

## Identifying and managing concerns about GPs in England:

an interview study and case-series analysis

### Abstract

#### Background

Underperforming doctors have been the focus of sustained interest from the media, policymakers, and researchers. GPs are more likely to be the subject of a complaint than any other type of doctor in the UK, and the management of concerns in primary care needs improvement, yet more is known about how concerns are managed in secondary care.

#### Aim

Although formal policies for NHS England's management of concerns are clear, little is known about how these are put into practice. This study explores how concerns are identified, investigated, and managed at a regional level.

#### Design and setting

A qualitative study of the management of concerns in primary care across eight area teams.

#### Method

The study comprised two main strands: in-depth interviews with NHS England staff; and the analysis of case file data.

#### Results

The process for raising concerns was identified as inconsistent and disparate, with potential weaknesses to address. The concerns process was flexible. A trade-off between adaptability and consistency was evident, but the correct balance of the two is difficult to establish. Performance concerns were most common, followed by behaviour. Conduct was the next most frequently raised concern, and a small number of health cases were identified. Outcomes of cases appeared to be dependent on the doctor's engagement and response rather than necessarily the nature of a concern or the consequences of a doctor's actions.

#### Conclusion

The way practices handle complaints and concerns remains unexamined, even though they are a key route for patient complaints.

#### Keywords

complaints; general practitioners; managing concerns; patient safety; quality of care.

### INTRODUCTION

Underperforming doctors have been the focus of sustained interest from the media, policymakers, and researchers alike.<sup>1-3</sup> This interest has been in part due to high-profile scandals, such as those of Harold Shipman, Daniel Ubani, and Gosport War Memorial Hospital.<sup>4-7</sup> Such extreme cases are, however, atypical of most concerns raised about doctors. Understanding how concerns are identified and managed is important for quality of care and patient safety.

GPs in the UK are more likely to be the subject of a complaint than any other type of doctor.<sup>8</sup> The management of concerns in primary care needs improvement,<sup>9</sup> yet more is known about concerns and how they are managed in secondary care.<sup>10</sup> This article therefore aims to contribute to our understanding by analysing the experiences of NHS England (NHSE) area team staff involved in managing concerns in primary care, and reviewing case records to identify patterns and variation in the process.

Complaints and concerns about doctors in primary care in England are received and managed at national, regional, and practice level. At a national level, the General Medical Council (GMC) reports that GPs are more likely to be the subject of a complaint than any other type of doctor. From 2012 to 2016 the GMC received almost 70 000 complaints, of which 42% were made against GPs.<sup>8</sup> In total, 17% of GPs were the subject of at least one complaint between

2012 and 2016; of these GPs, 5.3% were investigated and 0.7% received a sanction or warning.<sup>8</sup>

However, much of the identification, management, and resolution of concerns happens outside the national regulatory framework, either locally by GP practices, or regionally by area teams in NHSE's five regions. NHSE is responsible for the commissioning of NHS services in England. It directly commissions GP, pharmacy, dental, and specialised services, and supports local clinical commissioning groups (CCGs) to commission other health services. Every GP must be registered on a performers list by NHSE. The key guidance on managing these cases of concerns locally is the *Framework for Managing Performer Concerns*.<sup>10</sup> Box 1 sets out how, within this structure, concerns about doctors working in primary care in England are managed by area teams.<sup>11</sup> But complaints about GPs can be made direct to their practice, and little is known about the numbers of these concerns, or how they are managed. Practices can escalate a concern to the NHSE area team. Similarly, area teams may further escalate a complaint to the GMC if necessary, while the GMC will always inform area teams of any regulatory cases relating to doctors within their area.

Although the formal policies for NHSE's management of concerns are clear, very little is known about how these are put into practice and how they work. This article explores how concerns are identified,

**A Tazzyman**, PhD, research associate; **K Walshe**, PhD, professor of health policy and management; **A Boyd**, MA, MSc, research fellow, Alliance Manchester Business School, University of Manchester, Manchester. **M Bryce**, PhD, senior research fellow, Plymouth University, Plymouth.

#### Address for correspondence

Abigail Tazzyman, Alliance Manchester Business School, University of Manchester, Manchester, M15 6PB, UK.

