

### Agenda item 4 - Doctors who have died while in the fitness to practise procedures

Note: This paper has been redacted to remove references to any specific data or the content of discussions with stakeholders.

<b>Action</b>	To approve
<b>Purpose</b>	<p>This paper provides an update on the feedback obtained following meetings with key stakeholders to discuss the GMC's proposals for the publication of data relating to doctors who have died while in the fitness to practise procedures.</p> <p>It also seeks agreement to a recommendation that we publish the data annually for a three year rolling period (see example in paragraphs 18-19 below) with causes of death data broken down into broad categories.</p> <p>If the Executive Board agrees that we publish the above, Annex C of this paper sets out a proposed approach for doing so.</p>
<b>Decision trail</b>	This matter was last considered by the Executive Board in January 2020 (minutes at Annex A).
<b>Recommendations</b>	<ul style="list-style-type: none"> <li><b>a</b> To consider feedback from relevant stakeholders on the frequency of publication of doctors' deaths data</li> <li><b>b</b> To consider feedback from relevant stakeholders on the publication of cause of death data</li> <li><b>c</b> To consider and agree to our recommendation of publishing data annually for a three year rolling period (example at paragraph 19), with the cause of death data broken down into broad categories.</li> <li><b>d</b> If in agreement with recommendation c, to consider the proposed publication report at Annex C.</li> <li><b>e</b> To note the change in the coronial standard of proof when concluding a death as suicide as important context for our data.</li> </ul>
<b>Annexes</b>	<p>Annex A: Extract of Board minutes from 27 January 2020</p> <p>Annex B: Summary table of stakeholder feedback <b>[redacted]</b></p> <p>Annex C: Proposed wording for publication</p>
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## Background

- 1** Following a review we carried out with Professor Louis Appleby in 2015 to look at how we deal with fitness to practise cases involving doctors with health issues, we committed to improving our information about the cause of death of doctors who die while under GMC investigation to support learning and, where appropriate, improvements to our fitness to practise processes.
- 2** We subsequently committed to the publication of both the numbers of doctors who die while under GMC investigation and causes of death. We initially proposed to publish this data annually. However, in developing a process to support such publication, we identified the following risks in both reporting the causes of death and the frequency of reporting annually:
  - a** the risk that annual reporting will result in incomplete information being published due to delays in obtaining information relating to coroner's inquests, it can take some time for a death to be reported to us and for cause of death to be established, particularly where there are coronial proceedings, and;
  - b** the risk of identifying individual doctors from numeric data.
- 3** The risks were considered by the GMC Executive Board in January 2020. In order to provide appropriate mitigation, the Board proposed that the GMC publish:
  - a** the number of deaths during an investigation, in the context of the number of investigations that were carried out in that period;
  - b** the number of those deaths where the doctor took their own life based on information from the coroner (but not the detail of other causes of death);
  - c** the data less frequently than annually, in order to account for the delays in obtaining information relating to coroner's inquests and to address the risks of speculation or identification – either every three or five years.
- 4** The Board also proposed that discussions be convened with relevant stakeholders, including the British Medical Association (BMA), Practitioner Health Programme (PHP) and Professor Louis Appleby, to ensure that the proposals address any concerns they may have.
- 5** The project team met with the BMA, PHP and Professor Appleby in December 2020 and with the MPS, MDU and MDDUS in January 2021 to discuss the

proposals. We discussed both the frequency of publication and the publication of cause of death data. A table summarising the stakeholder feedback can be found at Annex B.

## Frequency of publication

### Option one: Publish annually with single year figures – Not recommended

- 6 This option would mean publishing each year the previous year's data. For example, publishing the data for 2020 in the year 2021. This option was previously put to the Executive Board, but decided against due to the risks relating to the small numbers involved.
- 7 Each of the stakeholders we met with understood and agreed with the risks of publishing single year figures on an annual basis.

[Redacted text]

- 8 We do not recommend this option due to our own and the concerns of key stakeholders about the risk of identifying individual doctors from the data and the impact this could have on their families.

### Option two: Publish every five years - Not recommended

9 [Redacted text]

10 [Redacted text]

11 [Redacted text]

- 12 We would not recommend this option as the gap between publishing the data would be too great, which could cause reputational damage and could negate one of the purposes of publishing the data, which is transparency.

**Option three: Publish in three year blocks (with a 3 year gap in publication) - Not recommended**

13 [REDACTED]

14 [REDACTED]

15 [REDACTED]

16 We do not recommend this option as there is a risk of reputational damage if the GMC is seen to be holding data for unnecessarily long periods of time. Publishing every three years, rather than annually, would make it more difficult to identify and learn from trends or spikes in the data. There are no additional benefits to this option, that are not covered by option four below.

**Option four: Publish annually with three year figures (with no gap in publication) – Recommended**

17 [REDACTED]

put forward a suggestion of publishing data annually, but in rolling three year periods, in order to balance the need for transparency against the risk of identification.

