005 via the internet, also for the Department of Health

    and
  - a representative sample of 2,195 UK adults aged 15+, conducted from 16 – 20 June 2005, face-to-face, in-home, using the MORI omnibus, also for the Department of Health
- Data for hospital doctors have been weighted to the known profile by grade, according to hospital, public health medicine and community health services medical and dental staff in England; DH 1994-2004; and by region, according to Binley's GB Database.
- Data for GPs have been weighted to the known profile of GPs, using ONS website data, and Binley's GB database for the number of partners.

Q1. **Firstly, could I just check your grade?** SINGLE CODE ONLY. INTERVIEWER: IF NECESSARY, READ OUT

	%	
Career Grade	*48*	
Professor/Reader/Senior Lecturer	-	
Consultant	33	
Associate Specialist	6	
Staff Grade	7	
Hospital Practitioner/Clinical Assistant	-	
Clinical Fellow	1	
Training Grade	*52*	COUNT TO QUOTA
Registrar	13	
Specialist Registrar/Senior Registrar	31	
Lecturer	-	
Senior House Officer/SHO	6	
House Officer	2	
Research Fellow	-	
Other	-	
None of these	-	CLOSE

Q2. **And could you tell me the English region or country (for Scotland, Wales and Northern Ireland) in which you work?** INTERVIEWER – PLEASE CODE COUNTRY / ENGLISH REGION.

	%
East Midlands	5
Eastern	10
London	18
North East	6
North West	12
South East	15
South West	6
West Midlands	8
Yorkshire and the Humber	6
Northern Ireland	-
Scotland	9
Wales	5

COUNT TO QUOTA

Q3. **How often do you think doctors should be assessed, if at all? Would you say…** READ OUT A-F. ALTERNATE ORDER. SINGLE CODE ONLY

		GPs	Hospital Doctors	Difference
		%	%	(±)
A	**…Every year**	16	25	+9
B	**…Every two years**	12	16	+4
C	**…Every five years**	43	37	-6
D	**…Every ten years**	3	2	-1
E	**…Only if there are concerns about their ability**	19	10	-9
F	**…Not at all once they qualify**	1	-	-1
	Never	1	-	-1
	Other	2	6	+4
	Don't know	3	5	+3

Q4. **Why do you say that that?** DO NOT PROMPT. MULTICODE OK

	GPs	Hospital Doctors	Difference
	%	%	(±)
A reasonable/practical interval	26	27	+1
To keep up to date with new innovations and patient management	12	30	+18
Regular assessments will discover any underperformers	2	10	+8
To maintain clinical quality	2	7	+5
Appraisal is helpful and motivating	3	5	+2
Need to balance continuing education with exams and burden of good clinical practice	3	8	+5
Happy with the way it is/Assessments are regularly taking place	-	6	-
Depends on their job/position on how often they are assessed	-	12	-
Only a small percentage of doctors are likely to be failing	4	6	+2
Change does not usually take place very quickly	2	5	+3
More often is of no more value	2	4	+2
Assessment every 1 or 2 years is too often	-	8	-

Too time consuming – it will take people away from the workforce/patients	-	5	-
Administrative issues	2	3	+1
Balance between burden of assessment and safety	31	2	-29
More frequent assessment would be too expensive	6	2	-4
Regulation is meaningless	6	2	-4
Newly trained doctors should be assessed yearly/frequently	-	5	-
Other professions are assessed, so why not doctors?	2	1	
Too generalised/Need more details	-	1	-
The public need to be reassured	5	-	
Other	-	6	-
Don't know	3	7	+4

Q5. **Could you tell me how strongly you agree or disagree with the following statements?** READ OUT A-C. ROTATE ORDER. SINGLE CODE FOR EACH

				Strongly agree	Tend to agree	Neither agree nor disagree	Tend to dis-agree	Strongly disagree	No opinion
A	**…Inspecting all doctors would be a waste of time and money**	General public	%	2	9	6	36	46	1
		GPs	%	14	20	15	30	21	-
		Hospital doctors	%	16	12	8	35	24	5
B	**…There is no need to regularly carry out checks on doctors as the public trust doctors**	General public	%	2	9	9	41	37	1
		GPs	%	4	14	13	41	27	1
		Hospital doctors	%	4	6	11	42	35	2
C	**…It is important that all doctors' competence is checked every few years**	General public	%	59	34	4	2	1	0
		GPs	%	22	49	11	12	5	*
		Hospital doctors	%	51	37	5	4	1	1

		% Agree	% Disagree
…Inspecting all doctors would be a waste of time and money	General public	11	82
	GPs	35	52
	Hospital doctors	28	59
…There is no need to regularly carry out checks on doctors as the public trust doctors	General public	11	79
	GPs	18	68
	Hospital doctors	10	77
…It is important that all doctors' competence is checked every few years	General public	93	3
	GPs	71	18

