Executive summary

In September 2015 we asked Professor Louis Appleby, a leading mental health expert, to advise on a fundamental review of our approach to cases relating to a doctor’s health and help us develop proposals for improvement. These proposals were signed off by the Strategy and Policy Board in July 2016 and we are now in the implementation phase of the programme.

Several of the changes we are introducing relate to the way that we interact with doctors under investigation. As such, we have developed new guidance for Investigation Officers to provide support and practical advice on handling particularly vulnerable doctors in a number of situations. The guidance at Annex A, *Interacting with vulnerable doctors – identifying and responding to vulnerability* includes content on:

- How to handle interactions with a doctor that staff may find challenging
- Recognising signs a doctor may be unwell
- Seeking specialist advice
- Pausing an investigation.

Recommendation

The Board is asked to review and approve the ‘*Interacting with vulnerable doctors – identifying and responding to vulnerability*’ guidance included at Annex A.
Background

1 Fitness to Practise (FtP) staff interact regularly with doctors who are under investigation, in writing, on the phone and occasionally face to face.

2 We acknowledge that an investigation is a stressful experience for any doctor and, for those who are unwell, an investigation into their health concerns may be an additional stressor which increases their vulnerability.

3 Interactions with doctors under investigation may be complex and challenging on occasion, both for the doctor and for the member of staff managing the case. This may be because the doctor is unwell or it may be that the interaction is challenging because of the behaviour exhibited by the doctor. We have developed new guidance with contributions from Policy, Equality and Diversity, a medical case examiner, Petros and Learning and Development to assist FtP staff in these circumstances and best meet the needs of the doctor.

4 The aims of the guidance are to:
   a Better support staff in their role.
   b Improve the way that we support doctors who are undergoing an FtP investigation.
   c Ensure consistency in our approach to dealing with situations that staff may find challenging, both in terms of the way that we communicate with the doctor, but also in relation to how we determine what the next steps are in relation to the ongoing investigation.

The new guidance

5 The new guidance can be found at Annex A. It has been drafted to include content on:

   ■ How to handle interactions with a doctor that staff may find challenging

   This section of the guidance provides staff with advice on; keeping focus during an interaction, managing challenging interactions, managing repeat emails and phone calls, managing a face to face interaction and personal safety.

   ■ Recognising signs a doctor may be unwell – how to identify this and what to do

   This section of the guidance provides staff with advice on types of interactions and common behaviours that may highlight that a doctor is unwell.

   ■ Seeking specialist advice

   This section of the guidance highlights to staff that there may be occasional situations where it is appropriate to seek specialist advice from a medical case examiner on how to
handle interactions with a doctor during the course of an investigation. It provides a link to operational guidance on how to request this advice.

- Acting on information that a doctor may be unwell

This section of the document provides links to existing guidance outlining the considerations that should be made when health concerns arise during the course of an investigation.

- Pausing an investigation

This section of the guidance provides information on; when it is appropriate to pause an investigation, how to apply a pause, reviewing a pause and when to lift a pause.

- Signposting doctors to other organisations for support

This section of the document provides contact details for a number of useful organisations that staff may want to share with doctors who require additional support.

- Managing your personal well-being

This section of the document provides a link to various learning resources (written guidance and training courses) for staff to access, should they feel that they require additional support in relation to a number of related topics.

**Engagement**

6 We have sought views on *Obtaining specialist advice* and *Pausing an investigation* from a number of external organisations including the:

- British Medical Association (BMA)
- Practitioner Health Programme (PHP)
- Medical and Dental Defence Union in Scotland (MDDUS)
- Medical Defence Union (MDU)
- Medical Protection Society (MPS).

7 There are a number of related pieces of work ongoing within the GMC at the moment such as; the customer service strategy, the health, wellbeing and resilience programme run by the Learning and Development team (in conjunction with Petros) and the introduction of the new vexatious complaints policy. We have engaged with colleagues who have been involved in these initiatives to manage any interdependencies and ensure that our guidance closely aligns with these other strands of work.
We have also sought the views of various staff members who will be primarily using the new guidance to ensure that it is fit for purpose.

Generally, both internal and external stakeholders were positive about the guidance and any feedback that we have received has been carefully considered and incorporated into the final draft where possible.

Equality and diversity

We have considered the equality considerations associated with the introduction of the new guidance and have sought advice from the Equality and Diversity team in relation to this.

We have considered the specific impacts for doctors who are particularly vulnerable in this context, including some doctors with mental health conditions that could be worsened by the stress of involvement in our procedures, and those doctors at risk of suicide.

