

# Managing risk to reputation

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## Abstract

Doctors, particularly in aesthetic surgery, are increasingly under public and press scrutiny. This paper sets out how, and why, the press can influence the outcome of a professional investigation or the expression of anger by a disgruntled patient. Seven steps are set out which clinicians can follow to minimize the risk to their reputation.

## Introduction

Reputation is a doctor's most valuable asset. Risk to reputation needs to be managed in the same way that other elements of a doctor's practice are assessed as the potential for a doctor's reputation to be damaged is increasing all the time. The intrusiveness of today's reporting, the techniques of modern news gathering and the speed with which inaccurate and unfair allegations can be published to a global audience mean that a reputation that may have taken years to build can be destroyed in the time it takes to open an email or read a headline. As a consequence, doctors are more exposed than ever before and are having to resort to measures that distance them from colleagues, patients and the challenges that led them into the profession.

## Risk to reputation in context

'Impact is what matters ... scandal or controversy beats ordinary reporting hands down. The fear of missing out means that today's media hunts in a pack. It is like a feral beast, just tearing people and reputations to bits.'<sup>1</sup> The media provides the context within which one has to manage risk to reputation. It is undergoing rapid and profound change with consequences for how doctors assess risk in every aspect of their life.

Rolling 24-hour news on television and radio requires a constant stream of stories so that newspapers have been 'turned into copy factories' as Nigel Hawkes commented: 'This leaves less time for real investigations, or meeting and developing contacts.'<sup>2</sup> In 2007 Cardiff University<sup>3</sup> found that fewer journalists are producing three times as many pages as they did 20 years ago and only 12% of stories are being properly checked. 'The everyday practices of news judgement, fact checking, balance, criticising and interrogating sources that are, in theory, central to routine day to day journalism practice have been eroded.'<sup>4</sup> The implications for doctors are serious. Journalists are

increasingly reliant on what is already in the public domain or their archives and what they are fed by the news agencies. Doctors must monitor the information that is publicly available about them and take immediate steps to remove or correct any inaccuracy.

The drop in advertising revenue has forced many out of the industry altogether so there are now fewer journalists with the specialist knowledge and contacts to properly report the issues that surround medical stories. Complexity, detail and accuracy are compromised. Important but complicated issues are not covered and if a story looks like it will require lots of time or work it is less likely to be investigated. This problem is particularly acute in the reporting of the GMC's Fitness to Practise adjudications. A journalist who does not understand such rulings or is unfamiliar with the background to the complaint can easily libel the clinician involved.

Doctors need to consider the highly intrusive nature of the British media. It is right that the press, as public watchdog, takes an interest in issues surrounding patient care and safety. However, the dry reporting of schemes, initiatives and waiting lists requires humanization to enter the public consciousness. Press interest inevitably focuses on the individual doctors and managers involved as all stories have to be told through 'the prism of people'.<sup>5</sup> Senior staff in an organization can quickly find themselves in the spotlight, with every aspect of their life under scrutiny. Intrusive journalism sometimes requires intrusive methods of obtaining private information. A recent police investigation, which looked into the black market of surveillance data gathered by private investigators for use by the media, revealed the prevalence of information being obtained unlawfully such as phone tapping, accessing mobile phone text messages and 24-hour surveillance. There is an assumption that these news gathering techniques are used to uncover celebrity gossip. In fact, their use is concentrated in researching stories about individuals not in the public eye about whom information is harder to collect.

But with ever more personal data in the public domain, a journalist may not need to resort to underhand methods of obtaining information. For negligible fees it is possible to find out, within minutes, who owns a property, to get telephone numbers, obtain birth, marriage and death details, plus any information held by Companies House. It is astonishing to consider how quickly an image can be

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created of you by the information legitimately available. Doctors need to consider risk to their reputation against this backdrop of an increasingly invasive, dispersed and demanding media.

## Specific risks to the medical profession

Post-Shipman, the press pays increasing attention to allegations concerning medical practitioners, attempting to justify intrusion on the grounds of social responsibility and public interest. The trust that doctors hold in society means that medical stories make good copy. Human interest stories drive sales. Life, death, health, wealth and welfare are the immutable ingredients of such stories. Add a salacious twist, a dash of poor practice and the editorial cocktail is complete.