Hospital doctors	89	5

Q6. **If all doctors were to be assessed from time to time which, if any, of the following do you think would be most important to ensure that everybody has a good doctor?** READ OUT A-H. ROTATE ORDER. MULTICODE OK

		General Public	GPs	Hospital Doctors	Difference GPs/Hospital doctors
		%	%	%	(±)
A	**…Demonstrations of technical skills**	31	23	74	+51
B	**…Evidence that the doctor is keeping up-to-date with medical developments**	67	81	85	+4
C	**…Monitoring the success rate of the doctor's treatments**	44	14	54	+40
D	**…Passing a written test of medical knowledge from time to time**	30	20	35	+15
E	**…Receiving high ratings from other doctors**	18	30	60	+30
F	**…Receiving high ratings from nurses**	19	19	56	+37
G	**…Receiving high ratings from their patients**	43	36	74	+38
H	**…Re-checking of doctors' qualifications from time to time**	33	15	36	+21
	None of these	2	5	2	-3
	Don't know	2	4	-	-

Q7. **If all doctors were to be assessed from time to time, on balance, do you think doctors should be assessed by…** READ OUT A-C. ROTATE ORDER OF A AND B. KEEP C LAST. SINGLE CODE ONLY

		Gen Public	GPs	Hospital doctors	Difference GPs/Hospital doctors
		%	%	%	(±)
A	**…Other qualified medical professionals only**	40	58	62	+4
B	**…Other expert lay people, who do not have formal medical qualifications**	4	-	-	-
C	**…A mixture of qualified medical professionals and expert lay people**	52	33	35	+2
	Do not expect doctors to be regulated	0	4	1	-3
	None of these	1	2	1	-1
	Don't know	2	3	1	-2

Q8. **And if a system of regulation and assessment were to be introduced, in your view, should a local NHS organisation, an independent national body or a combination of both be responsible for assessing doctors?** SINGLE CODE ONLY

		GPs	Hospital doctors	Difference
		%	%	(±)
A	Local NHS organisation	30	20	-10
B	Independent national body	30	32	+2
C	Combination of both local NHS organisation and independent national body	25	47	+22
	None of these	5	1	-4
	Don't know	9	-	-

Q9. **Why do you say that?** DO NOT PROMPT. MULTICODE OK

	GPs	Hospital doctors	Difference
	%	%	(±)
To avoid bias	18	26	+8
Combines national standards with local convenience and flexibility	2	16	+14
Local and national bodies should complement each other	6	13	+7
More knowledge/local knowledge	25	15	-10
Better to have an independent body/view/outside input	-	21	-
Assessors should be involved with doctors they are assessing	2	6	+4
Should be independent evaluation	8	-	-
More fair/fairer to have both	-	8	-
Keep politics out of it	2	6	+4
Most practical/Best method	3	5	+2
Finances/funding – to come from the government	-	4	-
To enable standard setting and quality control through the country	6	2	+4
For patient and doctor reassurance	2	3	+2
Too time consuming – it will take people away from the workforce/patients	-	1	-
PCTs should be kept out of it/Distrust PCT	3	-	-
Peer review is the least offensive option	2	-	-
Other	-	11	-
Don't know	-	-	-

Q10. **Now I will read you a list of different professional bodies. For each, please could you tell me whether you trust them… 'A great deal', 'A fair amount', 'Not very much' or 'Not at all'. Firstly…** READ OUT A-E. SINGLE CODE FOR EACH. ROTATE ORDER OF A-E

			A great deal	A fair amount	Not very much	Not at all	Don't know	% Trust	% Distrust
A	**…Department of Health**	%	10	42	27	17	4	53	43
B	**…General Medical Council**	%	23	43	28	5	1	66	34
C	**…Royal College of General Practitioners**	%	15	39	5	3	38	54	8
D	**…Royal College of Physicians**	%	36	41	1	-	21	78	1
E	**…Royal College of Surgeons**	%	23	43	2	1	31	67	2

Q11. **Which one or two of the following professional bodies has most responsibility for ensuring that everybody has a good doctor?** READ OUT A-E. ROTATE ORDER. SINGLE CODE ONLY

		%
A	**…Department of Health**	24
B	**… General Medical Council**	63
C	**…Royal College of General Practitioners**	13
D	**…Royal College of Physicians**	10
E	**…Royal College of Surgeons**	4
	None of these	3
	Don't know	6

Q12. INTERVIEWER – PLEASE CODE

	%
Male	59
Female	41

Q13. **Please can you tell me your age?** SINGLE CODE ONLY

	%
22-24	-
25-29	8
30-34	21
35-39	21
40-44	22
45-49	14
50-54	7
55+	6
Refused	1

REVEAL CLIENT IF ASKED. **This survey is being conducted on behalf of the Department of Health**

THANK RESPONDENT AND CLOSE