**Email:** [abigail.tazzyman@manchester.ac.uk](mailto:abigail.tazzyman@manchester.ac.uk)

**Submitted:** 17 October 2018; **Editor's response:** 21 November 2018; **final acceptance:** 24 December 2018.

©British Journal of General Practice

This is the full-length article (published online 8 May 2019) of an abridged version published in print. Cite this version as: **Br J Gen Pract 2019;** DOI: <https://doi.org/10.3399/bjgp19X703733>

## How this fits in

GPs are more likely to be the subject of a complaint than any other type of doctor in the UK. Although formal policies for NHS England's management of concerns are clear, little is known about how these are put into practice and far more is known about secondary care. Understanding how concerns are identified and managed is important for quality of care and patient safety. This article explores how concerns are identified, investigated, and managed at a regional level.

investigated, and managed at the regional level.

## METHOD

The study comprised two main strands: in-depth interviews with NHSE staff; and the analysis of case file data. Data collection took place between 2015 and 2017.

## Interviews

Thirty-six semi-structured interviews were conducted with clinical and non-clinical staff from eight NHSE teams spread across different regions. The first set of interviews took place in 2015. This consisted of 13 interviews within two area teams, as part of a larger study on revalidation. A second interview schedule was developed to explore the management of concerns in more depth, and was used in eight further interviews within these two area teams during 2016. Fifteen staff from across six more area teams were then interviewed in 2017. Interviews were conducted either in person or by telephone, according to the interviewees' preference, and were digitally recorded and transcribed for analysis.<sup>12</sup> Informed consent was given by all interviewees. Interviews were conducted

by four health service researchers, who had a wide experience of studying professional and organisational regulatory processes in health care.

## Case files

Data about individual cases of concern were collected from records held by five of the six area teams interviewed in 2017. A data extraction template was developed to standardise the data collected. Anonymised information for approximately 20 of the most recently closed cases from each team was extracted, giving data for 102 cases in total. Two cases involved more than one doctor; data relating to all doctors involved were extracted. Data collected included details about the source and nature of the concern, a timeline of the case's development, actions, and outcomes.

## Analysis

A coding framework was developed and tested on a sample of interview data. Coding was structured around the major areas of the concerns management process and themes were then identified within these through a process of discussion among the research team.<sup>13,14</sup>

The cases of concern data were reviewed by the research team, with individual case progress and patterns across the dataset considered. From this review, a list of 'case characteristics' was developed. This included key events within cases, actions by NHSE case management teams, doctors' responses, any involvement from other agencies, and how cases were resolved.

These categorisations were tested on a sub-sample of data, allowing the development of an analysis framework able to capture chronological development by recording multiple events or actions. The framework was then applied to all the collected data.<sup>15</sup>

Descriptive statistics were produced, identifying trends within the data. In addition to these insights, qualitative descriptions of cases were developed to illustrate the main features of the cases.

## RESULTS

The results focus on four main areas: the identification of concerns, the nature of concerns, managing concerns, and the outcome of concern cases.

## Identifying concerns

Across the area teams, concerns had arisen from a range of sources. The most prominent routes were: patient complaints ( $n = 46$ ); the GMC ( $n = 18$ ); and colleague

## Box 1. How NHS England manages concerns about GPs<sup>a</sup>

1. Area team becomes aware of concern.
2. Initial risk rating and information gathering by case reviewer where the risk to patients and likelihood of the concern reoccurring are assessed.
3. Initial risk rating taken to a PAG to determine whether an initial investigation is to be carried out or if the case can be closed.
4. If action is needed, the case is referred to the performers list decision making panel, which can put restriction on a doctor's practice, give out conditions to be fulfilled, such as learning, and also remove a doctor from the performers list.
5. Case closed by PAG.

<sup>a</sup>Adapted from NHS England guidance.<sup>11</sup> PAG = Performance advisory group.

