

# Doctors who commit suicide while under GMC fitness to practise investigation

## Internal review

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## Executive summary

### Introduction

This report was commissioned by the GMC to review those cases where doctors have committed suicide while under the fitness to practise procedures between 2005 (when the GMC introduced electronic data systems) and 2013. The aim was to establish whether the GMC's processes could be improved to reduce the impact on vulnerable doctors and whether there is more the GMC can do to prevent these tragedies from occurring. The report addresses lessons that can be learnt from these deaths, as well as any changes the GMC could make in the way it handles vulnerable doctors.

During the period under review there were 28 reported cases in the GMC's records where a doctor committed suicide or suspected suicide while under their investigation procedures.

The case reviews showed that many of the doctors who committed suicide suffered from a recognised mental disorder, most commonly depressive illness, bipolar disorder and personality disorder. A number also had drug and/or alcohol addictions. Other factors that may have contributed to their deaths included marriage breakdown, financial hardship, the involvement of the police and the impact of the GMC investigation.

### Case reviews

The review identified 114 doctors that had died during 2005 and 2013 inclusive and had an open and disclosed GMC case at the time of death.

An assessment was then undertaken of each case to ascertain the cause of death against case definitions of suicide and suspected suicide.

24 cases were classified as 'suicide' and 4 as 'suspected suicide'. The total cases under review are 28.

The review also included an overview of the GMC fitness to practise policy and process as well as interviews with GMC staff and associates and external stakeholders.

## **Recommendations**

### *Recommendations for current GMC practice:*

- 1** Doctors under investigation should feel they are treated as 'innocent until proven guilty'
- 2** Reduce the number of health examiners' reports required for health assessments
- 3** Appoint a senior medical officer within the GMC to be responsible for overseeing health cases
- 4** Introduce case conferencing for all health and performance cases
- 5** Set out pre-qualification criteria for referrals from NHS providers and independent employers
- 6** Make emotional resilience training an integral part of the medical curriculum
- 7** Expose GMC investigation staff to frontline clinical practice
- 8** Develop a GMC employee training package to increase staff awareness of mental health issues.

### *Recommendations for GMC stakeholders:*

- 9** Establish a National Support Service (NSS) for doctors

# Doctors who commit suicide while under GMC fitness to practise investigation

## Introduction

The GMC commissioned this independent report to review cases where doctors have committed suicide while involved with its fitness to practise procedures between 2005 and 2013.

The report considers whether the GMC's processes or procedures could be improved to reduce the impact on vulnerable doctors and whether there is more the GMC can do to prevent these tragedies occurring.

Within this context it is important to understand the GMC's role and procedures and the legal framework within which it operates.

## The GMC

The GMC is an independent organisation, established by UK statute. Its purpose is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. Under the Medical Act 1983 the GMC has four main functions:

- a) Keeping up-to-date registers of qualified doctors
- b) Fostering good medical practice
- c) Promoting high standards of medical education
- d) Dealing firmly and fairly with doctors whose fitness to practise is in doubt.

The GMC defines the knowledge, experience and behaviours that are required of doctors. It decides which doctors are qualified to work in the UK.

The GMC also oversees doctors' training and education and makes sure that they continue to meet these standards throughout their careers and that they are supported in doing so. The GMC looks into concerns about doctors and is charged with taking firm but fair action where the safety of patients or the reputation of the medical profession is at stake. It is committed to the idea that every patient should expect a high standard of care and that

its role is not just about minimum standards but also includes improving the standards of medical practice across the UK.

### **The GMC fitness to practise process**

When the GMC receives a complaint an initial assessment is carried out to decide if, on the face of it, the matter raises questions about the doctor's fitness to practise and if the GMC needs to investigate. The complainant, the doctor and the doctor's employer(s) are notified of an investigation.

Where a doctor is not managing his or her health adequately and it is judged that there is a risk to patient safety, the GMC will normally order an assessment of the doctor's health. This is carried out by two independent doctors (known as health examiners) appointed by the GMC. Where there is an immediate concern about patient safety or public confidence in doctors, the case may be referred for a hearing by a Medical Practitioners Tribunal Service (MPTS) Interim Orders Panel. The Interim Orders Panel carries out a risk assessment based on the available information and can restrict the doctor's practice or temporarily suspend them from the register while the GMC investigates.

Once the GMC has completed its investigation two decision-makers (known as case examiners) decide what should happen next. The case examiners, who work in pairs, one medical and one lay, consider the health assessment reports to determine the extent to which any health concerns may impact on the doctor's fitness to practise and whether they are safe to continue to practise with or without restrictions. The case examiners may close the case with no further action, give the doctor advice, issue a warning, agree with the doctor that restrictions are placed on their practice (called undertakings) or refer the case to a hearing of the MPTS. In most cases where action is required, the case examiners agree with the doctor that restrictions are placed on their practice. A case involving ill health would only usually be referred to a hearing if it also involved other serious concerns such as misconduct or because it has not been possible to reach agreement with a doctor about restrictions on their practice.

### **MPTS fitness to practise hearings**

If the matter is referred to a hearing, the MPTS may also request a health assessment if this has not been carried out during the investigation. At the end of a hearing, the MPTS panel may close the case with no action, issue a warning to the doctor, place restrictions on the doctor's registration (when these are imposed by a panel they are called conditions), or suspend or erase the doctor from the medical register. If the concerns

relate solely to the doctor's health, and not to performance or misconduct, then a panel cannot remove a doctor from the register.

Although MPTS hearings are generally held in public, matters relating to a doctor's health are considered in private session. Outcomes of hearings where doctors are found to have impaired fitness to practise are published against the doctors' names on the online medical register and any warnings remain in force for five years. However, any matters relating to a doctor's health are treated as confidential and are not published or disclosed by the GMC or the MPTS.

### **After a case is concluded**

The GMC monitors the progress of any doctor who is subject to GMC restrictions or has been suspended from the register. A dedicated GMC caseworker is allocated to each doctor to ensure appropriate management. As part of this process, the GMC will receive reports from a number of people working with the doctor, including a medical expert who acts as a medical supervisor for the doctor, someone in the doctor's place of work, their occupational health physician if they have one, their treating doctors, their clinical supervisor and their Responsible Officer. If the doctor has been assigned a mentor, this relationship is considered to be a confidential source of support and there is no requirement to provide a report on matters discussed to the GMC. These progress reports help the GMC decide when the doctor may be ready to return to unrestricted practice and GMC restrictions removed. Restrictions may also be varied to reflect improvements in the doctor's health.

### **Voluntary erasure**

Where concerns relate solely to a doctor's health, the GMC will usually grant a request from a doctor to have their name removed voluntarily from the medical register (called voluntary erasure) without concluding the fitness to practise proceedings, as long as to do so would not undermine public confidence in the profession. This principle applies at any stage of the fitness to practise investigation and hearings process.

In cases involving health and other issues such as performance and/or misconduct, GMC decision-makers weigh up the seriousness of any underlying health condition, the impact on the doctor's ability to instruct legal representatives, the likelihood of recovery and the impact on public confidence in deciding whether to grant a doctor's request to have their name removed from the register without concluding the fitness to practise proceedings.

## Workplace supervision and progress

### Responsible Officer

- Senior medical practitioner appointed by healthcare providers (likely the medical director)
- Responsible for local clinical governance
- Takes all reasonably practicable steps to investigate concerns raised about doctors
- Makes recommendation to the GMC every 5 years as part of revalidation stating that the doctor is up to date and fit to practise

### Workplace Reporter

- Approved by the Responsible Officer and GMC
- Usually doctor's immediate line manager or senior colleague (in exceptional circumstances – senior administrator or from the Trust/Board)
- Not expected to provide clinical supervision
- Provides periodic feedback to GMC, Medical Supervisor, RO:
  - whether the doctor is complying with work-related conditions and undertakings
  - any concerns raised in the workplace

### Clinical Supervisor

- Responsible for overseeing a doctor's clinical work on a day-to-day basis.
- Reviews and provides feedback to the GMC about the doctor's clinical or medical practice throughout the period of supervision
- Roles of clinical supervisor and workplace reporter may be merged

## Doctors and suicide

### Doctors and mental illness

A wealth of research suggests that doctors have higher rates of mental health problems, including depression, anxiety, substance misuse and 'burn-out'<sup>1,2</sup>, compared to other occupational groups.

UK studies suggest that between 10% and 20% of doctors become depressed at some point in their career.<sup>3,4</sup>

In a 2011 review of literature on the mental health of doctors the authors state that doctors may be slow to seek help or indeed may not seek help at all, perceiving it as a sign of weakness.<sup>5</sup> For instance:

- Many are clearly concerned about the implications of disclosing an illness, particularly where illegal or stigmatised activities such as substance misuse or alcohol are involved.
- Some worry that occupational health departments may not be independent of employer interests; others are understandably anxious to avoid a threat to their registration or employment.
- Even when doctors do disclose health problems, these often take the form of informal discussions with colleagues rather than formal consultations.<sup>6</sup>

### Suicide and doctors

A number of studies point to a higher rate of suicide among doctors compared to the general population. One US study suggests the overall suicide rate among doctors is between 28 and 40 per 100,000, compared to 12.3 per 100,000<sup>7</sup> in the general population. An examination of suicides in England and Wales between 2001 and 2005 showed that health professionals (not exclusively doctors) had among the highest suicide rates for both men and women.<sup>8</sup> In a different US study the rate for female doctors was 2.5-4 times that of women in the general population.<sup>9</sup> Certain medical specialties, such as psychiatry, appear to have higher rates of suicide than others. Others, such as paediatricians, have relatively low rates.<sup>10</sup>

An Australian study into doctors' mental health in 2013 reported higher rates of general distress and suicidal ideation than the general population<sup>11</sup>. Female doctors were at greater risk for both depression and suicidal ideation than male doctors.

In a survey of almost 8,000 US surgeons 30% of the sample screened positive for symptoms of depression, with rates of depression increasing as workload (and in particular night work) increased.<sup>12</sup> In a follow-up article the authors noted that as many as one in 16 (6.3%) had experienced suicidal thoughts in the previous year yet only 26% of those were seeking professional help. Making a medical error was significantly associated with suicidal thoughts.<sup>13</sup>

### **Risk factors for suicide**

In the general population when someone is diagnosed with a mental health condition they are at particular risk if support is not sought or provided by qualified experts. 90% of suicide victims suffer from a psychiatric disorder at the time of their death<sup>14</sup> and this is often compounded by other risk factors. Unsuccessful suicide attempts are an indication of risk. Approximately 20% of survivors of unsuccessful suicide attempts will attempt harm within a year and as a group they are twice as likely to succeed in committing suicide compared with those who have never attempted to take their own life.<sup>15</sup>

The risk factors for suicide among health professionals, including doctors, are similar to those found in the general population.<sup>16</sup> However, there are some additional risks among doctors such as their unwillingness to seek timely help, access to potent drugs and the skills to self-medicate.<sup>17</sup> Other risk factors include exclusion from work, poor support networks, ongoing investigations, complaints, court cases and inquests<sup>18</sup> and multiple jeopardy from having a complaint considered by a range of bodies including employers and the GMC.<sup>19</sup>

A UK study analysed 38 doctors' suicides over a three-year period<sup>20</sup> and found that most were suffering from a psychiatric disorder at the time of their death, with depression the most common diagnosis. Five had co-morbid psychiatric disorders, typically substance misuse. Eight had primary or secondary diagnoses of alcohol and/or drug abuse, all of several years' duration. Only two doctors had taken voluntary leave from work because of their mental health problems.

Specific risk factors are discussed in more detail below:



**Depression:** Rates of depression among training grade doctors in their first internships in the US have been reported to be 27%<sup>21</sup> and 30%.<sup>22</sup> A Canadian study showed that 23% of over 1,800 doctors had significant depressive symptoms, with female doctors twice as likely to be depressed.<sup>23</sup> A New Zealand analysis has suggested that mental health problems are nearly three times as prevalent in general practitioners than in the general population,<sup>24</sup> and another New Zealand study of hospital doctors found that 29% of doctors showed psychological distress – higher than in the general population.<sup>25</sup>

**Substance abuse:** Recent data suggests that the prevalence of alcohol dependence and illicit drug abuse by doctors is similar to that among the general population, however doctors may be at an increased risk for prescription drugs.<sup>26</sup> However, doctors used prescription drugs such as benzodiazepines more frequently,<sup>27</sup> presumably because of their relative ease of access. Self-reported drug use surveyed in a large US study<sup>28</sup> was most common in emergency medicine doctors (who used more illicit drugs) and psychiatrists (who used more benzodiazepines). Paediatricians had low overall rates of use, as did surgeons. Anesthesiologists had higher rates of use only for major opiates. In a sample of doctors attending the NHS Practitioner Health Programme, a confidential service for doctors and dentists living in London who have mental health and/or addiction concerns, anaesthetists, dentists and emergency medicine doctors were most likely to present with addiction problems.<sup>29</sup>

**Work and home:** In a study of 38 doctors who committed suicide in England and Wales between 1991 and 1993, 71% had significant problems at work. Seven were facing complaints and in five cases this appeared to be a key factor leading to suicide. These doctors were also facing other problems at work and at home.<sup>30</sup>

Many doctors prioritise their work over everything else. It has been suggested this serves the purpose of avoiding intimacy, which may place strain on both personal and working relationships.<sup>31</sup> Doctors may also face stigma if they admit they have a mental health problem and are unable to work as a result.<sup>32</sup>

**Personality factors:** The high-risk doctor has been described as driven, competitive, compulsive, individualistic, ambitious and often a graduate of a prestigious school.<sup>33</sup>

The American Medical Association and American Psychiatric Association conducted an extensive study of physician suicide in the 1980s.<sup>34</sup> It found that doctors who killed themselves were reported to have fewer friends and acquaintances and were emotionally detached.