The momentum behind such stories is the public interest in exposing hypocrisy. As Lord Denning remarked, 'If the image which [they] fostered was not a true image, it is in the public interest that it should be corrected'.<sup>6</sup> The Courts recognize, however, that the media are 'peculiarly vulnerable to the error of confusing the public interest with their own interest'.<sup>7</sup> On occasion, so do journalists: 'The truth is, too many British newspaper journalists have for too long confused verification with impact, independence with arrogance and the interests of the public with the basest interests of some sectors of the public'.<sup>8</sup>

While doctors have to work in an ever more exposed environment, the GMC has shifted its emphasis from guide to regulator and increased doctors' vulnerability to reputational risk. *Good Medical Practice* provides the GMC with a presumptive right to intrusion that, in turn, can be adopted by patients, colleagues and journalists to justify their own invasions into a doctor's private life. Clause 57 states 'You must make sure that your conduct at all times justifies your patients' trust in you and the public's trust in the profession'.<sup>9</sup> The inclusion of the words, 'at all times' opens up every aspect of a doctor's life for inspection and once a complaint to the GMC has been made the burden of proof is on the doctor to establish why he or she should be allowed to practise. Not only has the burden of proof shifted on to the doctor but the threshold of that proof has also shifted in favour of those complaining about the doctor. The implementation of the civil standard of proof in GMC adjudications now means that the evidence against a doctor only has to reach the 'balance of probabilities' rather than the higher threshold of 'beyond reasonable doubt'. In addition to being more exposed, doctors are judged to a higher standard than the ordinary person as the Court of Appeal recently noted; Doctors 'hold a position where higher standards of conduct can be rightly expected by the public'.<sup>10</sup>

Growing public recognition of the GMC has substantially increased the risk of a complaint being made. The simple fact that a complaint has been made or is being investigated can be very damaging to a doctor in itself. Press reports can also exacerbate the damage to a reputation even when the complaint was not upheld.

The GMC has been overwhelmed to the extent that many complaints, in my view, are not being dealt with

robustly enough at an early stage. The longer an investigation takes, the longer the individual doctor is exposed to damaging reporting which neither benefits the process nor the public.

The 'targets culture' of the medical world and the increase in competition that performance-related assessment has produced has led to a consequential rise in related defamation claims. The 'targets culture' of the medical world exists within a prevailing 'blame culture'. Medical opinion is being challenged in public more often with disgruntled patients more likely to call BBC's 'Watchdog' to complain than they are to raise concerns with a more appropriate body. In such circumstances it is difficult for PCTs and independent hospitals to justify the cost of supporting an individual doctor when the case may be against a patient or professional colleague and the money could be spent on patient care.

## How and where does risk arise?

The overriding concerns for doctors when assessing risk to reputation are escalation and proliferation.

Today's news can no longer be shrugged off as tomorrow's fish'n'chip paper. Within hours stories will become accessible via cursory Google searches and accessible to the public via the Internet almost indefinitely. If an article has not been corrected or withdrawn the allegations can be repeated indefinitely.

New media and social networking sites have meant a proliferation in the ways allegations can be published. A libellous allegation can be made by email, memo, letter, report, article or blog. Medical journalists comb all the relevant websites and receive daily updates of new postings. They will often scour patient blogs on which people post material anonymously. Generally, medical professionals welcome legitimate, accurate and fair criticism to enable improvement and maintain standards. However, free speech is only informative if accurate. It is not in the public interest for the public to be misled.

In assessing risk to reputation doctors need to consider all the people that may damage their reputation. Embittered ex-employees, aggrieved patients and colleagues can all pose a risk. Within the charged atmosphere of a hospital department practitioners frequently libel each other over issues of competence and derelictions of duty.

Escalation is the second concern when assessing risk to reputation. Relatively minor issues, if not dealt with quickly and appropriately can sometimes turn into a clinical incident, which can lead to a Departmental Risk Audit meeting. This could result in a Serious Untoward Incident (SUI) investigation. An SUI report can sometimes lead to a referral to the NPSA for assessment and/or an SHA external review. Many PCTs will automatically refer the case to the GMC with a risk of restrictions to practise and possible suspension while under investigation. Meanwhile the doctor concerned may find himself or herself to be the subject of undermining, confidence-sapping internal gossip and externally to media reporting. Many internal complaint procedures operate in limited timescales with insufficient time for the doctor to prepare a complete response.

## What steps can you take to manage risk to reputation?

The first step is to focus on process. As the source for so many attacks on reputation stem from patient care a doctor should ensure that as much of what they do can be broken down into protocols. They should become habit forming and so free up time for the more skilled elements of the job. They are also easily recordable and therefore useful in preparing and maintaining a good database of evidence should it ever be required.

Such protocols should extend to every aspect of the job and be strictly adhered to for the doctor's own protection. Maintain a paper trail of every procedure undertaken with detailed, appropriate notes that would not embarrass you if they were read out in Court.

The second step is to observe the protocols and procedures of others to ensure that you do not step outside any protection from liability. Keep up to date with your training and continuing professional development. A frequent opening gambit in cross-examining a doctor is to ask if they are up to date with their CPD. If the doctor has to concede the answer is no, their credibility is destroyed before any further evidence is given. A doctor should stay in touch with colleagues and professional bodies. Isolation is common and one of the least anticipated and most damaging by-product for doctors whose reputations are at risk.