**Table 1. The nature and frequency of concerns about GPs**

Core issue	Description	Frequency
Performance	Prescription errors, delayed referral, poor record-keeping, and diagnostic errors	77
Behaviour	Communication skills, failure to meet workload demands, avoidance of responsibilities, poor interpersonal skills, and lack of engagement with appraisal	28
Conduct	Sexual harassment, domestic violence, and dishonesty	19
Health	Mental health, physical health, and substance abuse	4
Total <sup>a</sup>		128

<sup>a</sup>Total is more than number of cases reviewed because some contained multiple concerns.

complaints (both doctors and other healthcare staff) ( $n = 11$ ). A mix of other external routes (such as safeguarding or police) ( $n = 22$ ) and internal routes (that is, within the NHS: self-reporting, pharmacist, or CCG) ( $n = 14$ ) also occurred. This variety of sources of information highlights the number of potential entry points into the system:

*'We get some through the complaints route ... work colleagues or CCG colleagues ... occasionally from the CQC [Care Quality Commission] in their inspections; and sometimes we get information from the GMC either that it doesn't meet their threshold or that they've got something that they're investigating that we would also look at locally.'* (Associate medical director; NHSE area team F)

Once received by NHSE, concerns were directed to and managed by complaints teams. This provided a formal pathway for outside organisations or patients to direct their concerns. These arrangements were not, however, guaranteed to be used. Patients often complained directly to their GP practice and, unless a practice forwarded these complaints to NHSE, they were outside NHSE's remit:

*'It's only when they get escalated to NHS England that we're able to manage that information ... we don't tend to get involved with issues unless the practice specifically flags it up as a concern.'* (Senior project officer for revalidation; NHSE area team B)

It was evident that some concerns could be missed or unreported, because investigations when a concern was raised sometimes identified other prior or unrelated concerns:

*'We're actually doing an end-to-end review of this one because there were some really serious patient safety concerns here relating to clinical practice and it hasn't been flagged by anybody in the system ... There's had to be patient recalls because they've not had the clinical care and treatment that they should have had. How has the system enabled that to happen?'* (Head of inspection, CQC; NHSE area team B)

Once a concern was raised, other separate or unrelated issues were found in 14 cases. Interviewees also reported that investigations uncovered other problems, sometimes going back substantial periods of time. When doctors moved between practices or areas, this could also lead to concerns being missed:

*'We try to link up with the other area teams as either people move around or are working in different localities. I think in [this region] we do that quite well, probably more tricky with other regions ... it feels a little bit counter-intuitive for us not to be sharing it.'* (Associate medical director; NHSE area team F)

How and, indeed, whether a concern was identified was quite variable but inconsistent.

### Nature of concerns

Concerns identified were categorised by the research team into four broad categories: health, performance, conduct, and behaviour (Table 1).

Concerns about doctors' clinical performance were most common. Within this category, the most frequently raised concerns were diagnostic errors and delays to referrals ( $n = 30$ ), or prescribing errors ( $n = 13$ ). For example, one case featured a misdiagnosis of type 1 diabetes in a child who was subsequently admitted to hospital with potentially serious complications. Cases of prescribing error included oversupplying vulnerable patients with potentially dangerous medication and the prescription of contraindicated medications. Other cases involved patients seeking alternative medications or disagreeing with doctors' prescribing decisions as well as poor record keeping.

Concerns about doctors' behaviour were the second most common category; and often related to communication skills ( $n = 20$ ). These concerns usually came from patient complaints, and were often secondary to a performance concern. Complaints referred to 'curt' or 'abrupt' behaviour by doctors towards patients and other staff members.

Other behaviour issues concerned avoiding responsibility or not fulfilling workload obligations ( $n=5$ ). There were allegations of doctors avoiding obligations under the Quality and Outcomes Framework and others more directly relating to patient care, such as a doctor falling asleep in consultations. These cases were usually reported by GP colleagues or in one instance a CQC adviser. Lack of engagement with appraisal ( $n=2$ ) also appeared, demonstrating that failure to comply with revalidation requirements can result in doctors coming to the attention of NHSE's performance management teams. Multifactorial cases, involving issues from two or more of the four broad categories, most typically included concerns about performance and behaviour ( $n=18$ ).

Conduct cases included allegations of domestic violence ( $n=4$ ) and sexual abuse, sexual harassment ( $n=5$ ), and using a work computer to view pornography ( $n=1$ ).

In only a few ( $n=4$ ) of the cases was the concern related to the health of the doctor, with all of these involving mental health issues. The relatively small number might be a result of selecting only closed cases for the sample or the NHSE processes for dealing with health concerns not always generating a formal record as a concern.