A further US study found that physicians were more likely to show traits of dependency, pessimism, passivity and self-doubt.<sup>35</sup> Another study highlighted that doctors also tended to be perfectionists.<sup>36</sup> Perfectionism may lead to conscientiousness during medical school and to a thorough clinical approach but it may also breed an unforgiving attitude when mistakes inevitably occur.

**Involvement with the regulator:** Doctors with severe mental health or addiction problems are referred to the GMC. Until recently<sup>37</sup> when a doctor was referred to the GMC for investigation they received no support unless they happened to be in a medical specialty that provided this type of support directly.<sup>38</sup> Doctors referred to PHP with some form of regulatory involvement ranged from one third of all doctors at the start of the programme in 2008 to less than 10% in 2013. This significant decrease may be attributed to doctors accessing support services before they get to the point where a regulator needs to be involved.<sup>39</sup>

Often a doctor will be involved in a number of investigation processes at the same time (*multiple jeopardy*), with the complaint process being stressful; the nature of multiple investigations including employer disciplinary processes means investigations can take many years, be intimidating and can lead to mental health problems and even suicide. During an investigation doctors could have their professional work dissected by a wide range of bodies, including:

- Employer
- Regulator
- Police
- Clinical commissioning group in England
- Criminal court
- Civil court
- National ombudsman and other bodies who handle complaints.

Some commentators have described this as 'death by 1000 arrows'.<sup>40</sup> In recent years the GMC has taken steps to help doctors who find themselves in this situation. In January 2012 it launched a website 'Your Health Matters'<sup>41</sup> which provides support and information for those who may for health reasons be involved in the GMC's fitness to

practise procedures. In May 2012 it also set up a pilot which provides any doctor subject to a GMC investigation with confidential, independent emotional support from another doctor throughout the process. The GMC commissioned the British Medical Association's Doctors for Doctors Service to provide the support - the pilot is still running and an independent evaluation of the service is due to be published before the end of 2014.

**Complaints against doctors:** Research published in New Zealand in 2004<sup>42</sup> looked at the immediate\* and long-term<sup>†</sup> impact on doctors who receive patient complaints. Of the 221 doctors who had received a medical complaint, the immediate impact revealed:

- 72.5% of respondents expressed feelings of anger
- 65.1% felt depressed
- 38.4% indicated they had reduced levels of enjoyment in practising medicine
- 36.4% had feelings of guilt and being shamed.

Longer term, 36.6% of respondents continued to have feelings of anger. Feelings of depression, guilt, shame, and loss of enjoyment in being a doctor fell to around 10%.

\* first few days, and up to six weeks, after receiving a complaint

† After a six-week period

## Review

The review used three sources of information: a desk-based case review of doctors who had committed suicide while going through the GMC process; an examination of the GMC processes; and interviews with GMC staff and associates as well as external stakeholders who have an interest in this area.

### Case review methodology

A desk-based case review was undertaken of doctors who had died during the years 2005 to 2013 where those doctors were known to have had open GMC cases at the time of their death. The aim was to identify those deaths that were considered to have been due to suicide or suspected suicide using a specific case definition approach (see below). Following the initial review those cases were subsequently reviewed by a medically qualified GMC staff member (a GMC Employee Liaison Adviser<sup>\*</sup>).

The identified suicide cases were then subject to a more in-depth review of the records held by the GMC to identify specific demographic, case investigation and death related characteristics and factors.

Data sources used included GMC 'Siebel' management information system, GMC Livelink document storage systems, FOI requests, GMC investigations teams, GMC case note archives (cases prior to 2006), death certificates from the General Register Office, Google search terms (doctor's name, death, coroner, inquest, obituary, BMJ).

### Methodological issues

Research involving deaths from suicide can be methodologically difficult because of acknowledged limitations in the recording and coding of such deaths. The use of open, misadventure, accidental and, increasingly, narrative verdicts by coroners where some doubt exists on suicidal intent can lead to under-recording of cases. The use of a specific case definition in a study that accepts the use of multiple sources of data rather than relying solely on coroner verdicts can potentially minimise the risk of under-recording. This helps ensure consistency and comprehensiveness of 'case' capture.

<sup>\*</sup> Conflicts of interest: The reviewer was involved in advising and supporting the doctor's MD / RO in three cases in his role as GMC ELA.

A desk-based review of cases also has its own limitations as important data may not have been collected previously within the information systems being used eg full reports of coroners' inquests, views of family, colleagues, death certificate copies not being present.

Given the sensitivity involved in publishing information relating to suicides and suspected suicides, efforts have been made to try to avoid identifying specific doctors within the data analysis to protect deceased doctors, their families, friends and colleagues.

### **Case definition of suicide:**

An open GMC fitness to practise (FTP) case at the time of death where death occurred during 2005 – 2013 and where doctor disclosure of the case had occurred

#### **AND**

Death certificate / coroner report confirmation of cause of death = suicide / open / narrative verdict suggesting intent

#### **OR**

Reputable source of information (GP / treating psychiatrist / immediate family member / medical defence organisation / police / employer) raising strong possibility of death by suicide

#### **OR**

Multiple media references to the strong possibility of suicidal intent

### **Case definition of suspected suicide:**

An open GMC fitness to practise case at the time of death where death occurred during 2005 – 2013 and where doctor disclosure of the case had occurred

#### **AND**

Death certificate / coroner report confirmation of cause of death = misadventure or accidental verdict but significant concerns raised about suicidal intent by one other party

**OR**

Awaiting inquest and death certification but reasonable evidence of suicidal ideation prior to death

**Data capture**

The following data were captured for those cases that met the definition of suicide or suspected suicide.

*Doctor information*

- Name / GMC UID / Age at death / Gender / Marital status / Employment status at death / UKPMQ / CCT Specialty / Training status

*GMC investigation related*

- Case Reference / Date case opened\* / Date case closed† / Date of removal from register / Referral source / Investigation stage at death / No of days in GMC investigation / GMC registration status at death / Health allegation / Performance allegation / Conduct allegation / Fraud or criminal allegation / Ongoing police or NHS Counter Fraud investigation at death / Ongoing National Clinical Assessment Service assessment where known / GMC health assessment or medical supervision / Date of most recent GMC health assessment or medical supervision / Most recent health assessment or medical supervision outcome / Health assessment or medical supervisor diagnosis / Whether GMC staff or medical supervisors had concerns over suicide risk / Doctor accessed other support services where known / Current medical care / Previous known self-harm attempt

\* Date of earliest case opened eg date of initial referral case opened that was closed subject to being transferred to a new case review case.

† Date that last case closed ie may be unrelated to original case opened.

### *Death-related information*

- Date of death / Country of death / Cause of death / Additional details on cause of death / Suicide method known / Death certificate available / Coroner inquest held / Coroner details / Coroner verdict

### *Other information*

- GMC Serious Event Report conducted

## **Results**

**The case review identified 114** doctors who had died during 2005 – 2013 inclusive and had an open and disclosed GMC case at the time of death.

Having applied the case definition, **24 were classified as 'suicide' and 4 as 'suspected suicide' ie a total of 28**. The following analysis has been applied to all these 28 cases treated as a single group.

### *Doctor Characteristics*

(NB: percentage totals do not necessarily add to 100% due to rounding)

#### Case definition

|                   |    |     |
|-------------------|----|-----|
| Suicide           | 24 | 86% |
| Suspected Suicide | 4  | 14% |
| Total             | 28 |     |

### Gender

|        |    |     |
|--------|----|-----|
| Male   | 20 | 71% |
| Female | 8  | 29% |
| Total  | 28 |     |

### Age group (at death)

|          |    |     |
|----------|----|-----|
| Under 30 | 1  | 4%  |
| 30-39    | 10 | 36% |
| 40-49    | 7  | 25% |
| 50-59    | 7  | 25% |
| 60-69    | 1  | 4%  |
| 70+      | 2  | 7%  |
| Total    | 28 |     |

### Marital status

|                     |    |     |
|---------------------|----|-----|
| Married / Partnered | 13 | 46% |
| Single              | 10 | 36% |
| Unknown             | 5  | 18% |
| Total               | 28 |     |



## PMQ

|       |    |     |
|-------|----|-----|
| UK    | 22 | 79% |
| Other | 6  | 21% |
| Total | 28 |     |

## Employment status at death

|  |    |     |
|--|----|-----|
| Employed<br>(including<br>self-<br>employed) | 15 | 54% |
| Unemployed                                   | 6  | 21% |
| Retired                                      | 1  | 4%  |
| Unknown                                      | 6  | 21% |
| Total  | 28 |     |

## Specialty / GP

|                                 |    |     |
|---------------------------------|----|-----|
| GP                              | 9  | 32% |
| Specialist                      | 9  | 32% |
| Neither GP<br>nor<br>Specialist | 10 | 36% |
| Total                           | 28 |     |

### Trainee status

|         |    |     |
|---------|----|-----|
| Trainee | 2  | 7%  |
| Other   | 26 | 93% |
| Total   | 28 |     |

### *Investigation Related Characteristics*

#### Case referred by

|               |    |     |
|---------------|----|-----|
| Employer      | 15 | 54% |
| Police        | 4  | 14% |
| Self-referral | 3  | 11% |
| Complaint     | 2  | 7%  |
| Other         | 4  | 14% |
| Total         | 28 |     |

### Length of GMC investigation at death

|               |    |     |
|---------------|----|-----|
| Under 1 month | 2  | 7%  |
| 1-3 months    | 5  | 18% |
| 4-6 months    | 3  | 11% |
| 7-12 months   | 5  | 18% |
| 1-2 years     | 4  | 14% |
| 2-5 years     | 5  | 18% |
| Over 5 years  | 4  | 14% |
| Total         | 28 |     |

### Concerns investigated

|       | Health |     | Performance |     | Conduct |     | Police / Fraud |     |
|-------|--------|-----|-------------|-----|---------|-----|----------------|-----|
| Yes   | 20     | 71% | 4           | 14% | 16      | 57% | 11             | 39% |
| No    | 8      | 29% | 24          | 86% | 12      | 43% | 17             | 61% |
| Total | 28     |     | 28          |     | 28      |     | 28             |     |

### *Doctors with Health Concerns*

Looking specifically at the 20 doctors with health concerns – two doctors (10%) also had performance concerns; nine (45%) conduct concerns; and six (30%) had police / fraud involvement.

Fourteen of the doctors (70%) with health concerns had had a health assessment or had seen a medical supervisor during their investigation. The view of the health assessor / medical supervisor in these 14 cases was that the doctor was fit to practise with supervision in eight cases (57%) and not fit to practise in the six remaining (43%).

The most recent health assessor / medical supervisor diagnoses for these 20 doctors included eight (40%) alcohol-related illnesses, seven (35%) doctors with depression, four (20%) with bipolar depression and two (10%) with substance misuse. Seven doctors (35%) had dual diagnoses.

In six (30%) of the 20 health concerns cases there was a specific risk of suicide known to the GMC (investigation staff and / or health assessors / medical supervisors). In ten cases (50%) there was a specific record that there was no known suicide risk. In four cases (20%) no mention of known suicide risk status can be seen.

Seventeen of the doctors (85%) with known health concerns were known to be receiving current medical care from either specialist psychiatry services and / or GP. Only one doctor (5%) was known to be refusing any medical care. In two doctors (10%) it was unknown what their current medical care was at the time of death.

Seven doctors (35%) with health concerns had had a known history of self-harm.