We consider that the introduction of this guidance is likely to have a positive impact on doctors in our procedures, particularly those who suffer with mental health conditions.
7 - Interacting with vulnerable doctors - identifying and responding to vulnerability

Introduction

1. This document contains guidance about:
   - How to handle interactions with a doctor that staff may find challenging
   - Recognising signs a doctor may be unwell – how to identify this and what to do
   - Seeking specialist handling advice
   - Acting on information that a doctor may be unwell
   - Pausing an investigation
   - Signposting doctors to other organisations for support
   - Managing your personal well-being

2. Fitness to practise staff regularly interact with doctors who are under investigation both in writing, on the phone and occasionally face to face. An investigation is stressful and doctors being investigated are potentially vulnerable. Some will have been referred to us because of concerns about their health. Others may become unwell due to the stress of life events that led to a GMC complaint and/or as a result of our investigation. Such interactions may be straightforward but they can also on occasion be complex and challenging, both for the doctor and for the member of staff managing the case.
Interactions that staff may find challenging

3 Occasionally an interaction between a staff member and a doctor may be perceived by that member of staff as challenging because of the behaviour exhibited by the doctor. This can create difficulty for both the doctor and the member of staff trying to help them.

4 The tips in this guidance are designed to help staff sensitively and confidently manage an interaction with a doctor that is perceived to be challenging and overcome any barriers. If a doctor or other individual appears to be distressed and at risk of harm (ie they have disclosed thoughts of self-harm or suicide) you must follow the steps in the policy *Lines to take when handling interactions with doctors, patients, complainants and witnesses where there is a risk of suicide or self-harm* or follow the steps in the interactive tool.

5 Typical types of behaviour that staff may perceive to be challenging to deal with are behaviours that put the doctor or those around them at risk, or impacts on the doctor’s ability to join in everyday activities. The behaviour may be underpinned by mental health issues but there may be other factors such as: the environment; situational factors; substance use or misuse; the dynamics of the current interaction; feeling defensive and cognitive impairment.

6 Some interactions which staff find difficult to handle may involve a disabled doctor. We have a legal obligation under the Equality Act 2010 to make reasonable adjustments for disabled people (including doctors). When you are handling interactions with someone who has a disability, focus on the barrier they are experiencing in engaging with us, and not on the disability – the tips and information in this guidance should help you to do that.

7 If you are struggling to engage a doctor in our processes after following this guidance please refer to your line manager for advice and support so the appropriate next steps can be taken.

Common behaviours displayed by a doctor which may present a barrier to effective interactions

8 Staff should be aware of common behaviours that may be displayed by a doctor which can present a barrier to an effective interaction:

- Disjointed conversation that jumps back and forth between ideas or thoughts - the doctor might ask you to do things without a clear reason.

- Erratic patterns of conversation - for example, taking a long time to respond or appearing confused or repeating themselves.
Muddled conversation – for example, the doctor’s speech may be slow or slurred and they may struggle to articulate themselves.

Ideas of persecution and paranoia - for example, making unusual comments concerning a perceived conspiracy or threat eg ‘everyone is out to get me.’

Mood swings or emotional behaviour such as being aggressive or tearful.

Negative thinking or not wanting to follow procedures because they don’t trust that it will deliver what they want.

Handling interactions with doctors who may require reasonable adjustments

9 Ask the doctor if they have communication and accessibility needs as soon as you begin to interact with them. Don’t make assumptions about what you think a person can or cannot do. The aim is to identify any potential barriers that the doctor might be facing, and adjustments that we may be able to put in place to make future interactions easier.

10 The TED technique (Tell, Explain, Describe) could open up a dialogue to help you find out what adjustments the doctor might need. Some questions you could ask using this technique are:

Tell

- ‘How can I help you?’ or ‘What can I do differently which might make things easier for you?’
- ‘I know I’ve given you a lot of information and it could be difficult to remember it all. Would you like me to summarise the key points in an email/letter?’

Explain

- ‘How would you like me to give this information to you?’ Or ‘What is the best way of me giving this information to you?’
- ‘What would you like to happen?’

Describe

- ‘What would you like to see as a solution?’
- ‘How would you like me to give this information to you?’ Or ‘What is the best way of me giving this information to you?’
- ‘I know I’ve given you a lot of information and it could be difficult to remember it all. Would you like me to summarise the key points in an email/letter?’
11 Managing the doctor’s expectations can mitigate anxiety and communication issues. For example, begin by clearly explaining your role within the team, the role of the GMC/MPTS and what we can and can’t do. Outline how often you will be in contact with the doctor and what information they will be asked to provide and when.