### Managing concerns

The way in which cases of concern were managed centred on the processes set out by NHSE in the *Framework for Managing Performer Concerns*.<sup>10</sup>

Most cases were dealt with by local performance advisory group (PAG) and case management staff. A smaller number of cases went through the GMC. The GMC notified NHSE in 18 of the 102 cases reviewed. In these instances, NHSE's actions and outcomes were largely guided by GMC processes and outcome decisions. The PAG's approach in such cases was typically to open its own case but then to monitor the situation and await the GMC outcome.

In three cases, the patient concerns were simply passed to the deputy medical director for review, who closed the cases with no further action. These complaints related to patients disagreeing with prescribing decisions or were about the practice at which the doctor worked, and were open between 2 and 6 weeks. Most cases were reviewed at one or more PAG meetings. Of all the cases, only seven were escalated to the local performers list decision making panel (PLDP), all involving dishonesty or non-compliance.

Actions taken included clinical reviews, audits, seeking information from doctors, and meetings between NHSE local case management staff and doctors. Meetings between case management staff and the doctors concerned occurred in 17 cases. NHSE teams proactively organised all meetings bar one in order to gather more information and seek the doctor's perspective:

*'We write out and you start to build that relationship up ... [in] 80, 90% of [cases], there isn't that much to the case. There are the 10% that are of a concern and we try to proportion the time that we have and not make anything too onerous for the practitioner ... By engaging with the practitioner, giving them that opportunity we feel we're in a better place to take forward the salient points of a case so that the PAG can make an informed decision.'*  
(Programme manager; NHSE area team G)

Clinical reviews were carried out in 28 cases, all but one of which involved performance concerns, including eight that also featured concerns about communication skills. Sixteen cases involved record audits. All these cases involved potential performance concerns relating to diagnoses, prescribing, and/or record-keeping. Risk rating, typically using a red-amber-green matrix, was used in 20 cases in the sample, all from the same NHSE area team, suggesting a difference either in the way this tool is applied in case management between teams or in the way the information is recorded.

Across the area teams, supporting doctors subject to concerns appeared high on the agenda. In particular, organisations were keen to limit the stress and burden of concern cases on doctors, and to use remediation to ensure workforce retention and quality improvement, rather than taking a predominantly punitive approach:

*'The majority of our time we spend on remediation, so it would depend on the particular concern that the doctor's raised. So we would routinely offer occupational health, we would routinely offer access to GP counselling helplines, the new national GP system for doctors who are in health difficulties. We also have, unusually, access to GP tutors and not all areas have them ... we use the appraisers as well to be able to help them to develop personal development plans to address any potential deficiencies.'*  
(Deputy director revalidation; NHSE area team G)

In addition to informal approaches, organisations also actively sought to provide support. The nature and extent of this support varied and was largely determined by available resources. Typically, support was not provided by area teams themselves but was rather signposted. Services frequently signposted included occupational health services, National Clinical Assessment Service (NCAS) for practices supporting doctors, royal colleges, training courses, local medical committee representatives, and the GP health service:

*'GP health service, we have referrals to occupational health as well, and we also do sort of informal support of talking to either appraisal leads ... And we link really closely with the LMC [local medical committee] and CCGs around it as well.'* (Associate medical director; NHSE area team F)

Providing support was stated to be important for two main reasons: the acknowledged stress and burden concern cases cause doctors, which was seen to increase with case length, and current workforce difficulties in primary care, including shortages and recruitment and retention challenges. Area teams were therefore keen to ensure doctors stayed within the profession.

#### **Outcomes of concerns cases**

The predominant factor determining case outcomes was the response of the doctor involved. Compliance was crucial. In particular, reflection, demonstration of insight, proactive behaviour, uptake of necessary training, and adherence to action plans were the forms of compliance valued by interviewees and documented in the cases of concern reviewed:

*'It's about the level of insight ... people without insight are just so difficult, occupy masses of time. Whereas the people with insight, our biggest worry is that they go too far the other way, blame themselves too much. It's the balance ... sometimes people are very defensive to start with but can accept it, but other times people are just very defensive and just put a wall up as though there's nothing wrong ... The first thing we do is tell them to talk to their defence body because they can often talk some sense into them about engaging with us.'* (Associate medical director; NHSE area team F)

The speed of case completion was overwhelmingly dependent on doctor

engagement and the response of other involved bodies rather than on the nature of a concern. The average case length was 205 days, but there was huge variety, with the longest case taking 1362 days and the shortest 1 day. Cases in which NCAS or the GMC were involved tended to take longer to reach completion:

*'There aren't nationally described timescales. There's no nationally described key performance indicators. Some timescales are really difficult. Just recently we lost a case of over 12 months, which is not what you'd want because the stress on an individual going through a concern is really high, so we wouldn't want cases that are going beyond that point ... long-standing cases ... tend to be ones where you've already had involvement of police and regulators and they're outside of our control.'* (Deputy director revalidation; NHSE area team G)

Overall, the most common outcomes were no further action or informal actions. Of the 102 cases reviewed, 46 were resolved with no further action. Reasons for this included: the PAG finding the doctor not at fault; issues been satisfactorily addressed; or the doctor relinquishing their licence to practise or retiring. In a further 46 cases outcomes were 'informal', meaning that the doctor was required to take actions but was not sanctioned. Typically, such conditions required doctors to reflect on the concern at their next appraisal. With enhanced annual appraisal now compulsory because of revalidation, using appraisal as a means of following up on concerns has become commonplace, even when no further action was taken.

Requirements for education and further training were implemented relatively frequently, with 27 cases including this as a condition for case closure:

*'We would monitor the cases, and if the doctors have been asked to do remedial action, either CPD [continuing professional development] or other things then the case manager will monitor that and take it back to the relevant panel, either PAG or PLDP to close it off if the action has been done and done satisfactorily to the panel, to the standard the panels require, and if not then obviously we go to performance regulations with regulatory action.'* (Joint programme manager revalidation and appraisal, and programme manager professional performance and revalidation; NHSE area team C)



In two further cases, doctors were offered advice about practice, and in three others, the PAG agreed a monitored action plan to be followed until it was satisfied. Only seven cases reached PLDP, and in only five of these did the PLDP enforce performer conditions. Such escalation was strongly linked to a lack of engagement and refusal to comply with more informal attempts to address concerns and ensure patient safety.

## DISCUSSION

### Summary

This article has explored how concerns about doctors are identified and managed in primary care in England. Key trends were identified in regards to the identification, nature, and outcomes of concerns in primary care by NHSE and in doing so made visible areas requiring further research.

The process for raising concerns was identified as inconsistent and disparate, with potential weaknesses to address. Examples of new cases unearthing previously unreported concerns made apparent the possibility of missed and unaddressed concerns within primary care.

The concerns process was flexible, enabling the application of informal discipline and remediation as well as formal sanctions, proving capacity for support as well as judgement. This helped to ensure the approach taken by NHSE was proportionate to the concern under investigation and best suited to individual doctors. However, flexibility did result in diverse approaches, perhaps meaning that doctors are inconsistently treated across organisations and nationally. A trade-off between adaptability and consistency was evident, but the correct balance of the two is difficult to establish. Practices remain the unexamined level in complaints and concerns handling, and a key route for patient complaints. Complaints made to practices were frequently dealt with in-house, with no information being passed on to NHSE.

Performance concerns were most common, followed by behaviour, and multifactorial cases were most likely to be a combination of these two. Conduct was the next most frequently raised concern, and finally a very small number of health cases were identified. Outcomes of cases appeared to be dependent on doctors' engagement and response, rather than necessarily the nature of a concern or the consequences of a doctor's actions.<sup>16</sup>

### Strengths and limitations

Very little is known about how the local

level management of concerns in primary care is put into practice and experienced. This research provides an insight into this process, enabling the experience and explanation to be provided alongside a contextual picture of the frequency of case types and pathways. However, the authors recognise that the GPs who were subject to concerns were not interviewed to understand their experiences directly, and that the sample of cases was not big enough to support statistical analysis and therefore findings on frequency are indicative only.

### Comparison with existing literature

The nature of concerns identified in the current research corresponds to existing information on concerns raised at national levels in England and the UK.<sup>8,17</sup> The means of concern identification was in line with that reported to NHSE (patient complaints most frequent), but differed from the findings of previous research on this topic.<sup>18,19</sup> This existing research was, however, conducted before the introduction of NHSE, suggesting structural changes may have impacted on what is reported to whom.