### Registration Status at Death

|                    |    |     |
|--------------------|----|-----|
| No IOP* conditions | 11 | 39% |
| IOP conditions     | 3  | 11% |
| IOP suspension     | 2  | 7%  |
| FTP suspension     | 2  | 7%  |
| Undertakings       | 10 | 36% |
| Total              | 28 |     |

### Stage of GMC Investigation at Death

|                        |    |     |
|------------------------|----|-----|
| Stream 2 cases         | 1  | 4%  |
| Collection of evidence | 14 | 50% |
| Referral to FTP Panel  | 1  | 4%  |
| Case review            | 12 | 43% |
| Total                  | 28 |     |

\* An Interim Orders Panel (IOP) hearing looks at whether a doctor's registration should be restricted while allegations about their conduct are resolved.

## Characteristics Related to Death

### Year of death

|       |    |     |
|-------|----|-----|
| 2005  | 4  | 14% |
| 2006  | 3  | 11% |
| 2007  | 1  | 4%  |
| 2008  | 1  | 4%  |
| 2009  | 1  | 4%  |
| 2010  | 2  | 7%  |
| 2011  | 3  | 11% |
| 2012  | 4  | 14% |
| 2013  | 9  | 32% |
| Total | 28 |     |

### Place of death

|       |    |     |
|-------|----|-----|
| UK    | 26 | 93% |
| Other | 2  | 7%  |
| Total | 28 |     |

### Suicide method

|                |    |     |
|----------------|----|-----|
| Self-injury    | 10 | 36% |
| Self-poisoning | 11 | 39% |
| Both           | 3  | 11% |
| Unknown        | 4  | 14% |
| Total          | 28 |     |

Of the 11 doctors that took their own lives through self-poisoning, three (27%) are suspected to have obtained the drugs through their workplace and five (45%) used medication prescribed for them.

### Coroner's inquest held

|         |    |     |
|---------|----|-----|
| Yes     | 22 | 79% |
| Unknown | 6  | 21% |
| Total   | 28 |     |

Of the 22 inquests known to have been held, the verdict was suicide in 19 cases (86%), misadventure in one case (5%) and a narrative verdict in one other (5%). The outcome from one inquest is not known.

### *Other Characteristics*

### GMC management review

It is current GMC practice for a senior manager to review all known or suspected suicide cases through a formal significant enquiry report (SER). All SERs are reported formally to Directors of the GMC on completion to ensure all lessons have been learnt and appropriate

management actions implemented. Prior to 2007 some cases would have been reviewed by the investigation officer and their manager to identify relevant issues.

|                         |    |     |
|-------------------------|----|-----|
| SER done                | 13 | 46% |
| Case review             | 5  | 18% |
| Awaiting SER completion | 2  | 7%  |
| No review recorded      | 8  | 29% |
| Total                   | 28 |     |

### **GMC fitness to practise process**

An overview of the GMC fitness to practise process was undertaken to understand and assess how these cases were dealt with at the time and identify any areas of improvement.

### **Interviews**

A number of GMC staff and associates involved in the GMC investigation process were asked to provide input into the review:

- GMC medical and lay case examiners
- Medical supervisors
- Other GMC fitness to practise staff.



The review also sought the views of a wide range of external stakeholders, including:

- BMA Doctors for Doctors support services
- Practitioner Health Programme (PHP), London
- Royal College of General Practitioners
- Royal College of Psychiatrists
- The Sick Doctors Trust
- The Royal Medical Benevolent Fund
- The Foundation Programme
- Connecting with People
- Independent doctors, including junior doctors
- Medical Protection Society
- NHS Clinical Leaders Network
- Patients First
- South London & Maudsley NHS Foundation Trust.

## **Review findings: interviews with staff and key stakeholders**

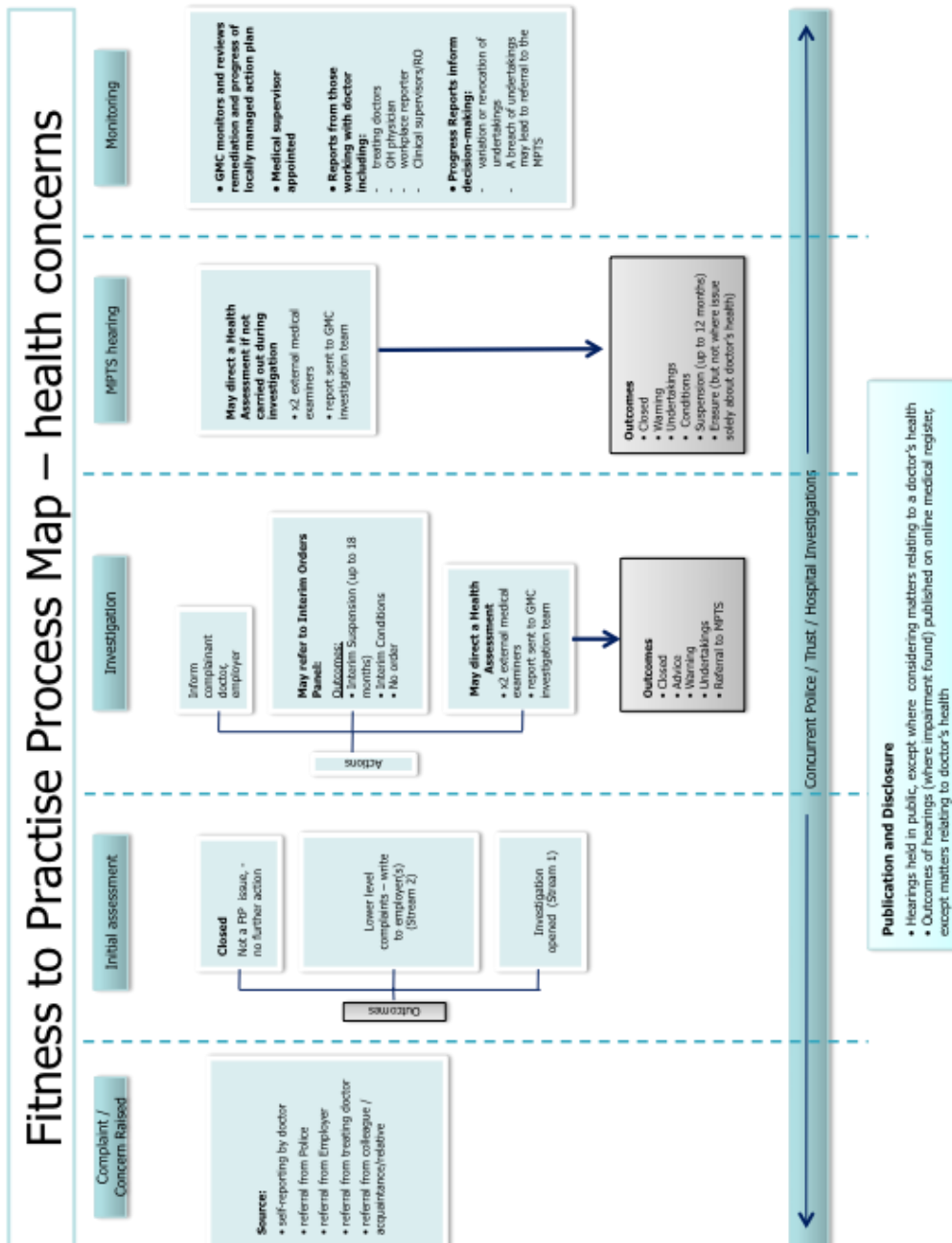
Following the case reviews a number of GMC staff and associates and key stakeholders, including doctors who had been subject to the GMC's investigations, provided feedback on the fitness to practise process. A range of concerns were raised that require further consideration. These include:

- 1** GMC's fitness to practise process
- 2** Communication from the GMC
- 3** Timeframes
- 4** Undertakings
- 5** Contributory factors leading to a referral to fitness to practise
- 6** Medical supervisors
- 7** Health examiners
- 8** GMC medical structure
- 9** Local procedures
- 10** Support services for doctors
- 11** Transition from medical school to the foundation programme

### **1. GMC's fitness to practise process**

The GMC's fitness to practise (FTP) process is well defined and has undergone significant improvements over the past few years. In particular the GMC has looked at the way it corresponds with doctors and others and has sought to reduce legal language and references and to be more sensitive in the way it words its letters. However, the responses of external agencies and those outside the organisation suggest that many still believe the GMC is a 'process' driven organisation focused on protecting the public and that the doctor can become marginalised with little interpersonal communication, support or compassion.

The administrative processes for dealing with a fitness to practise case are clearly defined. However, external commentators argue that because the system has been developed with a very specific structure and set of legal parameters, it at times lacks the flexibility to accommodate the circumstances of an individual case. The chart below outlines the current process.



There is also concern that once a case has been deemed to merit further investigation there is no way of stopping or shortening the enquiry period. One commentator described it as 'one size fits all [process] and once you are under investigation you need to endure the full timeframe determined by the GMC'. A process is needed that accommodates cases that do not need the full weight of the GMC FTP structure and can be expedited more promptly.

Many commented that the fitness to practise process creates an environment of uncertainty and makes doctors feel that they are judged 'guilty until proven innocent'.

The impact of the legal demands of the process can be considerable. For example, during one investigation a doctor was unable to attend the Interim Orders Panel (IOP) because they were in hospital. The IOP carries out a risk assessment based on the available information and can restrict a doctor's practice or suspend them from the register on a temporary basis while the GMC investigates.

The GMC is legally required to inform the doctor of what it is doing, and in this case went to some lengths, including couriering a letter to the hospital inviting the doctor to attend the panel. An email from the GMC to the doctor's treating psychiatrist said: '*I would therefore be grateful if you could confirm whether you would be willing to pass a copy of a letter regarding the hearing to Dr X, confirming in writing that this has taken place*'. While it is extremely important to ensure a doctor is notified of an IOP and is given every opportunity to attend if they are able, this does appear to be a very rigid process.

One medical supervisor wrote to the GMC after the doctor under their care died saying: 'The present arrangement discourages doctors from coming forward for treatment of mental health issues. The GMC health procedures put doctors under additional strain whilst unwell, and the delays in GMC procedures prevent their return to work at the time appropriate for their successful rehabilitation'. Another supervisor caring for a doctor who was in difficulties wrote requesting 'that the GMC reopen discussions with a view to developing a positive and supportive approach to the mental health of doctors'.

## **2. Communication from the GMC**

As each part of the process was completed, documentation was generated and issued to the doctor and all other relevant parties. This meant that the doctor often received multiple correspondence dated at the same time or within a matter of days.

In one instance, a doctor received multiple letters, all marked with the same date, and in another case a doctor received five letters over a four-day period from the GMC's investigation team. This can obviously create further stress and confusion. While it may be difficult to streamline and coordinate every piece of documentation, the GMC has an obligation to help the doctor understand the information it issues and to be sensitive about when letters are despatched.

In other case reviews, doctors received no notification from the GMC over a significant period and felt excluded from the investigation and did not receive any support during the delayed period of communication.

In one case the coroner asked the GMC to comment on a note in which the doctor said: 'I am extremely stressed and cannot carry on like this. I hold the G.M.C. responsible for making my condition worse with no offer of help'.

In a paper published in 2014 *You feel you've been bad, not ill*<sup>3</sup> researchers explored the views of sick doctors about the GMC process and their perception of its impact on return to work. Many participants described their interactions with the GMC as stressful and confusing. They highlighted what they saw as the 'accusatory' tone and legal jargon in GMC correspondence, which they found particularly uncomfortable. The length of the process was also considered stressful and some were left confused about whether they could continue to work during the process. On the other hand, many acknowledged that the GMC processes were necessary, particularly in protecting patients, and some felt it had been useful to undergo the GMC assessment and were grateful for the 'breathing space' they were given when declared not fit to work.

Several other participants described communication from the GMC as overly negative, accusatory and judgemental; they felt that the GMC implied they were a 'bad' doctor rather than an 'ill' doctor who might need treatment and support.

While these participants recognised the need for a regulator, they argued that processes employed by the GMC and the communication style used were often distressing, confusing and impacted negatively on their mental health and ability to return to work.

Some of the GMC's correspondence with the doctors under review reflected these shortcomings. They were clearly written from a legal perspective and did not show compassion nor did they reflect sufficiently the fact that some of these doctors were being assessed under health procedures. In short some of this correspondence did not

acknowledge the fact that the doctor was ill or undergoing treatment; it simply outlined the next step of the process and detailed the next course of action.

### 3. Timeframes

The time taken to complete the initial investigation process and conclude a case can differ significantly from one individual to another. This is due to the nature of an investigation and the wider requirements in completing the case.

While acknowledging that the GMC is not always responsible for delays, for example the GMC usually waits for the outcome of criminal proceedings because prosecuting authorities are reluctant to disclose their evidence until the prosecution process has finished, the case reviews suggest that the length of time the GMC takes to complete investigations causes stress for vulnerable doctors and needs to improve.