12 Acknowledge the emotional state of the doctor and express empathy. For instance if the doctor is angry then acknowledge the anger, ‘I can hear that you are angry’, even if it is directed at you or your actions. You can acknowledge the way a doctor feels without accepting their interpretation of events. Then ask them how you can move forward together to achieve the best possible outcome.

13 Use statements that are neutral or supportive to reinforce that you have been listening actively and sensitively and help move the conversation along. These statements could include:

- ‘I am very sorry that you are experiencing-going through this.’
- ‘It sounds like an upsetting/frustrating situation/time for you.’
- ‘It sounds like you’re having a difficult time.’

14 Summarise the information the doctor has told you. This demonstrates active listening and fosters joint understanding. Use phrases like:

- ‘I think what you’re saying is.. have I understood you correctly?’
- ‘I think you want me to do x, y and z – is that right?’

Where process adjustments may be required

15 There may be occasions where a doctor’s frustration is because there is something unusual about their circumstances that means that our usual procedures are not appropriate in their case. When dealing with a doctor who is expressing frustration, it is important to listen to what they are saying and seek to gain an understanding of their individual circumstances.

16 If you think that our usual procedures are not appropriate in the doctor’s case, you should speak to your line manager to discuss what adjustments may need to be made to our usual approach to deal effectively and appropriately with the doctor’s circumstances.

17 Line managers should also escalate any concerns in order to get senior approval for unusual adjustments where necessary.

Signposting to other organisations for support

www.gmc-uk.org
18 If you cannot help the doctor any further, or you think they might benefit from specialist support, it may be appropriate to signpost them to an organisation who can help them deal with their specific needs e.g. Samaritans or Doctor Support Service (see Annex A for a list of organisations). Signposting to other organisations can be sensitively raised with an individual by asking the following:

- ‘It sounds like you have had a lot to deal with. I would like to be able to help you further but I think it is out of my expertise. There are a lot of other organisations that you could talk to. Would you like me to give you their contact details so that you can contact them?’

- ‘I appreciate that it helps to talk about the situation. I can help you with X, but I am not able to help you with Y. However, I can suggest some options for where you might be able to find further help with Y, if you would like.’

**Maintaining focus during an interaction**

19 If you are finding it difficult to get relevant information during your interaction, then you could try asking closed questions one at a time. A closed question requires a yes or no response and doesn’t require any additional detail from the doctor. This will focus the conversation and add structure. This can help overcome other communication barriers (including where English is not the doctor’s first language) and move the interaction along.

**Managing abusive interactions**

20 If a doctor becomes abusive, you should politely ask them to modify their behaviour and explain that you find it unacceptable and will end the call if it continues. If the behaviour does continue you should remind them that you have given them an opportunity to modify their behaviour and end the call. Our corporate policy on unreasonable behaviour is for the manager of the member of staff involved to then send a written warning, with a view to limiting future communication to written only. We may make an exception to this in circumstances where we know that the doctor is unwell and they have since modified their behaviour. Below are some practical steps to help you manage abusive interactions:

- Remain polite, professional and assertive

- Describe the behaviour you find abusive and advise the doctor that you will end the conversation if it continues. Eg ‘when you refer to my colleagues as “insert customer’s actual words” I find it offensive and unnecessary. Please stop doing it or I will be forced to end the conversation.’
Be honest about what you can do. If you are unsure how to deal with the situation tell the doctor that you will need to speak to your line manager. Tell them when they can expect to hear back from you.

Don’t try to talk over the doctor or interrupt them if they are in mid-flow. This may make them angrier. Let them finish what they are saying and remain silent for a few seconds after they have run out of things to say before responding. If the doctor interrupts, tell them that you have listened carefully and would be grateful if they could extend you the same courtesy. Don’t be afraid of silences.

End the conversation if you feel that it is continuing to be abusive. Explain politely that the conversation cannot continue under the circumstances and that you’re going to hang up. Advise the doctor that they may call back and continue the conversation but it will be terminated again if the abusive behaviour is repeated.

If you’re dealing with the doctor face to face make sure that you are aware of the local security protocol and alert the appropriate colleague to assist if you need a doctor to leave the premises.

21 After the interaction, seek support and advice from colleagues and your manager on appropriate next steps. Discuss any thoughts or feelings this interaction may have brought up and take time to process this before starting another task or taking another call.

22 We have corporate guidance in place on how to deal with unreasonable behaviour and vexatious complaints which may be relevant in these instances.