Existing research has found that doctors have been reluctant to report each other in regards to concerns or complaints,<sup>20,21</sup> and that as a profession, doctors are also unlikely to self-report health-related issues.<sup>22</sup> Research from the GMC from 2017 does suggest, however, that the proportion of referrals from colleagues is increasing.<sup>8</sup> Given these factors, as well as the fact that most concerns in the current study (62.7%) were reported to NHSE either by patients or the GMC rather than by colleagues or GP practices, further research into how concerns are dealt with at a practice level and the criteria for escalating concerns to NHSE would be beneficial.

Compliant and penitent doctors were more likely to have shorter cases, less likely to have a case escalated to the PLDP or GMC, and faced less disciplinary action against them. This approach can be seen as positive, as it focuses on doctors' intentions and attitudes, and their ability to be safe in future, providing perhaps a more open and supportive environment, that values remediation. These are all factors that have previously been identified as positive for patient safety.<sup>23</sup> However, this approach is open to the possibility of doctors 'gaming the system', knowing that by appearing to be compliant they avoid more severe consequences from complaints raised against them<sup>24,25</sup> In addition, those doctors who have already been the subject of concerns are more likely to have a subsequent concern raised

than those who have not.<sup>26</sup> Research into the effectiveness of remediation-focused concerns management would be beneficial to help better evaluate this approach.

### **Implications for research and practice**

The ad hoc nature of concerns identification suggests that some concerns or, indeed, connections between cases, may be missed, pointing to the potential for targeting improvement initiatives to develop better, more reliable, reporting mechanisms.

This study identified a need for improved data collection and sharing of concerns information between NHSE and practices. Clear criteria and routes for escalation to NHSE would help to facilitate this, but

are currently missing. Given that patient complaints were the most prominent route of identification to NHSE in the current study (45.1%), further research into how this relates to what is or is not reported at a practice level is needed.

There may be trends in the types of issue arising and therefore data about concerns could be a valuable source of information to support targeted CPD initiatives.

Overall, more research to understand how complaints made at practice level are managed and resolved is needed to ensure a fuller understanding of the nature, prevalence, and management of concerns in primary care encompasses all levels of this complex system.

---

### **Funding**

This study is an output from independent research commissioned and funded by the Department of Health Policy Research Programme (PR-R9-0114-11002: Evaluating the development of medical revalidation in England and its impact on organisational performance and medical practice). The views expressed are those of the authors and not necessarily those of the Department of Health.

### **Ethical approval**

Ethical approval for this study was awarded by the University of Manchester ethics committee (REC 15028).

### **Provenance**

Freely submitted; externally peer reviewed.

### **Competing interests**

The authors have declared no competing interests.

### **Open access**

This article is Open Access: CC BY-NC 4.0 license (<http://creativecommons.org/licenses/by-nc/4.0/>).

### **Discuss this article**

Contribute and read comments about this article: [bjgp.org/letters](http://bjgp.org/letters)