Below are two examples:

Example 1:

*One doctor who referred a colleague to the GMC for investigation has grave concerns over the timeframe and investigation process. The doctor that was referred subsequently committed suicide and the referring doctor felt that 'if the GMC had responded in a more timely fashion the death may have been prevented'.*

Example 2:

*The GMC overestimated the number of cases that could be heard at an Interim Orders Panel sitting. As a result, one case was deferred and allocated a new sitting date. The doctor involved subsequently committed suicide before the new IOP review date and, following the coroner's inquest, it was noted that one of the contributing factors to the suicide was 'matter of a regulatory nature'. In a letter to the GMC the doctor who initially referred this doctor commented: 'We cannot know whether this doctor would be alive today had we not referred them to the GMC, however neither can we exclude that possibility'.*

In both these examples there are a number of contributing factors to the loss of life. But it is evident that the timeframes of an investigation case and the associated stress on a doctor could be one factor.

#### **4. Undertakings**

In a number of these cases undertakings imposed by the GMC had perhaps unintended consequences for the doctor and their livelihoods. In some cases medical supervisors requested that the GMC reconsider its position on individual doctors' undertakings because they felt the recommendations were not appropriate and would be detrimental to the doctor's rehabilitation. The examples below suggest that the GMC should at least consider carefully any concerns raised by medical supervisors and others involved in a doctor's care. It is also clear that some stipulations - while quite possibly justified in the circumstances - leave doctors in a position where they can only comply by not working at all.

Example 1:

*One medical supervisor was so concerned about the state of the doctor under their care they requested the GMC to remove undertakings and allow the doctor to do some form of work as they were becoming extremely distressed about their financial situation. The GMC response was that the undertakings had recently been reviewed and the doctor would need to wait until the allocated time for them to be reviewed again.*

Example 2:

*A medical supervisor wrote to the GMC after the doctor under their care had committed suicide. They said they thought the GMC could have been more supportive and accommodating about their request for this doctor to do further locum work. 'This doctor was floundering early on and we (medical supervisor and the GMC) failed to pick up on it and make reasonable adjustments', they added.*

There will always be a tension between the GMC's obligation to make sure patients are protected and the desire of all parties to see the doctor rehabilitated and back to work as soon as possible. These are complex and difficult decisions and it is easy with the benefit of hindsight to advocate a different approach. There must be a case though for the GMC to ensure it considers carefully, and at an appropriate level, any proposal to amend what it is doing to have less impact on the doctor within its procedures.

#### **5. Contributory factors leading to a referral to fitness to practise**

There are many contributory factors that lead to a doctor being considered for a fitness to practise investigation.

The GMC understandably concentrates on areas of impairment and the doctor's ability to practise medicine safely, and this should be the priority. However, in some instances the wider factors that contributed to a doctor's referral are not always taken into account. The GMC is concerned about risk and therefore focuses on assessing the *symptom* rather than understanding the *cause*.

In each of the reviewed cases there were a number of factors that contributed to the complaints or referrals of the doctor. These factors (not ranked) could include:

- Breakdown of a marriage
- Financial hardship
- Mental health (excluding drugs and alcohol)
- Poor career choice (not suited to being a doctor)
- Occupational
- Legal issues
- Police investigation
- Bereavement
- Workload.

It is also clear, as noted earlier, that the GMC referral itself is very often a compounding factor, adding to the stress the doctor is under.

It is not for the GMC to address these wider factors and it has neither the resources nor the expertise to do so. However, it is important that the contributory factors in any fitness to practise investigation case are recognised, that there are services that can help doctors to address the whole range of their circumstances and that the GMC has processes to refer doctors to appropriate services, swiftly and effectively. At present no single organisation or service exists that could fulfil this function.

Although beyond the scope of the review, there is a strong case for establishing a national support organisation (see recommendation 9. National Support Service) to ensure appropriate services and support are made available to doctors in need.



## 6. Medical supervisors

### Medical supervisor

External specialist medical practitioner – majority are psychiatrists – cannot be the doctor's treating physician

An associate contracted by the GMC

Meets regularly with doctor to discuss progress

Carries out testing in substance abuse cases, approves posts and prescribing arrangements

Provides periodic 3-6 monthly reports to the GMC case review team:

- Doctor's progress and compliance with conditions or undertakings
- Any significant problems
- Advises GMC regarding:
  - the doctor's fitness to practise in general
  - any variation to the undertakings
  - doctor's readiness to return to unrestricted practice

In most cases medical supervisors' recommendations are accepted by the GMC and doctors are often able to return to full practice. However, there are occasions when this does not happen. This is usually because a health examiner (a psychiatrist appointed by the GMC) has taken a different view of the risks involved. Better communication and discussion around each case could help to resolve some of these differences and make agreement about next steps more likely.

There is certainly a feeling among some medical supervisors that their decisions are increasingly being superseded by the health examiner's reports.

A few medical supervisors also felt their induction with the GMC should include more about the assessment standards required for their supervisory role.

Some medical supervisors also noted that their role can be quite a lonely one. While they do have GMC-organised sessions together and can contact one another, there is no process after a doctor's suicide for debriefing to reflect on what has happened and consider any lessons for the future.

## 7. Health examiners

### Health examiner

Two external medical specialists for each fitness to practise case to assess risks relating to health issues (psychiatrist, if relates to mental health issues)

An associate contracted by the GMC

Liaise with the GMC health and performance assessment team regarding the health assessment

Conduct health assessments (may include physical assessment/mini-mental test/chemical testing where concerns relate to substance misuse)

Provide reports to the GMC HPA team for use by the investigation or case review team:

- diagnosis (ICD10 / DSM4)
- doctor's insight into condition
- whether doctor is fit to practise generally, on a limited basis, or not at all
- recommendations about management of case

As part of the investigation process, the GMC requires a doctor with health concerns to be assessed by two GMC health examiners (psychiatrists) who provide independent reports on the doctor and submit their assessment as to whether the doctor is fit to practise. As part of this process the GMC asks the health examiners to address specific questions and these form part of the report.

A number of external stakeholders as well as doctors who have undergone a fitness to practise investigation expressed concerns about areas of this process, including:

1. There is an expectation that the doctor referred to the GMC health procedures should disclose all their medical records, including GP records and any relevant hospital records. While a doctor can choose to withhold their records, this may have a negative impact on the outcome of their case. This information can, and often does, involve personal data, such as sexuality, past psychiatric history, history of abuse in childhood or later as a victim of domestic violence, and third party information about family members, and covers the whole of the doctors' life.

2. Where there is a prospect of the doctor's fitness to practise being judged to be impaired, the case will be referred to an MPTS panel. This panel is expected to hear confidential health information and make a judgment based on this information and reports from treating psychiatrists. The panel will be presented with any information that the GMC considers relevant although any information about a doctor's health is discussed in private and no health information is placed in the public domain. The panel consists of both medical and lay members and has a legal assessor who sits with each panel. Some doctors feel they lose their right to medical confidentiality as a result and that their medical details should only be made available to those within the medical profession.

It is important to note that both lay and medical members of the MPTS panel are bound by confidentiality when hearing information about doctors who are referred to them. It is also clear that the GMC must operate within pre-determined legal parameters which are necessarily complicated and may appear at times both rigid and impersonal. However, the views and comments raised independently by stakeholders are important and should be given due consideration.

The GMC continually refines specific areas of its fitness to practise procedures. It has also tackled the criticism that some health examiner reports failed to express an opinion on whether the doctor was fit to practise or whether supervision was appropriate. As a result the GMC has introduced more explicit guidelines to assist health examiners in completing their assessment reports.

A number of GMC case examiners and medical supervisors have questioned the quality of the health examiner reports. The GMC is currently undertaking a review of the role of experts and their contribution to investigations and decision-making and this issue should be included within that review.

## **8. GMC medical structure**

At present 10 doctors are employed directly by the GMC as case examiners with a further four doctors as part of the wider GMC staffing. The GMC also has 877 doctors who provide services to the GMC. The GMC has a senior medical adviser who is a member of the senior management team.

More importantly it would appear that there are insufficient practising doctors employed by the GMC to support present caseloads and this is having a direct impact on areas like Health Assessments where there is no opportunity to ensure standards are being maintained in areas like reporting or developing further standards that medical, education or workplace supervisors should adhere to.

The medical supervisors and examiners have commented that they would benefit from a senior medical figure at the GMC who would provide the following:

- Clinical governance
- Quality assurance
- Oversight of the health procedures
- Training and development in best practice.

There is a case for appointing a senior medical officer who would provide strategic guidance on the overall fitness to practise process from a clinical viewpoint.

## **9. Local procedures**

It would appear from the case reviews that a few doctors were referred to the GMC by their employer without going through the employer's local procedures. It was felt that some doctors therefore missed out on local support services in helping to manage their specific situation and did not have access to the local network to provide an appropriate plan.

There are instances where local organisations provided an excellent support mechanism for doctors when required; this enabled close monitoring and interaction on a regular basis. However, in some instances local organisations for whatever reason referred the doctor to the GMC to resolve. There will be instances when a doctor needs to be automatically referred through to the GMC and it is crucial that both the GMC and local organisations ensure that support arrangements go hand in hand to protect both patients and the doctor concerned.

## **10. Support services for doctors**

Doctors in secondary care can access occupational health services but that can be more difficult in primary care. Support services for doctors do exist around the country but they offer variable services and may only serve a specific geographical area. Many only offer assessment and/or brief psychotherapy (eg Mednet, Doctors for Doctors, House Concern Newcastle), peer support (Doctors' Support Network, British Doctors and Dentists Group, Sick Doctors Trust), mentoring (Health for Health Practitioners West Midlands) or practical support when going through complaints or disciplinary processes. For instance, many local medical committees offer pastoral support while the GMC offers a support service via BMA Doctors for Doctors (see below).

These services provide a variety of telephone advice, web advice, face-to-face consultation, psychological treatment and advocacy services.

The GMC implemented a pilot support service for doctors undergoing its fitness to practise proceedings in May 2012, provided through the BMA's Doctors for Doctors support service.<sup>44</sup> The doctor 'supporters' from the BMA are experienced in providing unbiased peer support to those undergoing a GMC investigation.

Although feedback on this support service has been very positive, some doctors will not always phone the helpline as they are reluctant to disclose highly sensitive information that could have a direct bearing on their career.<sup>45</sup>

The lack of consistent local support clearly reduces the recovery opportunities for doctors and it is evident from the case reviews that receiving comprehensive support depended on geographical location.

The 2007 White Paper on medical regulation, *Trust, Assurance and Safety – the Regulation of Health Professionals in the 21<sup>st</sup> Century*<sup>46</sup>, proposed a working group to

advise on a national strategy on the health of all health professionals, including doctors.  
This recommended:

- Rapid access to confidential specialist assessment and treatment (particularly for mental health and addiction problems) to enable sick health practitioners to seek help promptly without fear of stigma or discrimination and minimising any potential impact on quality of care.
- Specialist services staffed by appropriately trained professionals with expertise in treating healthcare professionals with mental health and addiction problems.

The Boorman<sup>47</sup> *NHS Health and Well-being Review Interim Report* in 2009 also examined the support and opportunities that staff need to maintain their own health and wellbeing.

The report recognised the difficulties that clinical staff can face in accessing health care:

*'In this context we are aware that there are very real complexities in dealing with sick doctors and other clinical staff who may be reluctant to admit to serious health problems, such as drug or alcohol addiction, or to seek early advice from occupational health services. It is important that staff with such problems have sufficient confidence in local services to seek the support that they require; however, we recognise that some cases may raise issues that go beyond the capacity of occupational health units.'*

In view of these reports and the increasing numbers of doctors presenting with mental health problems, it was proposed to establish a national health service for (mentally) sick health professionals to ensure that all health professionals had access to specialist health services if their needs could not be met by local services.

The main justifications for a national service were:

- The insight of sick doctors into their condition and the impact that it has upon their performance may be compromised
- Illness in doctors may be poorly managed and appropriate assistance may not be sought for a variety of reasons (including low rates of registration with a general practitioner)
- Doctors may be able to mask their illness from others (perhaps through self-prescription)

- Where illness is recognised to adversely affect performance, there may be a reluctance to refer a doctor into a system that is perceived as 'disciplinary' and there is a lack of knowledge about alternatives
- An excessively stressful work environment may have a significant and negative impact on a doctor's health and wellbeing
- The issue of doctors who become mentally unwell can be especially complex given the relationship doctors have with patients and the requirements of doctors under their GMC responsibilities. This means that expert services should be set up to provide accurate advice, sign posting and liaison with relevant bodies.

On the basis of these reports, the NHS Practitioner Health Programme (PHP) pilot was established in 2008 with the expectation that if successful it should be rolled out across England; however to date this has not occurred.

## **11. Transition from medical school to the foundation programme**

Two doctors who committed suicide while under the GMC fitness to practise assessment procedure were in postgraduate training (2/28 7.1%).

