

Guidance for staff on recognising signs a doctor may be unwell and pausing an investigation

- 1 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.
- 2 Human interactions and communications are complex and it would not possible to provide 'rules' for the infinite variety of possible encounters.
- 3 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

- 4 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

- 5 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.
- 6 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

- 7 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

- 8 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

- 9 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.
- 10 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 the third party you are speaking to 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

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

Suicidal thoughts or self-harm Severe feelings of anxiety Dissociation, unusual ways of thinking Delusions	Serious or persistent negative ways of thinking or talking. Failure to respond to communication, or excessive frequency of communication.	Anger Tearfulness Irritability Poor memory, difficulty recalling facts or events
---	--	---

Rapid or severe fluctuations in mood	Failure to meet deadlines	
Pressurized and rapid speech	Changes in appetite, weight, sleeping patterns	

Suicide or self-harm

- 12** 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

- 13** 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.
- 14** 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

- 15** 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 (eg long pauses, mumbling, very quiet or hesitant way of speaking)
- 16** 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.

Failure to respond to communication or deadlines

- 17** 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.
- 18** 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

- 19** 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

- 20** 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.
- 21** 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.
- 22** If either situation arises, 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.
- 23** Handling advice requests should be sent to a medical Case Examiner who is in the health group and should be made following the process outlined in our *Guidance for staff on requesting specialist handling advice during the course of an investigation*.
- 24** There may be very occasional circumstances where a Case Examiner recommends that we would benefit from a second opinion from one of our associate health examiners or medical supervisors. This may be because they would like input from a specific speciality, or because the request is particularly complex.
- 25** In these instances it is important that sensitive personal information about the doctor or any third party is anonymised in all conversations and correspondence. Any documents from the doctor that are required for the discussion must have all identifiable information redacted prior to sending to the medical supervisor.
- 26** 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

- 27** 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.
- 28** 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](#)
- 29** 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

- 30** 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) during the investigation (ie. Before Rule 8) to allow the doctor sufficient space to seek treatment without being regularly contacted with updates. 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.
- 31** In post Rule 8 cases where a doctor is very unwell and struggling to engage with us and a pause is considered appropriate in order to enable the doctor to obtain treatment, we should seek to list the hearing as soon as possible so that a postponement may be sought on the grounds of health.

Where concerns about a doctor are multi-factorial

- 32** In most cases where the doctor's case is multi-factorial (ie 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) we will not be able to offer a pause because we have a statutory obligation to investigate and delaying our gathering of information may undermine our statutory purpose (such as where a delay causes evidence to 'go cold' or causes public confidence concerns in cases involving serious conduct or performance concerns). If we consider that a doctor with concerns that are multi-factorial is too unwell to engage, a communications preference plan should be explored with the communications team to limit the impact our investigation has on the doctor's health.
- 33** There may be some exceptional circumstances where the concerns about a doctor are multi-factorial and we are able to offer a pause for example, if the concerns relate to health and criminal matters and we are awaiting the outcome of criminal proceedings. Another example may be where a health case and a case under another head of impairment are open concurrently and it is deemed appropriate to offer a pause on the health only case while the doctor seeks treatment.

Obtaining information about a doctor during a pause

- 34** 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

- 35** 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 data protection legislation, Article 8 of the Human Rights Act and the duty of confidence owed to the doctor against the public interest.
- 36** 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) during a pause.

Circumstances where investigations may be paused

- 37** 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.
- 38** 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
- 39** 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 67, 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

- 40** 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 agreement 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 there may be evidence that a doctor lacks capacity in situations where 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.
- 41** 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

- 42** 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).
- 43** 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

- 44** 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.
- 45** 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.
- 46** 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

- 47** 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.
- 48** 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

- 49** 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