23 Further support for staff, including links to training modules to help build resilience, is outlined at Annex B.

**Managing repeat emails and phone calls**

24 Receiving repeat emails or phone calls can be difficult and frustrating to deal with. If the query has been answered and emails or phone calls continue then following the steps below may be help to break the loop:

- Remain calm and assertive but not aggressive in your responses
- Recap any previous contact recorded on SIEBEL; what they have needed and what you have helped them with in the past
- Ask the doctor what they are hoping to get out of the interaction - don’t get involved in a discussion or an argument
- Remind the doctor that you will contact them with an update in the timeframe you set out during your initial response, and patiently explain when to expect this.
Seek support from a line manager if the emails or phone calls from the same doctor persist. Further support for staff, including links to training modules to help build resilience, is outlined at Annex B.

Managing a face to face interaction

25 Some areas of the business (eg Patient and Doctor Liaison Service) will have challenging face to face interactions with doctors. This can be difficult, particularly if the behaviour is unexpected, but there are some steps that staff can take to manage the interaction:

- Use a reassuring tone and display positive body language – nod and use active listening skills to show understanding
- Listen sensitively – allow the doctor a chance to express how they are feeling and don’t interrupt them, unless necessary
- Offer a tissue or glass of water to the doctor if they become upset and reassure them that they can take some time to gather their thoughts. Offer to leave the room for a few minutes if the doctor is uncomfortable being upset in front of you
- If you think that the doctor might find the meeting upsetting, suggest that they may wish to bring someone with them to support them eg a friend or member of the family
- If the doctor becomes angry then acknowledge the anger and explain that it is making you uncomfortable. Offer to leave the room to give them a few minutes to compose themselves before continuing the conversation

26 Alert a colleague once you leave the room if you feel unable to manage a face to face interaction alone. They can provide support to remove a doctor from the premises if this is necessary.

27 It is our policy to avoid making physical contact with individuals, although it may be your natural instinct to comfort someone in distress. This is to protect your own safety and the professional boundaries of the relationship. Offering a glass of water or a tissue is a more neutral gesture.

How can I manage my own personal safety?

28 You should consider your personal safety and professional boundaries. Before meeting a doctor face to face, it may be helpful to ask the following questions:

- Does the information you have received indicate that the individual has a history of violence or drug abuse?
- Does the location of the interaction provide a risk to personal safety? Would offering a telephone meeting instead of a face to face interaction be a better option?

- Are there any other factors which lead you to think that the doctor may be a risk for any other reason?

29 Further information about maintaining your personal safety during face to face interactions is available on the intranet.

30 It is important to note that a doctor displaying behaviour that may be challenging for an Investigation Officer to deal with may be a sign of a health problem. Further guidance on what to do in this situation is set out below.

**Guidance for staff on recognising signs a doctor may be unwell - how to identify this and what to do**

31 It is important that we are aware of a doctor’s state of well-being so that, where appropriate, we can take this into account in our communication with a doctor.

32 Human interactions and communications are complex and it would not possible to provide ‘rules’ for the infinite variety of possible encounters.

33 This guidance is intended to supplement training and to aid staff in thinking about the signs that a doctor may be struggling to cope or becoming unwell.

**How might you become aware that a doctor is unwell?**

*Self-reporting*

34 A significant number of doctors declare mental or physical health issues during a GMC investigation. It is important to remember that a person’s state of well-being can vary from day to day. Even if you are aware of an existing health problem, remember to consider whether there may have been a change in a doctor’s health during an investigation.

*Direct telephone communication*

35 It may not be appropriate to ask directly about a doctor’s health during a routine telephone conversation, but it would be reasonable as a matter of courtesy-establishing rapport to ask ‘How are you Dr X?’ If a doctor reports that they are feeling unwell/stressed/overwhelmed you should acknowledge and discuss this where appropriate. You should also record this as important information.
36 Even, if you are aware of an existing health problem you should record the details of any reported change in well-being and agree with your line manager what (if any) action is required in response.

Written communication

37 Written correspondence (e-mail and letter) may also contain information about a doctor’s health. The written correspondence may be a direct communication from the doctor or information from third parties (eg Local investigation, comment from treating doctors and NCAS reports). Such information is also important and any reference to mental health problems, stress or vulnerability (past or present) should be noted and discussed with your line manager.

Face to Face Meetings

38 The GMC occasionally meets face to face with a doctor for a specific purpose (eg during a performance assessment or at a doctor meeting). During such encounters, GMC staff will interact with the doctor and it is important that any relevant health information disclosed is recorded and brought to the attention of the person who is managing the investigation.