Medical schools provide their students with a sound grounding in the knowledge and skills to practise as a doctor. But according to doctors in postgraduate training who the review spoke to they do not always feel they have the appropriate practical training to deal with the transition to a stressful work environment.

Both internal GMC staff and external stakeholders have pointed out that the transition between medical school and the foundation programme can be the point at which warning signs or difficulties arise.

The review has identified a number of contributing factors, which in many circumstances are experienced by junior doctors. They are as follows:

- Clinical responsibilities
- Unrealistic workloads
- Significantly long working hours
- Inadequate staffing levels

- Stressful environment.

A wealth of information and evidence exists about the transition between medical school and medical practice. The GMC explores the issue of preparedness as part of its National Training Survey. It has not been possible to review all of the literature as part of the review but, given the death of two young doctors during the period under study, it is important that the GMC and others look again at what pressures face doctors in the early stage of their career.

It would be helpful to ensure that there is sufficient resilience training or information on how to emotionally handle the transition from student to junior doctor. And to explore the need to help students develop other coping mechanisms to deal with stressful situations and the exacting demands of being a doctor.



## Recommendations for current GMC practice

### 1. GMC investigation process

The GMC needs to create an environment where doctors undergoing a fitness to practise investigation feel they are treated as 'innocent until proven guilty' – as with any judicial process. Investigations need to be conducted in a compassionate manner and as quickly and effectively as possible, taking into account legal constraints and the need to protect patients. Perhaps, inevitably, doctors undergoing the process feel that it can stigmatise and often creates a culture of fear and discrimination.

The GMC's Fitness to Practise team is currently undertaking an internal review to assess the organisation's processes for triage and streaming of cases. The intention is to establish a new approach that extends the triage process and would only progress those cases that require a full and comprehensive investigation.

Adopting this new practice should alleviate some of the initial pressure and stress that an investigation generates for those complaints that do not meet the threshold for investigation.

**It is recommended** that the above changes be implemented as soon as practical.

**It is also recommended** that the fitness to practise process be reviewed from a doctor's viewpoint (similar to the work already done around complainants and witnesses) to identify aspects of the process that have a direct effect on their wellbeing.

The doctor's process review would also include minimising and streamlining the timing and quantity of correspondence forwarded to a doctor. It is important that investigation officers are as sensitive as possible when communicating with the affected doctor and that they understand the impact the investigation may have on that individual. At the same time they need to take a proactive approach in compiling and distributing the information that needs to be issued to a doctor rather than relying on a process-generated system that can lead to duplication and confusion.

This approach would include:

- Tailoring correspondence to doctors and including, where applicable, key information they need to understand

- Ensuring that the GMC maintains regular contact with doctors during the investigation process, not only through written correspondence but also by phone, to ensure a more personal approach
- Allowing, and encouraging where appropriate, medical supervisors and case examiners to work more closely and discuss directly any potential changes to a doctor's undertaking. This would require all recommendations and agreements to be documented
- Promoting closer liaison between medical supervisors and case examiners
- Taking a personalised approach to a case where appropriate. This could include suspending the process if required. For example, where a doctor has been sectioned under the Mental Health Act and clearly is not practising or is unwell, they should not have to respond to an investigation. An interim order may of course be needed to manage any direct risk to patients.

Any doctor referred to the GMC should be considered to be vulnerable and therefore supported and assisted in a compassionate manner. Given the stress of the investigation process, it is possible any doctor could develop mental health problems or an addiction habit as the very nature of the investigation process creates significant stress and mental anguish.

## 2. Health examiner reports

Serious concerns were raised about the number of health examiners' reports the GMC requires for health assessment cases.

**It is recommended** that the GMC consider reducing the number of health examiners' reports that are required at the beginning and end of a supervisory period where the doctor has been deemed fit to practise by their GMC-appointed medical supervisor. At present there is a statutory requirement for two reports. Having two independent assessments at times creates conflict with the medical supervisors (who feel their recommendation and case knowledge at times are undermined). If there is no agreement on the doctors' fitness to practise, the GMC will act to protect patient safety by taking the risk-averse option and potentially prolonging the supervisory period, which could prove to be detrimental to the doctor.

**Therefore it is also recommended** that one report should be required at the beginning of an investigation where the doctor is unwell but already has an agreed diagnosis and is engaging with treatment.

The medical supervisor's report plus one further independent health examiner's report should be sufficient at the end of a supervisory period to complete a health assessment case.

Such a change would require a change in legislation. If the GMC still feels there is a need for two independent psychiatric views, then it is strongly recommended that the two psychiatrists commissioned should be required to confer to produce *one* agreed report based on their independent assessments. This single report would, if possible, include an agreed diagnosis and treatment proposal for the doctor concerned and would outline any areas that the health examiners do not agree on and require further consideration by the GMC.

### **3. Medical staffing**

The GMC should have an appropriate understanding of the medical input that doctors receive when going through the fitness to practise investigations process. In the past there was strong criticism that the process was too medically dominated and that the legal or objective oversight was insufficient. However, those who are involved with doctors who have mental health and related problems argue it is now too heavily weighted towards the legal aspects of the Medical Act. The creation of a senior post within the fitness to practise operation would help to ensure that medical considerations were being taken into account in the investigation process. An executive senior medical director could work alongside existing case examiners to improve areas of the health assessment within the process. At the moment, for instance, there are no standards for psychiatric reports being submitted to the GMC so there could be inconsistencies around diagnosis.

**It is recommended** that the GMC employ a senior medical officer to oversee aspects of its fitness to practise procedures. The role would include:

- Oversight of the current health procedures, developing opportunities to improve the overall process, reporting and outcomes
- A professional supervisory role for medical supervisors, medical case examiners and health examiners. Decisions in individual cases would continue to be made by medical case examiners

- Ensuring that training for all roles is reviewed and reshaped to deliver the best outcomes for both the GMC and the doctor being supervised
- Creating regional learning sets for medical supervisors and examiners who could meet regularly to share learning experiences and highlight outstanding issues. The objective is that every doctor under supervision would be discussed in a regular supervision group
- Overseeing meetings to review cases. This would ensure that medical supervisors are engaged on a regular basis and would minimise the perception that they are over-involved with the doctors they are supervising.

#### 4. Case conferences

Case conferences bring the key parties together to agree goals and establish appropriate strategies. They are an efficient and effective case management tool that ensures all parties understand their roles and are committed to achieving agreed outcomes. Case conferences should be a regular part of the investigation process and held at regular intervals.

**It is recommended** that the GMC adopt case conferencing. This would ensure a more personalised approach to the fitness to practise process for both health and performance cases.

The purpose of case conferencing would be to progress an individual doctor's investigation by bringing all the necessary parties together. This would include:

- The doctor involved
- Treating medical practitioners
- Work or educational supervisors (where applicable)
- The doctor's representative or family (if applicable)
- The GMC.

The advantages of a case conferencing approach, particularly for complex cases (including health and performance assessments), include:

- Assessment on how to effectively manage the doctor to ensure any risk factors are mitigated. This would include input from all agreed professional support teams
- All parties are involved in assessing whether the doctor will ever be able to return to the profession. If it is agreed the doctor is competent, then a structured return to work plan and timeline can be developed in conjunction with that individual
- Case conferencing will ensure the doctor has focused involvement from all professionals who can discuss their progress and agree a treatment plan. This will guarantee that all parties' expectations are maintained and provide for an accurate timeline for treatment. It also creates a positive and open forum for the doctor where there is no preconceived judgement, building a more transparent relationship of openness
- At the moment all data and documentation relating to a doctor's case are held in the GMC's data system (Siebel). However, this information must be made accessible online to all professional parties involved in a case to ensure transparency and timely access. At present the GMC sends hard copies of documentation to relevant parties by post but this is not efficient and in many instances prolongs the process. Case conferencing will ensure readily available information is accessible to the relevant participants at any time.

This case conference approach could also reduce the burden of unnecessary paperwork and create a more efficient process. It will enable case examiners to be more fully engaged and for the doctor under investigation to be directly involved in improving their situation.

## **5. NHS providers and independent employers**

It was clear from the review that local NHS Trusts and Boards did not always undertake their own investigations before referring the doctor to the GMC. A number of these cases date back to 2005 when it may be some Trusts and Boards could not provide the support required.

**It is recommended** that the GMC ensures that local procedures have been exhausted before accepting a referral – unless it meets the required GMC threshold. The GMC introduced employment liaison advisers in 2012 to support employers in monitoring the quality of their medical workforce, advising on fitness to practise thresholds and on revalidation and related matters. It should continue to increase the support its

employment liaison advisors (ELAs) provide to employers and encourage closer working in deciding when a referral should be made to the GMC. In some instances it may be appropriate for the GMC to be listed as a notified party should specific cases need to be referred based on their severity and the fact they are at odds with the GMC's *Good medical practice* guide. In essence having the GMC as a listed party would ensure it is kept fully up to date with progress and any other relevant issues.

**It is recommended** that NHS England and the Devolved Administrations ensure all NHS Trusts, Boards and associated employing bodies undertake due diligence in relation to medical staff. This will ensure a case is referred once it has engaged the GMC threshold. Currently the GMC ELAs have an established programme of individual meetings with all Trust medical directors to discuss doctors in difficulty and the threshold for formal referral to the GMC, revalidation issues and other matters relating to regulation. In particular where NHS Trusts and Boards have specific cases the GMC could consider allowing greater local handling and remediation without a formal referral to the GMC. The Trust's medical directors and ELAs would work closely together in managing such cases and could call on the GMC for formal intervention should local handling not prove successful.

## **6. Medical students**

It is extremely important that medical students have not only the clinical skills and knowledge to move from medical school to the Foundation Programme but also have the resilience and coping techniques to help them face difficult circumstances as their careers progress.

### **It is recommended that:**

- The GMC continue to work with medical schools to ensure that emotional resilience training is a regular and integral part of the medical curriculum
- Both medical students and doctors in training have specific training modules in their curriculum that explain the implications should they be subject to a serious complaint and investigation
- The GMC continue to work with medical students and doctors in training to promote its regulatory requirements
- The GMC continue to work with all medical schools to ensure its standpoint on recreational drug use and alcohol is better communicated to students.

## **7. GMC employees**

Most staff employed by the GMC (Fitness to Practise) have never worked in the health industry before joining the GMC and therefore have a limited knowledge or understanding of the day-to-day realities of frontline clinical practice. It would be beneficial for those GMC staff dealing with doctors under investigation to have a grounded understanding of doctors' daily work environment.

**It is recommended** that staff be given the opportunity as part of their personal development plan to spend time in a clinical setting on an ongoing basis.

The benefits of this are twofold:

- 1** The GMC staff member would have a greater appreciation of the working environment of the doctor, seeing first-hand the pressures and demands from patients, and perhaps have a greater appreciation and empathy when formally communicating on behalf of the GMC.
- 2** The interaction between GMC staff and frontline doctors would help to provide a forum for greater communication and feedback. This in turn would reduce the perception of the GMC as a bureaucratic and uncaring organisation.

The GMC could also consider recruiting new staff from the health sector with experience of working in a clinical environment. Employing staff with knowledge, understanding and practical experience of the often stressful and demanding health sector would have very positive benefits for the GMC.

## **8. Workplace health and wellbeing**

Given the nature of the fitness to practise work, it has been noted that despite the GMC's wealth of training and development opportunities, there is an additional need to provide in-depth specific training for those individuals or teams servicing complex cases.

A number of GMC staff had direct contact with the doctors during the investigation process into these cases and were affected by the consequences. It is important that the GMC has the appropriate systems and training in place to support staff in cases that have a tragic consequence.

**It is recommended that the** GMC implement an employee-training package focused on increasing staff awareness of mental health issues and developing resilience techniques

when coping with stress, anxiety or depression.<sup>48</sup> It is important that both managers and staff have the appropriate tools, knowledge and mechanisms to discuss and cope with difficult situations.

## **Recommendation for GMC stakeholders**

### **9. Consideration of National Support Service for Doctors**

**It is recommended** that the Department of Health (England), NHS England and the Devolved Administrations (Wales, Scotland and Northern Ireland) consider making the legislative changes necessary to develop and establish a National Support Service. The service would be managed by a senior medical officer who would assume responsibility for the day-to-day management of doctors with health concerns incorporating the assessment (currently undertaken by the GMC), case management, monitoring, reporting, treatment, and education and prevention elements within a single system. It would be prudent to ensure that all medical students have access to this service. It would be important that the National Support Service refer immediately to the GMC any serious allegations it becomes aware of or persistent failures by a doctor to comply with an agreed treatment plan.

**Further details on the benefits and indicative costs have been included in Annex A.**



## Supporting information

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# ANNEX A

## Modelling a National Support Service (NSS)

Further to recommendation 9, this section describes a possible model for the establishment of a National Support Service.