18 This option would therefore involve publishing each year, but rather than publishing the data for a single year – we would publish a three year rolling period, e.g. *2018, 2019, 2020*. This would mean higher (albeit not extremely high) numbers, as it would be the total of the three years combined.

19 In order to mitigate the issue of coroner delays, we propose publishing towards the end of each year. For example, in December 2021 publishing: *2018, 2019,*

*2020, in December 2022 publishing: 2019, 2020, 2021 and in December 2023 publishing: 2020, 2021, 2022.*

20



- 21 This option would mean information is shared on an annual basis but would remove the risks around identifying doctors. Rolling publication of every three years with no gap is easier to identify trends/spikes and therefore any problems with the fitness to practise process, rather than publishing in three year blocks (option three).
- 22 We would recommend this option as it would allow the GMC to balance the need for transparency with the risk of identification and speculation. It is also important to note that this option received the most support from the relevant stakeholders we met with. We have therefore outlined how this option would look in the proposal at Annex C.

## Publishing the causes of deaths

### **Option one: Publish all causes of deaths - Not recommended**

- 23 This option would involve publishing all causes of death as ruled by the coroner, and would include rare causes of death, which could lead to a doctor being identified.
- 24 Publishing all causes of death carries a risk of disclosing sensitive details about a deceased doctor's health, which may cause distress to their family. For example, in a year where there are a small number of deaths or a single death during fitness to practise proceedings, an individual who knew a doctor had died while under investigation may deduce from our published data that the only possible cause of death for that doctors was, for example, an alcohol/drug related death.
- 25 With less common causes of death, where the cause of death is more widely known, there is a risk of disclosing that the doctor was under GMC investigation at the time of their death, information which we treat as confidential.

- 26 We discussed the risks of this option with the stakeholders and all agreed that this option would not be favourable due to the risks of identification or speculation about a doctor's health or investigation status. We would therefore not recommend this option.

**Option two: Publish suicide deaths only - Not recommended**

- 27 This option would involve publishing only the number of suicide deaths in a particular period. This would achieve the purpose of the recommendation set out by Professor Appleby in his 2015 review, however, some of the stakeholders have commented that it would be useful to see other causes of death for reasons set out below. We would therefore not recommend this option.

**Option three: Publish causes of deaths in broad categories - Not recommended**

- 28 This option would involve breaking down the cause of death data into broad categories, for example: *heart disease/cardiovascular, cancer, medical, neurological, accidental, suicide*. Any rare causes of deaths, for example, a rare genetic condition would be grouped into 'other'. This would mitigate the risk of identification and speculation.
- 29 ██████████ raised concerns about publishing 'alcohol and substance misuse' deaths as a category of their own – as this may lead to the same issues and risks as suicide deaths. ██████████ suggested these deaths be grouped as 'medical' to avoid any identification or speculation about a doctor's health.
- 30 ██████████ raised a potential risk, which was the potential difficulty of grouping some types of deaths. When grouping the ONS data, the deaths are professionally coded – however this isn't done for the GMC's data, so it would be down to the team publishing the data to 'code' the deaths directly from the coroner's report, which would carry risks of incorrectly coding and therefore publishing incorrect data. In order to mitigate this risk, we could group any deaths that aren't clearly specified by the coroner in the 'other' category.
- 31 ██████████ were in favour of publishing broad categories of the causes of death in order to understand the impact that a GMC investigation may have on a doctor with a pre-existing medical condition or general deterioration of their health. ██████████ did recognise the risk of inferences potentially being made with this option.

- 32** We would not recommend this option due to the risk it carries, however, if the Executive Board prefers this option, we could seek advice from Professor Appleby as to how we could mitigate the risks here.

#### **Option four: Publish causes of deaths as natural vs unnatural - Recommended**

- 33** This option would involve breaking down the cause of death data into two categories: natural and unnatural. According to Professor Appleby, this is the conventional way of recording and publishing deaths.
- 34** This option provides more information than just the number of suicide deaths alone (option two) but would balance the risk of identification and specification. It would also mitigate the risk of the GMC potentially incorrectly coding deaths.
- 35** For this option we would break down *'unnatural'* deaths to show the number of deaths by suicide. We have set out how this would look in the proposal at Annex C.

#### **Change in coroner's standard of proof**

- 36** We were helpfully reminded, during our meeting with [REDACTED], of a change to the standard of proof for coroners recording a death as suicide. Prior to 2020, the standard of proof required for a suicide verdict was the criminal standard – beyond reasonable doubt.
- 37** However, in a 2020 [Supreme Court](#) judgement, the standard of proof threshold was changed to the civil standard – balance of probabilities. We are highlighting this change as important context for our data.

#### **Proposed wording for publishing data**

- 38** The project team have prepared a draft report with proposed wording for publishing the cause of death data at Annex C, which is based on our recommendations outlined above.
- 39** Our recommendation would be to use the proposed wording and to publish the first report in December 2021 (to allow a year's delay for coronial information).