Third party telephone communication

39 Telephone contact with third parties (eg treating doctors, colleagues or relatives) may also contain information about a doctor’s health. You should record the details of the third party and any information they provide. Such information is important and any reference to mental health problems, stress, vulnerability (past or present) should be noted and discussed with your line manager.

40 However, you should not disclose sensitive information we hold about a doctor’s health unless the doctor has previously consented to its potential disclosure to other relevant parties or there is an immediate need to breach confidentiality because of the risk the doctor might pose to themselves or others.

Types of behaviour that may suggest that a doctor is unwell

41 The following types of behaviour or communication should prompt you to ask yourself whether the doctor could be unwell.

| Suicidal thoughts or self-harm | Serious or persistent negative ways of thinking or talking. | Anger |
| Severe feelings of anxiety | Failure to respond to communication, or | Tearfulness |
| Dissociation, unusual ways | | Irritability |
| | | Poor memory, difficulty |
### Executive Board meeting, 24 July 2017  
**Agenda item 7 – Interacting with vulnerable doctors – identifying and responding to vulnerability**  

<table>
<thead>
<tr>
<th>of thinking</th>
<th>excessive frequency of communication.</th>
<th>recalling facts or events</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delusions</strong></td>
<td><strong>Failure to meet deadlines</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Rapid or severe fluctuations in mood</strong></td>
<td>Changes in appetite, weight, sleeping patterns</td>
<td></td>
</tr>
<tr>
<td>Pressurized and rapid speech</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Suicide or self-harm

42 You must take these types of thoughts or actions very seriously and follow the approach outlined in the FtP suicide policy tool and/or the guidance ‘Lines to take – handling interactions with doctors, patients, complainants and witnesses where there is a risk of suicide or self-harm’.

### Emotional distress and anger

43 Being under investigation by the GMC can lead to upset, frustration and negative ways of thinking and it is possible that doctors will show this type of behaviour. However, these can also be signs of emotional distress and even illness, especially when this is serious or persistent or is different to previous interactions with the doctor.

44 Doctors may be angry or confrontational as a result of the investigation and its consequences and this is not necessarily the result of illness. Some people can lose their temper or show signs of irritability/rudeness, when they become frustrated. They may also calm down and moderate their behaviour if spoken to in a reasonable way. However, signs of extreme anger, volatility or irritability that the doctor appears to be unable to control or that is evident in every communication can be a sign of illness.

### Depression and low mood

45 Depression and low mood can severely affect how a doctor functions, or the way that they engage with us. People affected by depression can sometimes find it very difficult to formulate and express thoughts and ideas (e.g. long pauses, mumbling, very quiet or hesitant way of speaking)

46 In telephone calls it might seem that a doctor is reluctant or unwilling to talk with you, or they may seem unable to focus on the matter under discussion. Sometimes people who are depressed or anxious feel that they are detached from their situation as if it isn't real. This type of behaviour and thinking may be easier to detect when you have had previous contact with the doctor. Although it might appear as if the doctor is being evasive, rude, or inappropriately sarcastic or jovial this could also be a sign that they are unwell.

[www.gmc-uk.org](http://www.gmc-uk.org)
Failure to respond to communication or deadlines

47 Although some doctors may consciously disengage from communicating with the GMC, people suffering from depression sometimes do not feel that they have enough energy or concentration to be able to respond to correspondence or deadlines. People suffering from depression sometimes avoid official correspondence or even withdraw from contact with almost everyone they know because they feel overwhelmed by such encounters. If the doctor has previously engaged with the GMC and then fails to respond, don’t assume that this is always a ‘non-compliance’ issue; consider also whether the doctor may have become unwell.

48 Anxiety and depression can cause significant ‘biological’ changes and these may be reported by the doctor or in correspondence. Some types of mental health problem can lead to very rapid ‘highs and lows’ of mood and can make communication unpredictable. People suffering from, for example, bipolar disorder can sometimes seem elated, overly talkative or irritable and may express very grand ideas about their plans or their own importance. Sometimes in the hypomanic phase of a bipolar illness, because thoughts are racing, a person may send multiple communications where the ideas are difficult to follow or seem only loosely connected.

Delusions and unusual ways of thinking

49 Some severe types of mental health problem can lead to disordered thoughts and a person might make unusual connections between themselves and events to which they have no obvious link. This might also include fixed, unshakeable beliefs that seem illogical or are plainly untrue but the person believes them; these are known as delusional beliefs.

Seeking specialist handling advice

50 There may be instances where you feel you would benefit from obtaining specialist advice on how to communicate with a doctor during the course of an investigation.