Doctors invest considerable amounts of time and financial commitment in training to become a doctor and associated organisations (including government) commit time, money and resources in ensuring doctors deliver the best care for their patients.

Given the number of risk factors doctors face and the number of unique and complex factors making it difficult to seek help, doctors may benefit from a specialised service developed specifically for doctors where confidentiality is assured and rapid, efficient diagnosis and treatment can be provided. People often ask, '*Why should doctors get special treatment?*' Healthcare in the UK is provided to almost 64 million people and the NHS remains free at the point of use for all residents. It is imperative doctors maintain good health and wellbeing to be able to continually provide excellent healthcare to those whom they serve.

### 1. Establishment of a National Support Services (NSS) for doctors

#### *Patient safety*

It is of course necessary and important to protect the public against potentially rogue doctors or doctors whose fitness to practise might be impaired through adverse ill health. However, there has to be a balance between protecting patients and supporting a doctor who is ill. The current statutory process strongly emphasises the protection of the patient and public interest as the first and primary purpose and does not provide a route for both protecting patients and supporting sick doctors.

Many doctors, even when clearly unwell are able to function at work and even retrospective trawls (employer quality assessment of patient records) rarely identify evidence of patient harm due to the doctor's mental ill health. It is the experience of Health Programmes that it is very rare for sick doctors to harm their patients; in fact what

is more common is for sick doctors to continue working well beyond where it is good for their own mental health.

For example, over the past five years PHP has had to disclose information against the consent of the practitioner patient on four occasions (4/1078). For each of these patients the PHP team felt that there was sufficient concern about potential harm to the doctor-patient or to the patients they treated to breach confidentiality.

These occasions included:

- Two doctors (whose alcohol consumption was known to be a problem by their employers) who did not agree that they were unfit to work.
- A doctor with a probable psychotic illness (who was not working) who refused to accept that they were unfit to work, and no reassurance was given that they would comply with their treatment.
- A doctor who was suffering from early dementia who lacked insight.

In all of the above cases no patients were harmed by the doctor, however it was felt that there was sufficient risk of lack of insight associated with a mental health problem that the doctor posed a risk to patients. PHP has acted, in a number of cases, as the authorised GMC treating psychiatrist, ensuring that patients are protected.

### *Supporting doctors*

Practitioner health programmes in other countries are separated from regulatory process, with the understanding being that if the doctor does not adhere to the treatment and conditions imposed there will be implications on their licence to practise.

If there is a potential for sick doctors to harm patients, then it is even more vital to provide those doctors with an accessible, safe and confidential space to disclose problems in a non-judgemental manner such that they can receive timely and appropriate treatment in the process. This service PHP has been providing, and even where the doctor is not known to the regulator, they *risk-rate* any potential risk to patients and where necessary has involved the regulator or employers or other relevant individuals. Patients approaching

PHP are told at their initial assessment that they will be treated confidentially unless PHP feels they are placing themselves or their patients at risk and, if so, will act appropriately.

With PHP patients, where doctors are using illegal substances the GMC is always involved as there are some cases of doctors with alcohol addiction (for example, where there has been repeated drink-driving offences). The GMC mandates that the doctor attends a treatment and a supervising psychiatrist and undertakes regular monitoring for drugs and/or alcohol. It is difficult therefore to tease out whether the high rates of success with the PHP/GMC cohort is due to the combination of both acting in a complementary manner or whether success would be as high with one organisation working alone.

PHP does provide additional support for addicted doctors and in many cases when they approach in crises; PHP is able to support them through this allowing them to be in a better position ahead of disclosing their problem to the regulator.

In the US, addicted doctors are 'mandated' to pass through a Physicians Health Programme if they want to maintain their medical licence. This programme is financed by the doctor, unless the doctor is eligible for financial aid; however very few are eligible. The terms of the programme with respect to testing and attendance are intense, for example some programmes require the doctor to be tested for drugs on a weekly basis for a year. The outcomes for the doctors attending these programmes are good with reported long-term abstinence rates of around 80%, and with 70% returning to regular medical practice.

In Ontario, Canada, the health and wellbeing of doctors, trainees and medical students is supported through the Physician Health Program (PHP) and includes doctors where there are concerns around addiction. As with many Physician Health Programmes across the world, the service provides:

- Information and advice
- Assessment and referrals
- Direct intervention
- Case management, monitoring and advocacy
- Education/prevention workshops and presentations.

Figures for the GMC are not known but where doctors are engaged in a health programme, for example the NHS Practitioner Health Programme, 88% and 90% long-term abstinence rates for alcohol and drug addiction respectively and 75% of doctors not at work at presentation return to work during their treatment at PHP.

Going forward, it is important to separate out the functions of treatment from regulation with the regulator receiving necessary reports about progress but not taking part in any of the assessments, case management and treatment unless the doctor crosses an agreed threshold.

This separation of functions has been established with other practitioner-health services across the world.

The service configuration of most Physician Health services is that they provide assessment, case management, workplace supervision, monitoring and report writing with no treatment included within the service. This makes it very difficult for doctors who have limited income (which is not unusual when one is considering that many doctors have been sick for a while and will have incurred debts).

It also means that the treatment element is out-with the programme and, whilst treating practitioners can be part of an accreditation system, it is difficult to insist (when a doctor is funding themselves) that they use named treating practitioners only. The current UK system relies heavily on NHS psychiatrists to undertake the 'treatment' aspects of care and a GMC appointed supervising psychiatrist to carry out the monitoring functions. Increasingly some commissioners and employers may not allow psychiatrists to do this work as part of their NHS offering, as in many cases the impaired practitioner is well and is merely seeing the psychiatrists to 'touch base' for GMC purposes, hence using an appointment slot that could be used for an acutely unwell patient or for someone with complex needs. Using psychiatrists as part of ongoing 'case management' is therefore going to become increasingly difficult unless the GMC pays for this service at NHS or other tariff rates.

In addition, Trusts and Boards are becoming concerned about patients being seen on their premises by their staff in cases where these patients do not form part of their patient population and have no records other than what is contained in the assessing psychiatrists' private system. This means that going forward it is likely that, given the forces of change in the NHS (in England), the GMC may have to address how it

commissions psychiatrists and other personnel to undertake functions on the GMC's behalf.

**It is recommended** that the Department of Health (England), NHS England and the Devolved Administrations (Wales, Scotland and Northern Ireland) consider delivering the legislative changes that would be necessary to develop and establish a national support service. The national support service would be managed by a senior medical officer who assumes the responsibility for the day-to-day management of doctors with health concerns (currently undertaken by the GMC) incorporating the assessment, case management, monitoring, reporting, treatment, and education and prevention elements within a single system. It would be prudent to ensure that all medical students also have access to this national support service. It is important that the national support service will refer immediately to the GMC any serious allegations they become aware of or persistent failures to comply with an agreed treatment plan by a doctor.

It is important that any service is compassionate, consistent, comprehensive, accessible and confidential, and ensures the right cases are referred and the process is designed with patient safety at its heart.

This national support service could have different areas of care:

- Early prevention where doctors who have insight into requiring support would be provided the right access to services.
- An alternative route to the disciplinary pathway for some doctors whose practice could be affected by illness.
- Assessment, treatment and case management within a single service.

The underlying value of a national support service is that:

- It provides initial assessment of practitioners with health-related issues that could be considered to pose a risk to patients.
- The doctor's case management can be individualised according to the type of illness ensuring they receive a consistent standard of service.



- It ensures doctors are well informed about their impairment, its likely course, outcome, and appropriate treatments.

The National Support Service established would:

- Build on existing specialist services for health professionals.
- Encourage health professionals with mental health problems to disclose them in a timely and confidential manner.
- Be proactive in its focus rather than reactive.
- Provide an effective interface with occupational health services, especially around particular requirements for return to work and vocational rehabilitation.
- Have a reasonable annual caseload to ensure that the focus of expertise is built up and developed.
- Take account of the differences in the healthcare resources and geography across different regions in the UK.
- Provide value for money by enabling the health problems of doctors to be addressed more efficiently.
- Thought could be given to whether the service could furnish the GMC with necessary reports to be able to make a determination about the fitness to practise of a particular doctor. If so, this could be determined through a Memorandum of Intent (MOI) between the National Support Service (NSS) and the Registrar of the GMC.

How the service is configured will need to be designed dependent on:

- The numbers expected to attend
- The scope and remit of the service
- Designing the service to provide both prevention and treatment services

- Whether the service would extend to doctors with a range of mental health issues, rather than just those conditions that would have met the criteria for investigation under health procedures
- Whether the service is UK wide or just in England and Wales
- Whether the service includes education programmes.

Experience from other similar services would suggest that it would be best to configure as a Hub-and-Spoke model, with a single provider providing overall leadership of the service to ensure that quality and standards are delivered and maintained.

This configuration would:

- Allow for economies of scale and sufficient volume of doctors to ensure expertise is maintained
- Minimise the risk in particular with managing those doctors who are already under GMC processes or those who might be referred if their health deteriorates
- Allow the GMC and hence the public to have trust in the quality of the service and not compromise patient safety
- Allow standards and developments across this area to be rapidly disseminated and implemented.

The hub arrangement would be able to provide first assessments (unless there were exceptional reasons why this couldn't be the case).

Local spokes using trained doctors would provide case-by-case support for referred doctors dependent on initial (and ongoing) risk assessment. Ideally, the hubs could consist of an integrated service with both dedicated and on call doctors drawn from primary care, psychiatry, and occupational health. In addition, this arrangement could allow for GMC employer liaison advisers to form part of the core team, helping to bridge the gap between health and regulation.

Specialist health services (Hubs) should work closely together, sharing learning and experience (including medical supervisors/examiners and case examiners). This could

include developing a dataset to enable analysis of cases and increased understanding of the illness of health professionals, as well as comprehensive evaluation. The service would also be in a good position to provide support and training to other health professionals in areas related to prevention, identification and brief intervention of mental health and addiction problems in doctors and to support the network of trained doctors and provide opportunities for shared learning.

The Royal College of General Practitioners and the Royal College of Psychiatrists have developed a competency framework which could be utilised by trained health professionals to deliver specialist care to those doctors who have been referred to the national support service.

This nationally approved competency framework would include a skills, knowledge and competency based approach including a curriculum and training programme for practitioners. The original framework fell under the Health for Health Professionals (HHP) Caritas programme which was a partnership between the Royal College of General Practitioners, the Royal College of Psychiatrists and the Association of Occupational Health Nurse Practitioners. A cadre of practitioners therefore currently exists who are already trained in this competency framework and could provide services to the NSS. It would be advisable that the NSS would be clinically staffed where appropriate by Caritas practitioners who would have the following competences:

- Flexible in their approach to practitioner-patients and able to deal with multiple physical, psychiatric or social issues.
- Understand the working environment of health professionals, pressures and requirements.
- Work effectively with occupational health services on return to work programmes.
- Have an awareness of the requirement to protect the safety of patients who may be cared for by the practitioner-patient.
- Understand the regulatory processes for health professionals.
- Have training and be experienced in treating individuals with complex needs.