## Executive Board

### Minutes of the Meeting on 27 January 2020 (extract)

#### Doctors who have died while in the fitness to practise procedures (item 3)

- 8 The Board received a paper setting out proposals to follow up our previous commitment to publish the numbers of doctors who die while under GMC investigation and the causes of death.
- 9 The Board noted the risks connected with publishing incomplete data and of inadvertently disclosing that an individual doctor was under investigation, the cause of their death and any serious health concerns we were investigating prior to their deaths.
- 10 The Board noted that:
  - a The risks relating to incompleteness of data and disclosing details that could be used to identify an individual doctor, as a result of the small number of cases involved, could be mitigated by publishing the data less frequently than annually.
  - b Categorising the cause of death was not always straightforward, especially with narrative verdicts or deaths abroad, but including that data was important to avoid the implication that all such deaths during an investigation were suicides.
- 11 During the discussion, the Board noted that:
  - a The proposals would be revised to incorporate more standardised causes of death; and to include plans to publish data (preferably with other regular Fitness to Practise data) at a frequency that reduces the risk of making it easier to identify individual doctors.
  - b Discussions would be convened with relevant stakeholders, including the British Medical Association, Professor Louis Appleby and GP Survival to ensure that the proposals address any concerns.



- 12** Having reviewed the risks, the Board agreed to proceed *in principle* with publication of the numbers of deaths and causes of deaths during investigations, but only when the proposals are right. The Board did not agree the proposed wording for publishing the data relating to numbers of death and causes of death, which were set out in Annex A to the paper.

## Doctors who have died while under investigation or during a period of monitoring

### Background

- 1 This report provides information about the number of doctors who have died while under investigation or monitoring for 3 year period between 1 January 2018 and 31 December 2020 and provides the cause of death where possible. We do not proactively collect nor do we publish this information for doctors who are not under investigation or monitoring.
- 2 The General Medical Council (GMC) investigates concerns raised about the fitness to practise of doctors. Our [investigating concerns factsheet](#) summarises the process that we follow when we open an investigation.
- 3 At the end of an investigation, we may agree restrictions with some doctors, which then results in a period of ongoing monitoring, until we receive sufficient evidence of remediation to allow that doctor to return to unrestricted practice. Further information can be found in this leaflet - [Information for doctors who have undertakings or conditions that affect their practice](#).
- 4 When we are aware that a doctor has died by suicide during our investigations, we conduct a significant event review (SER) to review our interaction with them.
- 5 Following a review that we undertook with leading mental health expert, Professor Louis Appleby, we implemented widescale changes to our fitness to practise process to reduce the impact and stress of investigations on doctors. Full details of these improvements can be found at <https://www.gmc-uk.org/about/how-we-work/corporate-strategy-plans-and-impact/our-impact/reducing-stress-for-doctors>.
- 6 As part of the changes listed above, we committed to improving our information about the cause of death of doctors in our fitness to practise processes and in January 2018 we introduced a new process for recording cause of death for doctors who die while they are under investigation or being monitored. We have introduced a more systematic process to obtain this information to help us to reflect on the impact of our investigation and

address any learning points as quickly as possible. We have committed to publishing statistics on the number and causes of deaths that occur during investigation or monitoring. This is the first report that we have produced on this topic.

## Data

- 7** The data used in this report covers a three year period from 1 January 2018 – 31 December 2020. We publish the data on a three year rolling basis to avoid the publication of data where there are very low numbers in order to avoid identification of sensitive information about doctors. We have delayed publishing the data by one year to ensure we have the most accurate and up to date information on cause of death as a result of coronial processes that can take time to complete. The dynamic nature of fitness to practise casework means that there may have been some minor updates to these numbers since the data was extracted.
- 8** Over the 3 year period (1 Jan 2018 – 31 Dec 2020) our records show that █ doctors died while under GMC investigation or monitoring. This is broken down as follows:

*Table 1: Number of doctors who have died while under investigation/monitoring for 3 year period between 1 January 2018 and 31 December 2020.*

Number of investigations carried out between 1 Jan 2018 – 31 Dec 2020	█
Number of doctors who have died while under investigation during this period	█
Number of doctors who have died while being monitored during this period	█
Total	█

- 9** Where possible, we have also sought to capture evidence on the cause of death for these doctors. We are generally able to obtain this information for those doctors who die while in the UK, however this has not been possible in some instances where the doctor has died overseas (recorded as 'other').
- 10** In order to mitigate the risk of identifying doctors who have died, we have broken the causes of death down into two broad categories of death: natural (including medical) and unnatural. We have also included a category of 'other/unknown' for those we are unable to obtain coronial records for or have yet to receive confirmation of cause of death.

*Table 2: Cause of death of doctors under investigation/monitoring for 3 year period between 1 January 2018 and 31 December 2020.*

<b>Cause of death</b>	<b>Number of doctors</b>
Natural (including medical)	■
Unnatural	■
<i>Number of which were suicide or suspected suicide</i>	■
Other/unknown	■