The third step is to maintain access to a broader network of other professionals that may be useful at short notice such as legal advisors and PR advisors. It is more cost-effective to maintain an ongoing dialogue with advisors than it is to wait until you are forced to take advice and when your options may be limited. Do not rely on Trust or hospital management to help you. As Trusts are accountable to a broader number of stakeholders it is not uncommon for conflicts of interest to arise.

The fourth step to managing risk to reputation is to control your communications both externally and internally, with professional advice if necessary. Develop a clear and consistent strategy for engagement with Trust management, departmental management, colleagues and patients and keep a paper trail of all communications.

The fifth step is to observe due process and procedures in all your dealings with PCTs even if others do not. Make sure that all investigation procedures are strictly adhered to. You may experience considerable pressure to expedite procedures or waive formalities particularly where colleagues are involved. Preliminary investigations into complaints can often appear more relaxed and informal than they should be. One of the main reasons for complaints escalating to SUIs is that the initial complaint investigation was not robust enough. Devote sufficient time to prepare the evidence to answer any complaint and stop the process developing further momentum.

It is possible that the media spotlight will fall on you at some time during your career. The sixth step is to be prepared to engage with the media. Make detailed notes of any conversations that you have with a journalist and ask for everything in writing. Never speak 'off the record' or breach patient confidentiality. Do not panic or feel

pressurized to respond to a journalist's enquires. 'News travels faster than the speed of thought'<sup>11</sup> so use any time available to consider and prepare your response. Do not ignore press enquiries. It is better to know what a journalist intends to publish and plan possible outcomes. Make sure everything you say is scrupulously accurate.

The seventh step is to actively police your reputation and take immediate steps to correct any inaccurate information about you. As journalists increasingly source and fact-check stories online it is vital that the accessible information about you is accurate. Internal communications are at least as important as external communications, so do not allow 'corridor conversations' to go unchecked. Externally, if you do not correct an inaccuracy it will become increasingly difficult to remove from the public domain. Speed is critical: an apology published while the allegations are still in the readers' minds will have far more impact than something published weeks or months later. Allegations harden in the memory until they are indistinguishable from truth.

## Conclusion

Risk, reputation and revenue are inextricably linked. Protecting one's good name is essential to doctors whose livelihoods depend on their personal and professional standing. A trust and faith that may have taken years to build can be destroyed in hours by a defamatory publication. The risk to reputation is increasing all the time, but an awareness of the scale and extent of that risk will usually be enough to take control of such a situation before it controls you.

## References

- 1 Reuters speech on public life; Tony Blair; 12 June 2007. See [http://news.bbc.co.uk/1/hi/uk\\_politics/6744581.stm](http://news.bbc.co.uk/1/hi/uk_politics/6744581.stm)
- 2 Nigel Hawkes, Health Editor, The Times. See <http://www.mediawise.org.uk/files/uploaded/Quality%20and%20Independence%20of%20British%20Journalism.pdf>
- 3 Lewis J, Williams A, Franklin B, Thomas J, Mosdell N. The Quality and Independence of British Journalism. Cardiff: Cardiff University Media Department, 2008. See <http://www.mediawise.org.uk/files/uploaded/Quality%20and%20Independence%20of%20British%20Journalism.pdf>
- 4 Professor Justin Lewis, Cardiff University Media Department; February 2008. See <http://www.cardiff.ac.uk/jomec/newsandevents/news/08fourthrate.html>
- 5 Lord Dacre's speech to the Society of Editors Conference; 9 November 2008. See <http://www.pressgazette.co.uk/story.asp?sectioncode=1&storycode=42394>
- 6 Woodward v Hutchins [1977] 1 WLR 760
- 7 (Para 898) Francome v Mirror Group [1984] 1 WLR 892
- 8 Kevin Marsh, BBC College of Journalism, February 2008. See [http://www.bbc.co.uk/blogs/theeditors/2008/02/journalism\\_not\\_churnalism.html](http://www.bbc.co.uk/blogs/theeditors/2008/02/journalism_not_churnalism.html)
- 9 General Medical Council. Good Medical Practice. London: GMC, 2006. See [http://www.gmc-uk.org/guidance/good\\_medical\\_practice/probity/honest\\_trustworthy.asp](http://www.gmc-uk.org/guidance/good_medical_practice/probity/honest_trustworthy.asp)
- 10 Ash & another v McKennitt & others [2007] 3 WLR 194
- 11 Rosenberg H, Feldman CS. No Time To Think. New York, NY: Continuum Publishing, 2008