## REFERENCES

1. Locke R, Scallan S, Leach C, Rickenbach M. Identifying poor performance among doctors in NHS organizations. *J Eval Clin Pract* 2013; **19**(5): 882–888.
2. Chamberlain JM. Reforming medical regulation in the United Kingdom: from re-stratification to governmentality and beyond. *Medical Sociology Online* 2014; **8**(1): 32–43.
3. Goodwin N, Dixon A, Poole T, Raleigh V. *Improving the quality of care in general practice: report of an independent inquiry commissioned by The King's Fund*. 2011. [https://www.kingsfund.org.uk/sites/default/files/improving-quality-of-care-general-practice-independent-inquiry-report-kings-fund-march-2011\\_0.pdf](https://www.kingsfund.org.uk/sites/default/files/improving-quality-of-care-general-practice-independent-inquiry-report-kings-fund-march-2011_0.pdf) [accessed 25 Apr 2019].
4. Gosport Independent Panel. *Gosport War Memorial Hospital: the report of the Gosport Independent Panel*. 2018. [https://www.gosportpanel.independent.gov.uk/media/documents/070618\\_CCS207\\_CCS03183220761\\_Gosport\\_Inquiry\\_Whole\\_Document.pdf](https://www.gosportpanel.independent.gov.uk/media/documents/070618_CCS207_CCS03183220761_Gosport_Inquiry_Whole_Document.pdf) [accessed 25 Apr 2019].
5. Simpson JM, Esmail A. The UK's dysfunctional relationship with medical migrants: the Daniel Ubani case and reform of out-of-hours services. *Br J Gen Pract* 2011; DOI: <https://doi.org/10.3399/bjgp11X561230>.
6. Dixon-Woods M, Yeung K, Bosk CL. Why is UK medicine no longer a self-regulating profession? The role of scandals involving 'bad apple' doctors. *Soc Sci Med* 2011; **73**(10): 1452–1459.
7. Waring J. Adaptive regulation or governmentality: patient safety and the changing regulation of medicine. *Social Health Illn* 2007; **29**(2): 163–179.
8. General Medical Council. *The state of medical education and practice in the UK*. 2017. <https://www.gmc-uk.org/-/media/about/somep-2017/somep-2017-final-full.pdf?la=en&hash=B6AD13C9D672F7FCD927498A3F50BB0A2A4286F2> [accessed 23 Apr 2019].
9. Sir Robert Francis QC. *Freedom to speak up. An independent review into creating an open and honest reporting culture in the NHS*. Report. 2015. [http://webarchive.nationalarchives.gov.uk/20150218150953/https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU\\_web.pdf](http://webarchive.nationalarchives.gov.uk/20150218150953/https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf) [accessed 25 Apr 2019].
10. NHS England. *Framework for managing performer concerns*. London: NHS England, 2018. <https://www.england.nhs.uk/wp-content/uploads/2017/04/framework-managing-performer-concerns-v3.pdf> [accessed 25 Apr 2019].
11. NHS England. *Toolkit for managing performance concerns in primary care*. London: NHS England, 2016.
12. Green J, Thorogood N. *Qualitative methods for health research*. London: Sage, 2013.
13. Fereday J, Muir-Cochrane E. Demonstrating rigor using thematic analysis: a hybrid approach of inductive and deductive coding and theme development. *Int J Qual Methods* 2006; **5**(1): 80–92.
14. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006; **3**(2): 77–101.
15. Murad MH, Sultan S, Haffar S, Bazerbachi F. Methodological quality and synthesis of case series and case reports. *BMJ Evid Based Med* 2018; **23**(2): 60–63.
16. Case P. The good, the bad and the dishonest doctor: the General Medical Council and the 'redemption model' of fitness to practise. *Leg Stud* 2011; **31**(4): 591–614.
17. NHS Digital. *Data on written complaints in the NHS, 2016–17*. 2017. [https://files.digital.nhs.uk/pdf/va/data\\_on\\_written\\_complaints\\_in\\_the\\_nhs\\_2016-17\\_report.pdf](https://files.digital.nhs.uk/pdf/va/data_on_written_complaints_in_the_nhs_2016-17_report.pdf) [accessed 25 Apr 2019].
18. Cox SJ, Holden JD. Presentation and outcome of clinical poor performance in one health district over a 5-year period: 2002–2007. *Br J Gen Pract* 2009; DOI: <https://doi.org/10.3399/bjgp09X420527>.
19. Gray J. Recognising and dealing with poor performance amongst general medical practitioners: local arrangements in two English health districts. *Qual Prim Care* 2005; **13**: 29–35.
20. Waring JJ. Beyond blame: cultural barriers to medical incident reporting. *Soc Sci Med* 2005; **60**(9): 1927–1935.
21. Hooper P, Kocman D, Carr S, Tarrant C. Junior doctors' views on reporting concerns about patient safety: a qualitative study. *Postgrad Med J* 2015; **91**(1075): 251–256.
22. Cohen D, Winstanley SJ, Greene G. Understanding doctors' attitudes towards self-disclosure of mental ill health. *Occup Med* 2016; **66**(5): 383–389.
23. Colla JB, Bracken AC, Kinney LM, Weeks WB. Measuring patient safety climate: a review of surveys. *Qual Saf Health Care* 2005; **14**(5): 364–366.
24. Chamberlain JM. Portfolio-based performance appraisal for doctors: a case of paperwork compliance. *Social Res Online* 2010; **15**(1): 1–9.
25. McKinstry B, Peacock H, Shaw J. GP experiences of partner and external peer appraisal: a qualitative study. *Br J Gen Pract* 2005; **55**(516): 539–543.
26. Bismark MM, Spittal MJ, Gurrin LC, *et al*. Identification of doctors at risk of recurrent complaints: a national study of healthcare complaints in Australia. *BMJ Qual Saf* 2013; **22**(7): 532–540.