51 This is likely to arise in situations where:

- it is known from the outset that the doctor concerned is suffering from a specific disorder which may require us to tailor our approach to communications

- you think the doctor that you are in communication with is showing signs of illness that we are not previously already aware of

52 If either of these situations arise of you should speak to your line manager about how to respond in the first instance. They may advise you to seek advice from the Communications Investigation Team on the best way to handle subsequent interactions with the doctor, or may recommend that you seek advice from a medical Case Examiner.
53 Handling advice requests should be sent to a medical Case Examiner who has a special interest in mental health and should be made following the process outlined in our Guidance for staff on requesting specialist handling advice during the course of an investigation.

54 There may be very occasional circumstances where a Case Examiner feels that we would benefit from a second opinion from one of our associate health examiners or medical supervisors. In these instances it is important that we get the doctors consent to discuss their sensitive personal information with someone outside of the GMC. If consent is not given we are unable to proceed with our request for this advice and should continue communicating with the doctor in line with our normal processes.

55 Any specific handling advice obtained should be clearly recorded on Siebel on a Communication Plan so that anyone else who may need to correspond with the doctor during the course of an investigation can follow these instructions. The Communications Investigation Team will be able to advise you on how to complete a Communication Plan.

**Acting on information that a doctor may be unwell**

56 It may be necessary to review our approach to an investigation when we receive information that suggests a doctor is unwell, particularly if we know that the doctor is working and the concerns may present a potential patient safety risk.

57 In these instances you should refer to:

- Guidance for decision makers on assessing risk in cases involving health concerns
- Guidance for decision makers on assessing the impact of health in conduct and conviction or caution cases

58 If from the information you hold (such as a view of a treating doctor) it is clear that the doctor is so extremely unwell, it may be appropriate to pause the investigation for a defined period to enable them to obtain treatment. Further guidance is set out below.

**Pausing an investigation**

**Where concerns relate solely or mainly to the doctor’s health**

59 In circumstances where a doctor is very unwell and struggling to engage with us, an Assistant Registrar (with advice from a medical case examiner where necessary) may offer a time-limited pause (for a maximum period of 6 months) to allow the doctor sufficient space to seek treatment without being regularly contacted with updates about the investigation. During this time, we will cease our investigation but will continue to...
monitor the doctor’s health. We will do this by liaising with their advocate, treating physician or general practitioner (GP), but will not communicate with the doctor directly. The investigation will be resumed once the pause has been lifted.

**Obtaining information about a doctor during a pause**

60 Where a case is known to involve concerns about the doctor’s health, the investigation officer should seek consent from the doctor to contact their treating psychiatrist or GP in circumstances where they have become too unwell to engage with us. This is to ensure that we can continue to obtain information about a doctor and that we support them appropriately. In the absence of consent, we may still request information from the doctor’s treating psychiatrist or GP by exercising our powers under Section 35A of the Medical Act 1983 if the information is relevant to the discharge of one of our functions, which in this case would be our statutory duty to investigate fitness to practise concerns. The information requested should be limited to that which is necessary to fulfil this function.

**Disclosing information about a doctor during a pause**

61 In some circumstances, particularly where we are seeking information about a doctor’s health, we may wish to disclose information about the context of our investigation to a doctor’s treating psychiatrist or GP. Before we make a limited disclosure we need to acknowledge our duty of confidentiality to the doctor and seek their consent where this is possible. Without express consent, a limited disclosure about the doctor’s case may still be justified through our discretionary powers under S35B of the Medical Act if it is necessary to support our statutory duty to investigate and is proportionate.

62 In limited circumstances, particularly where we are seeking information about a doctor’s health, we may wish to disclose information about the context of our investigation to a doctor’s treating psychiatrist or GP. Before we make a limited disclosure we need to acknowledge our duty of confidentiality to the doctor and seek their consent where this is possible. Where we have been unable to obtain consent, sharing information about the doctor’s case may still be justified through our discretionary powers under S35B(2) of the Medical Act if such disclosure is in the public interest. We need to balance our legal obligations under the DPA, Art 8 and the duty of confidence owed to the doctor against the public interest.

63 However, if the doctor has expressly refused consent to share information about their case, it is unlikely that we will be able to justify sharing information about their case with their treating psychiatrist or GP under 35B(2).