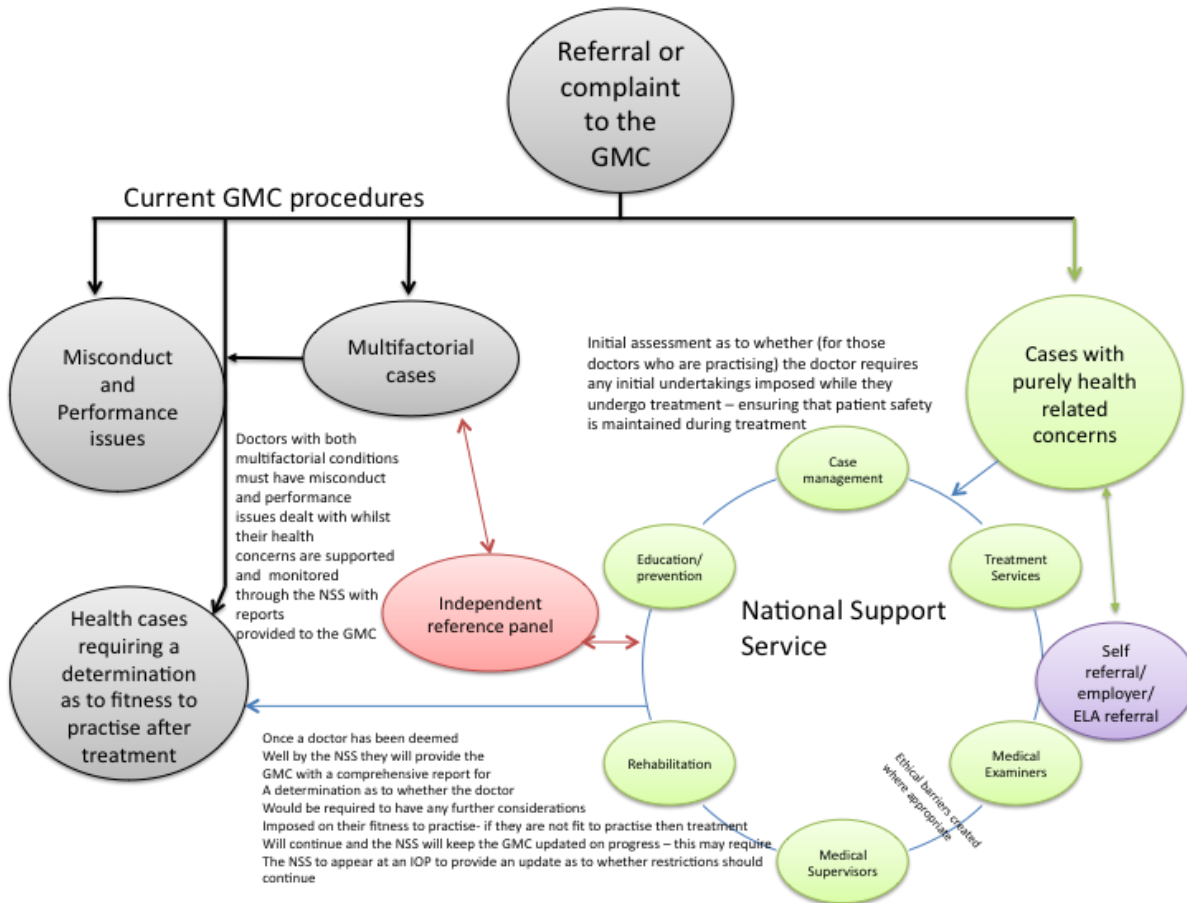
- Capable of understanding those practitioner-patients who may have been suffering from complex and unidentified health problems for long periods of time.
- Understand the regulatory processes for doctors.
- Understand the education and training environment for doctors.
- Support an integrated multi-professional team with personalised clinical meetings.
- Provide case management functions.

Other aspects of the service provision would also include workplace supervision mentoring and psychological interventions using health and allied professionals that meet the criteria for inclusion in the service.

Exclusion criteria for the service could include:

- Suspected child abuse or neglect
- Sexual abuse of patients
- Other criteria as agreed with the GMC.

## Conceptual overview of the NSS



## Service elements

The specification for service delivery will require further development. It is important that the specification is developed to encompass a comprehensive support service for doctors. There will be components of occupational health, however the envisaged national support service is not a dedicated occupational health or a return to work service. The National Support Service would be expected to liaise closely where required with both occupational health and employers to ensure a cohesive and supportive programme approach.

In essence the specification would include the following:

### *Initial contact*

The service will include a confidential helpline able to listen to callers' concerns (including those of doctors, colleagues and employers) and offer advice or recommendations on the appropriate resources available to resolve those concerns.

### *Referral process*

Doctors may be referred through the following means:

- 1** Doctor may refer themselves
- 2** Colleagues or employers may refer the doctor
- 3** GMC may refer a doctor either by means of a purely health concern or as part of a multifactorial case
- 4** GMC may refer (this could include an urgent referral) a doctor who initially may not be vulnerable but who could however develop serious health concerns during the investigation process

When a doctor is referred to the NSS and the case involves issues of probity, illegal or very serious behaviours these would be referred to the GMC via an agreed process. The purpose of the initial screening at initial contact is to determine the nature of the condition, its urgency and more importantly the potential risk to patients.

Following the initial referral process, should the nature of the referral be sufficiently concerning and the doctor not want to access the service, then the referral would automatically be handed over to the GMC for further investigation.

### *In-depth assessment of practitioner-patients*

A full assessment of the practitioner-patient needs to be undertaken by a suitably qualified practitioner. Initial assessment would be offered within 48 working hours from first contact and would be delivered from one of the Hubs in agreement with the doctor. Should the

doctor be unable to attend one of the designated Hubs (within the agreed timeframe) the NSS will make contact with another suitably qualified doctor (eg from the RCGP Caritas Programme) who could complete the initial assessment. If the assessment diagnoses an impairing condition, the NSS will work with the doctor to develop an individualised treatment plan. If the diagnosed impairing condition puts patient safety at risk, the NSS will continue to treat the doctor; however it will, in discussion with the GMC, qualify whether the doctor requires any conditions imposed on their registration for the short term. This would be continually reassessed and monitored at the multidisciplinary team meetings.

### *Multidisciplinary teams*

These teams would primarily consist of doctors working within the health service and who have the skills and experience drawn from mental health (psychiatry, general practice), regulation (GMC liaison) and occupational health. Multidisciplinary teams would meet frequently so that every new case could be discussed. These teams would convene normally within a week from the date of initial assessment. An individual treatment plan will be agreed and where appropriate any monitoring arrangements that need to be put in place including near-place testing, random unannounced testing and hair analysis will be provided. A nominated case manager will be allocated for respective doctors under care who will be an NSS clinical staff member or one of the Caritas doctors.

### *Monitoring and case management*

Monitoring will continue either after the doctor has successfully completed a period of residential care (where the doctor has an addiction problem) or when a doctor is actively involved in treatment with the NSS. The doctor may have a medical supervisor assigned to oversee their progress, which may include in some instances a case report being furnished to the GMC. Types of monitoring will include:

- Proof of attendance at relevant recovery programme, eg AA, NA, BDDG
- Therapist/case worker reports of progress
- Drug screening for chemical dependency collected by various methods

- Workplace reports (including timeliness, reliability, relationship with patients and staff and personal appearance)
- Periodic assessment by the NSS Medical team (including a medical supervisor) or anyone else the case worker or medical team suggest which will allow the NSS to evaluate progress and compliance with treatment, with the ability to respond to any indications of further difficulty with treatment.

Similar monitoring processes currently are in place for GMC supervision. The NSS would still retain these processes as part of a treatment service and would deliver them within the context of a multidisciplinary expert health service rather than through a number of individual GMC-appointed practitioners.

#### *Treatment services*

- Access to a range of clinical interventions as appropriate, such as cognitive behaviour therapy, family therapy, mentoring.
- Referral for specialist assessment or treatment (inpatient or outpatient).
- Occupational health expertise to liaise with a practitioner's occupational health service, providing support for a return to work programme.
- Advice to other practitioners managing health professionals.

#### *Education and prevention*

Educating doctors on areas including wellness and work-life balance through to burnout, substance use disorders and mental health concerns is essential. This education will not only promote personal resilience and prevent health problems, but also encourage early identification of those doctors who are experiencing stress, distress or illness. The NSS would be able to offer or facilitate the following educational opportunities, including:

- What constitutes impairment and how to recognise it
- The vulnerable doctor – substance use disorders (signs and symptoms of addiction)



- Mental health in doctors
- Resilience practices for doctors – taking care of the basics
- How to recognise and respond to distressed doctors
- The importance of personal health for medical students
- Return to work for doctors.

### **Referral to the GMC**

The GMC currently does not intervene if the following practices are being undertaken by a doctor personally or via their employers or other support services.

- The doctor poses no risk to patients or to public confidence.
- The doctor is aware of a health issue and has insight into the extent of their condition.
- The doctor is seeking appropriate treatment.
- The doctor is following the advice of their treating physicians and/or occupational health departments in relation to their work.
- A doctor is restricting their practice appropriately.

Doctors who do not accept or acknowledge they have a health condition or have other serious allegations or persistent failures relating to their performance will be referred to the GMC investigation process through a referral process.

Should a health concern be identified through the GMC investigation process this issues will be referred to the NSS for treatment. The NSS will through an agreed established process provide necessary progress reports to enable the GMC to take appropriate action if required.

## **Medical examiner reports**

Health cases that require an assessment of the doctor's physical or mental health will be provided through the NSS.

Where the doctor is willing to undergo the assessment, the NSS will make arrangements for the examinations to take place and be completed by a qualified medical examiner.

The medical examiner undertaking the examination will prepare a covering report that should include the following:

- Events leading to be referred or self-referral
- Family history
- Mental state examination including personality assessment
- Past medical history including current medication and allergies
- Drug and alcohol history
- Current test results
- Collateral information
- Diagnoses
- Is the doctor with a health concern fit to practise either generally or in a limited way
- Recommended treatment or management plan for the case.

The NSS would employ medical examiners who would provide an in-depth assessment and overview of a doctor's case where the impairment could have a direct consequence on the safety of patients.

The medical examiner's report would be supplied to the GMC directly by the NSS should the specific case be under the GMC's investigation process.

## **Medical Supervisors**

The NSS will provide a dedicated medical supervisor to support a doctor when appropriate. The medical supervisor will periodically monitor progress in conjunction with the tailored treatment plan and strategy to either return to work or modify working conditions, the medical supervisor's report would include:

- The doctor's current health in conjunction with the agreed treatment plan
- Changes in personal circumstances which may impact the doctor's health
- Seek feedback from employer on doctor's current performance in workplace
- Feedback and rating on the doctor's tests regime
- Compliance with undertakings or conditions
- Any significant problems or breaches of undertakings or conditions
- Opinion of fitness to practise
- Recommendations
- Assess whether the restrictions placed on their registration are working or require modification.

## **Accountability and independence**

In order to provide assurance that the NSS is operating effectively and is delivering against its mandate the accountability for delivering the service, it is envisaged that the NSS should remain under the GMC's authority.

Although the NSS will operate independently from the GMC there will need to be an effective working relationship and an agreed service process that supports a cohesive and transparent management of fitness to practise cases that have a health element. Detailed below are a number of key considerations.

New legislation would provide for the GMC to create a service specification for the NSS and establish specific mandates for performance. The NSS would:

- Provide an annual assurance report to the GMC outlining performance against the agreed service specification, including:
  - Number of cases referred
  - Types of health cases
  - Cost analysis (annual spend)
  - Trend and data analysis
  - Treatment services
  - Success rates
  - Improvements and educational training
- Resolve any policy or operational issues that may arise
- Identify any areas of joint working
- Provide an internal feedback mechanism between other areas of the GMC and the NSS

### **Leadership of the NSS**

The NSS would require strong medical leadership to ensure that it manages its service commitment to both doctors and the GMC effectively.

Experience from both PHP and other service providers internationally have demonstrated that a strong clinical leader is key to success. Therefore it would be appropriate for the NSS to be led by an individual with excellent leadership and management skills, and have

the appropriate clinical experience and knowledge. The successful individual must be an excellent communicator and a champion for health professionals with health concerns.

This role would act as a senior medical officer who would not only have oversight of the NSS but also provide a key link into the GMC where they will be responsible for:

- Continuous improvement of the service
- Development of new innovative testing mechanisms
- Ensure the health procedures in the NSS and the referral procedures from the GMC are robust yet subtle enough to pick up early signs of vulnerability
- Close working relationship with the GMC Case Examiners to ensure continuous feedback on improvements areas
- Oversight (RO) of the medical supervisors and examiners ensuring that training and development opportunities are implemented.

It would be appropriate initially to appoint an interim medical officer for a period of 12 months to help establish and design the service. This would provide the opportunity for an initial pilot of the service to be tested and services qualified before full commitment to a procurement process is adopted.

### **Independent reference panel**

To ensure continuity of business it is crucial that both the GMC and the NSS work closely together to deliver a seamless service, and it is important that both the GMC and the NSS have the trust and confidence of both the public and doctors.

To achieve the seamless service it is important that an independent reference panel be established that would consist of:

- GMC Case Examiners
- GMC employer liaison advisers
- NSS's senior medical officer and key medical staff

- independent overseer and additional panel members where appropriate.

The purposes of this independent reference panel would be to:

- Discuss improvement areas on the referral process between the GMC and NSS, including those health cases that are referred back by the NSS to the GMC.
- Quality assure
- Discuss cases that require any of the following:
  - Referral to an Interim Orders Panel
  - Medical examiners and supervisory reporting on cases that have multifactorial considerations
  - Where new probity, illegal or very serious behaviours have been highlighted
  - Complex cases that might require additional support or interventions.

The independent reference panel would act as a firewall and would ensure that while the two organisations focus on delivering their own specific obligations there would be the appropriate forum and opportunity to discuss potential improvements in collectively handling cases and implementing changes in both the referral process and patient safety.

### **Costs of providing a National Support Service (NSS)**

Detailed below is a budgetary cost analysis pertaining to the NSS. Greater discussion and input from the GMC and other key stakeholders will be required to provide a detailed and comprehensive cost model.

The basis of the cost analysis below is to provide an estimate based on the combined health cases currently handled by the GMC and PHP. These figures are based on an annual average for the past three years.