**Multi-factorial cases**

64 If a case is multi-factorial (i.e. the doctor’s fitness to practise is alleged to be impaired on grounds of misconduct, language, a criminal caution/conviction or performance as well
as health) an investigation cannot be paused as information will still need to be gathered to evidence the concerns relating to the misconduct or performance element, whilst ensuring that public safety is protected. However, it may be possible to stop communications if the doctor is particularly vulnerable. Please follow the Guidance and Protocol for the use of the stop communication flag or speak to the Communication Investigation Team to explore this further.

Circumstances where investigations may be paused

65 Being the subject of a fitness to practise investigation can be an extremely stressful experience for a doctor, particularly those who are unwell. However, few doctors in our processes will be unwell to the extent that they are unable to work and engage meaningfully with an investigation. For those doctors who are very unwell due to physical or mental ill-health, we may be able to offer additional support by applying a pause to their investigation whilst they seek treatment or specialist communication.

66 The factors we will consider when deciding if we may apply a pause to a doctor’s case include circumstances where:

- A doctor is an inpatient as a result of a serious medical condition (this could include circumstances where they have suffered a road traffic accident or they have been detained under the Mental Health Act)
- A doctor is seriously unwell due to mental ill health and undergoing treatment (eg a doctor with a severe addiction has entered a detox programme)
- A doctor is seriously unwell due to physical ill health and undergoing treatment (eg chemotherapy)
- A doctor is seriously unwell and life stressors or significant events have further impacted on their mental or physical well-being. For example a doctor is seriously unwell and they are adversely impacted by the death of a close relation.
- We receive information that a doctor is suicidal

67 When an investigation officer identifies that a doctor is seriously unwell and experiencing difficulties engaging with an investigation they should escalate this to an assistant registrar without delay to consider whether a pause is appropriate. A pause will only be appropriate where it can be introduced without a risk to the public for example because we have reliable assurance that the doctor is not working and will not seek to work or because there are interim restrictions in place to manage any risk to the public. The assistant registrar must carefully consider each case on an individual basis taking into account the factors at paragraph 65, public safety and our statutory duty to investigate and whether the pause would be in the best interest of the doctor. Advice should be sought from a medical case examiner where necessary.
Offering a pause to the Doctor

68 Once an assistant registrar (with medical case examiner advice where necessary) has decided that a pause may be appropriate, the doctor, their legal representative or their union representative (where they have given explicit permission for the union to act on their behalf) must be contacted to seek their consent before the pause is applied to the investigation. The only exceptions are circumstances where we have robust evidence that the doctor does not have capacity to make this decision (eg they have been detained under the Mental Health Act or they are suicidal). In these circumstances we may decide to apply a pause to the investigation in the best interests of the doctor.

69 The assistant registrar (with medical case examiner advice where necessary) must also consider whether the case should be referred to the Interim Orders Tribunal to place restrictions on the doctor’s practice in the interest of protecting patients (see paragraph 74). If the doctor is referred to the Interim Orders Tribunal the notification letter must be sent to the doctor before the pause to their investigation is applied.

Applying a pause

70 When a pause is applied to a doctor’s investigation, the assistant registrar and medical case examiner must explain how the decision was reached and the reasons why the doctor was not contacted directly (if this is the case).

71 Once a pause is applied, the investigation officer must schedule a review of the pause to occur within 2 – 3 months. They should also add a note to the case or update the communication plan detailing the doctor’s treating psychiatrist, GP or other nominated person who is providing details of the doctor’s health and how often they should be contacted.

Reviewing a pause

72 When reviewing a pause on an investigation the assistant registrar should ensure that recent evidence has been gathered that reflects the doctor’s current health before deciding whether to lift or extend the pause. An assistant registrar should obtain a medical examiner’s input before deciding to lift the pause.

73 If the doctor has been discharged from an inpatient facility, the assistant registrar should be mindful that the doctor may still be in an advanced stage of an acute illness and seek advice from a medical case examiner where necessary about whether the pause should be lifted.

74 Advice from a medical case examiner may also be needed about whether a pause should be lifted where evidence about the doctor’s health is limited (eg we have
received information that the doctor’s health has improved but their condition may be subject to fluctuation and could become worse).

**Interim orders**

75 If a decision maker has directed that an interim orders hearing or review hearing is required to protect patients we must fulfil our legal duty[1] to notify the doctor. Even in the event of a paused investigation, the notice of hearing must be served to the doctor directly unless they have given explicit permission for a legal representative, union representative or appointed power of attorney to accept service on their behalf.

76 If the doctor does not have an appointed legal representative, union representative or power of attorney, we may seek assistance from an appropriate advocate (such as the doctor’s treating psychiatrist, General Practitioner or medical supervisor) to facilitate serving notice of the interim tribunal hearing to the doctor. Advice on how to approach serving the notice in this circumstance may be sought from the Communication Investigation Team. However, in circumstances where we have exhausted both options and we are still unable to serve notice on a very unwell doctor in line with our legal duty, advice should be sought from the legal team to explore alternative approaches.

**Early review hearings**

77 If the doctor’s circumstances have changed (eg they have been discharged from an inpatient facility) and more than three months have passed since an interim order has been imposed, it may be appropriate to schedule an early review hearing. This hearing will review the order to ensure that it is appropriate to protect public safety and that it is in the best interests of the doctor. It will also provide the doctor with an opportunity to make representations to the tribunal.

[1] Notice of hearings must be served in accordance with Schedule 4, paragraph 8 of the Medical Act 1983 and Rule 40 of the Fitness to Practise Rules 2004

www.gmc-uk.org
Annex A – List of organisations providing support for doctors

Support for doctors

- **The Doctor Support Service** - a confidential support service for doctors undergoing GMC fitness to practise investigations. This service is funded by the GMC and delivered by the BMA.

  Tel: 020 7383 6707 (Lines are open Monday – Friday, 9am – 5pm)

- Medical Defence Organisations - these organisations will often provide medico-legal advice and support to their members:
  
  i. **The Medical Defence Union (MDU)**
  
  ii. **The Medical Protection Society (MPS)**
  
  iii. **The Medical and Dental Defence Union of Scotland (MDDUS)**

- **NHS Practitioner Health Programme (PHP)** is a free confidential service for doctors with mental or physical health problems. It covers London and some surrounding areas (see website for more details).

Doctors working in the London area

- All referrals are self-referrals – doctors can either refer themselves by phone on 020 3049 4505 or via email.

Doctors working outside of the London area

- For practitioner patients who live outside of London direct self-referrals are not accepted, however, NHS referrals can be accepted on a cost per case basis.

  contact the PHP team on 0203 049 4504 for details

GPs and GPs in training

- PHP has a service for GPs and GP Trainees in England to help with issues relating to a mental health concern, including stress or depression, or an addiction problem, in particular where these might affect work

  All referrals are self-referrals – doctors can either refer themselves by phone on 0300 0303 300 or via email on gp.health@nhs.net.
Mental Health

- **The Samaritans** - Samaritans is available 24 hours a day for anyone struggling to cope and provide a safe place to talk where calls are completely confidential.
  
  Tel: 116 123
  
  Email: jo@samaritans.org

- **MIND** - Mind is a charity that provides advice and support to power anyone facing mental health problems
  
  Phone: 0300 123 3393      Text: 86403

Local support

- **It's Good to Talk** - a search tool to find local therapists

- **General Practitioner** - discussing mental health concerns with a GP is a good first step to accessing local support

Disability

- **Stroke Association** - support for people who have suffered a stroke
  
  Tel: 0303 3033 100
Annex B - Staff Resources

Managing personal well-being

It is important to take time to reflect after a challenging interaction and process any thoughts and feelings that may have arisen during the conversation. Make sure that you take a break, get some fresh air and recharge before you start another task. It may also be helpful to discuss the issues you encountered with your line manager, well-being champion or another colleague you feel comfortable with. You can explore the resources below to support your overall wellbeing and resilience.

- **SkillPills** tutorials and related self-led activities including topics such as dealing with conflict, disagreeing nicely, managing unconscious biases, negotiating without conflict, active listening and influencing without authority

- Guides on reflective practice and action learning sets to aid you in embedding the learning from our classroom sessions

- **Tips on building resilience and managing wellbeing** - including a presentation on ‘The role of intuition in resilience.’

- **Lines to take when interacting with vulnerable customers** and guidance on Interacting with customers who are suffering bereavement

- **Health & Resilience toolkit** for managers, alongside models for effective 1:1s, coaching, feedback, team meetings

L&D have developed a package of workshops around mental health awareness and handling challenging interactions. Please visit the L&D portal to book any of the below and for more information.

- **Customer Service at the GMC** – ½ day

- **Building Resilience** – Full day

- **Mental health Awareness** – ½ day

- **Handling Challenging Interactions** – Full day (with actors)

- **Supporting Staff with Challenging Interactions** – ½ day

**The Employee Assistance Programme** is a confidential counselling and information service available to GMC staff members offering advice on work related issues, personal problems, practical issues and family care services. AXA PPP's freephone number for

www.gmc-uk.org
free confidential advice and support for you 24 hours a day, 365 days a year is: 0800 072 7 072

81 Speaking to your GP about stress/mental health issues is a good first step to accessing local support.