## **PHP London established costs**

At present the PHP is funded by the London Specialised Commissioning Group and receives an annual budget of approximately £1.2m to provide support services for London practitioner-patients.

Over a three-year period (2009-2011) PHP treated 554 practitioner-patients out of approximately 30,000 doctors living in London.

In order for PHP to determine the associated costs during their initial pilot phase they developed five categories for assessment that included:

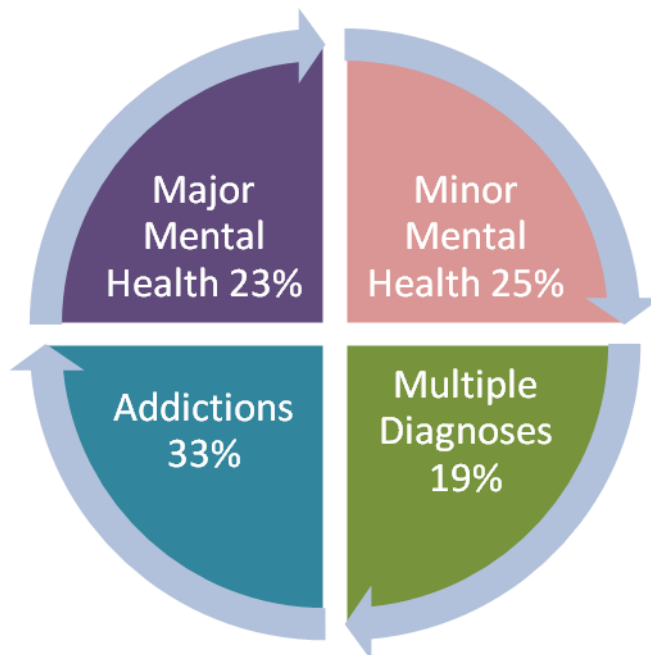
- Major mental health
- Minor mental health
- Addiction
- Multiple diagnoses
- Physical health.

A cost assessment was allocated to each of these respective categories based on the understanding and consideration of treatment required and provided by a recognised clinician. A budgetary cost has been developed for each category and this is represented in the table below. The PHP costs reflected below represent an average costs per doctor by category. It is important to note that some doctors may require multiple services from each category which will increase the costs depending on treatment.

### Cost per patient by category

| Category            | Cost per annum |
|---------------------|----------------|
| Major mental health | £5,000         |
| Minor mental health | £3,500         |
| Addiction           | £5,000         |
| Multiple diagnoses  | £7,500         |
| Physical health     | £2,500         |

**PHP specialist referral category cost represented as a percentage by practitioner-patient for the third year based on annual income of the organisation**





The above category cost model includes the initial assessment and treatment provided by the integrated team and includes any ongoing case management requirements. It is important to note that the costs represented do not include any external specialist assessment or treatment should that case require further independent consideration. Where there are additional external costs for medical treatment it is envisaged that these expenditures would be absorbed by the PHP costing summary and would require regular assessment to ascertain the future funding values.

### **National Support Service (NSS) potential costs**

A full assessment will need to be undertaken by the Department of Health and other key stakeholders including the GMC to ascertain the exact costs of establishing and delivering a National Support Service that is in principle based on the PHP business model. Detailed below are budgetary cost guidelines for consideration.

#### **Total GMC and PHP case reviews**

|  |              |
|--|--------------|
| <b>GMC health cases for the past 3 years</b> | <b>1370*</b> |
| <b>PHP cases for the past 3 years</b>        | 554          |
| <b>Total for three years</b>                 | 1924         |

\*These figures are approximate only and include case reviews

|   |               |
|---|---------------|
| <b>Average cost per category per case from PHP</b>  | <b>£5,000</b> |
| <b>20% increase to take into account those doctors who may access the service voluntarily and not through the GMC</b> | 384           |
| <b>Total possible cases over a 3 year period</b>  | 2,308         |
| <b>Total funding for a basic service</b>  | £11,540,000   |
| <b>Additional funding for specialist services/education (3 years)</b>   | £2,500,000    |
| <b>Administration costs (3 years)</b>   | £2,000,000    |
| <b>Total funding for a 3 year period</b>  | £16,040,000   |

The above figures include the current GMC and PHP health case averages for the past three years; these combined figures provide a baseline to assess a national coverage.

### **Funding options**

The current economic environment and limited public financial resources would not allow for one organisation to provide complete funding. The anticipated costs of providing the NSS would need to be supported by multiple stakeholders that could include the following:

- The GMC
- Department of Health (England)
- Devolved Administrations (Wales, Scotland and Northern Ireland)
- NHS England
- All UK registered doctors.

The report outlines four potential funding models:

- Financed by a single organisation
- Financed by multiple organisations
- Financed by doctors
- Financed by a combination.

### **1. Financed by a single organisation**

As highlighted above it would be difficult for a single organisation to provide the entire funding for the NSS as there are often changes in budgets driven by policy change and political landscape.

Given the nature of the very specific care requirements it is recognised that the services are provided by a dedicated provider, which is able to focus completely on delivering the service and is not potentially burdened by other business obligations.

At present there is no dedicated national organisation in the healthcare system that is responsible for the care of doctors.

### **2. Financed by multiple organisations**

It could be feasible for a number of key organisations to provide the funding requirement for the NSS, however there would need to be a very clear policy agreement and stakeholder commitment in order to establish the perimeters, working guidelines and

financial allocation. The key organisations listed below already have a direct level of input regarding health practitioners:

- The GMC
- NHS England
- Department of Health
- Devolved Administrations.

Detailed below, is an overview regarding each of the defined organisations as detailed above and the reason for the inclusion.

#### *General Medical Council*

The GMC considers the fitness to practise of doctors referred with health concerns and has established processes to support the doctor's recovery.

#### *NHS England*

NHS England is responsible for commissioning primary care nationally; this includes the service and standards provided by General Practice doctors in the community.

#### *Department of Health*

The Department of Health (DH) is the overarching government office responsible for policy development. The DH has the capacity and responsibility to ensure appropriate governance and standards are in place when considering policy regarding the health concerns of doctors.

The four defined organisations clearly have a level of interest regarding healthcare for doctors, however a combined approach, whilst fundamentally appropriate, could have difficulties in achieving an agreed strategy and securing long-term funding.

### *Devolved Administrations*

The very nature of a devolved administration means that the country operates completely independently from the Department of Health in England and will require consultation about the development of any national support service to initially understand the services being provided and the respective cost implication in participating in the delivery and support of this service.

### **3. Financed by doctors**

The NSS is a dedicated support service available for all health practitioners. Therefore it could be argued, as the NSS service is very specific, it is in the best interests of all doctors to directly fund the initiative. The service would essentially offer the same benefits as a private health insurance cover and be available to all doctors, however in order to optimise the service this would require compulsory participation.

In order to achieve compulsory participation the GMC is the only organisation that has a mandatory requirement for doctors to pay an annual retention fee. The GMC retention fee provides an existing mechanism for the funding and recording of all registered doctors.

Presently the annual retention fee for all registered doctors is defined as follows:

- 1** Doctors holding registration with a licence to practise (currently 236,461).
- 2** Doctors holding registration without a licence to practise (currently 23,364).

The table below reflects the set annual retention fee charged by the GMC, which represents a reduction from the previous year.

|  | <b>Current cost per doctor</b> | <b>Increased cost per doctor</b> |
|--|--------------------------------|----------------------------------|
| Doctors holding registration with a licence to practise    | £390                           | £22.61                           |
| Doctors holding registration without a licence to practise | £140                           | N/A                              |

The NSS is a service to all doctors licensed to practise and ultimately has a mandate to ensure the safety of all patients under care. Therefore consideration as to whether compulsory participation is required for non-licensed to practise doctors will require clarification.

For the purposes of this cost model only doctors with a licence to practise have been included. It would be envisaged that, not until medical students become licensed to practise and therefore subject to the GMC fees (which would include the cost for the NSS), would they be required to pay for accessing this service.

In order for the NSS to receive funding directly from each licensed to practise doctor, the GMC could increase their annual retention fee from £390 to £412.61 to provide for this service.

The increase represented in the retention fee has been calculated by the following method:

|  |                   |
|--|-------------------|
| <b>Total funding annualised</b>  | <b>£5,346,666</b> |
| <b>Total number of registered doctors licensed to practise</b>             | 236,461           |
| <b>Average cost per doctor (those registered and licensed to practise)</b> | £22.61 per annum  |

#### **4. Financed by a combination**

The NSS is a service that would benefit all practising doctors in both private and public healthcare sectors. Implementing the NSS as a dedicated service provider will also benefit previously mentioned key stakeholders as the level and quality of healthcare are improved and the risks to patients are minimised.

The three previously mentioned stakeholders could fund the initial cost and establishment of a pilot service for the first two years, with subsequent years funded by the annual retention fees collected by the GMC. At present no further investigation has been undertaken as to the potential costs for a combined service.

##### *Annual retention fees*

Following the two-year pilot period there are two possible options for consideration when assessing the annual retention fee values, and they include the following:

**Option 1:** Doctors holding registration with a licence to practise will have an increased cost in their retention fee of £22.61 (the retention value uplift may increase periodically depending on the cost of the services provided).

**Option 2:** Alternatively the GMC could consider allocating a proportion of the annual retention fee (£22.61) towards the services provided by the NSS with no additional costs to the doctor (the retention value reallocated for the NSS may increase periodically depending on the cost of the services provided).

If there was policy consensus that the NSS should be established and the necessary legislative change was implemented and the GMC adopted this option, it is conceivable that doctors would consider the investment towards the NSS service as a favourable solution. The GMC as a regulator supporting the NSS financially could develop a stronger partnership with doctors and show a level of investment in their health and wellbeing.

The benefits of a combined funding approach would include:

- Investment by the stakeholders in establishing and developing a prevention service for doctors.
- Stakeholders' greater ownership of policy regarding practitioner healthcare.
- A combined partnership between stakeholders and doctors that enhances working relationships.
- A personalised and dedicated service that is owned and supported by doctors following the two-year pilot period.
- This would not be influenced by changes in government, policy or economic circumstances following the two-year pilot period.
- Funding by doctors ensures a sustainable future.
- Essentially a compulsory health insurance policy for doctors that ensures a service is readily available nationally for their health and wellbeing.

**It is recommend that the Department of Health** consider model 4 as a funding model for the NSS with the annual retention fees considered under option 2.

### **Legal considerations**

Any significant modification to the services that the GMC currently delivers or provides will require legislative amendments to fulfil the service obligations to the NSS model and would be subject to a full consultation process.

### **Expert working group**

It is recommended that the Department of Health should consider establishing an expert working group to take forward the NSS recommendation. This expert group could develop a business case that would include the following:

- Developing the national service specification
- Ensuring key stakeholders' views and concerns have been recognised and taken into account



- Ensuring a robust financial plan is developed
- Ensuring adequate consultation on the service has been undertaken and feedback has been assessed and taken into account
- Developing a comprehensive risk assessment of separating out health cases from the GMC to be delivered by the new organisation
- Establishing legislation requirements and timetable
- Assessing whether the proposed service is clinically and financially sustainable
- Defining an agreed implementation timetable
- Establishing a pilot scheme proposal
- Developing a draft MoU (Memorandum of Understanding) that would support both the service specification and the risk assessment
- Establishing agreed outcomes and reporting
- Preparing the outline business case
- Reporting to the Department of Health on progress.

This expert working group would develop all the necessary documentation for agreement by the GMC and other participating organisations.

## ANNEX B

### **Independent Consultant's background**

Sarndrah Horsfall was the Chief Executive for the National Patient Safety Agency (NPSA) in the UK, the independent public body responsible for patient safety, research ethics and monitoring the performance of medical practitioners. Sarndrah has held a number of senior executive posts in both the public and private sectors, with a specific focus on establishing, developing and maintaining efficient and effective organisations in complex political environments.

## ANNEX C

14 December 2014  
Niall Dickson  
Chief Executive  
General Medical Council  
350 Euston Road  
London  
NW1 3JN

Dear Niall

Please find attached my final report into doctors who committed suicide while under the GMC's fitness to practise investigation between 2005 and 2013.

This report was commissioned by the GMC in September 2013 to understand what improvements could be made in the fitness to practise process to reduce the impact on vulnerable doctors and whether more could be done to prevent these tragedies from occurring.

The report addresses lessons that can be learnt from these deaths, as well as any changes the GMC could make in the way it handles vulnerable doctors.

The final report includes a number of recommendations for the GMC to consider and has further wide-ranging considerations for the GMC's stakeholders.

Finally, I hope this report enables the necessary changes to be made internally to the GMC's systems and processes, which ultimately will ensure the safety of both patients and doctors.

Yours sincerely

Sarndrah Horsfall