

This report includes sensitive data about doctors who have died by suicide while in our processes

**General
Medical
Council**

Supporting vulnerable doctors

Report on doctors who have died while under investigation or during a period of monitoring

This report includes sensitive data about doctors who have died by suicide while in our processes

About the report

If we decide we need to investigate a doctor's practice, we know it can be a difficult time for everyone involved. Complaints can be extremely distressing for doctors, patients and their families. Although we've come a long way in improving how we handle them, we continue to seek and act on feedback to make sure our processes are efficient, effective and as supportive as possible at every stage.

Following an [independent review](#) we commissioned in 2014 about the tragic deaths of doctors by suicide while under investigation, we appointed leading mental health expert, Professor Louis Appleby, as an independent expert, to advise us on how we could make our interactions with doctors more sensitive, supportive and compassionate to their needs.

We implemented all his recommendations to reduce the impact and stress of our processes as much as possible and as part of this work, in January 2018, we introduced a new process for obtaining and recording the cause of death of doctors who die while they're in our fitness to practise procedures. Any suicide is tragic and when it happens, we want to ensure that we can identify and act on any lessons as quickly as possible.

We've committed to publishing this information annually. Our first report provides information about the number of doctors who have died while under investigation or monitoring between 1 January 2018 and 31 December 2020 and the cause of death, where possible. In future, we'll publish this data annually with our fitness to practise annual statistics.

Preparing this report

In preparing this report, as well as consulting closely with Professor Louis Appleby, we consulted a range of organisations on its format and the timing of publication. This included the British Medical Association, NHS Practitioner Health (formerly Practitioner Health Programme), the Medical Defence Union, the Medical and Dental Defence Union of Scotland and the Medical Protection Society.

About our processes

The General Medical Council (GMC) investigates concerns raised about the fitness to practise of doctors. Our [investigating concerns page](#) summarises the process that we follow when we open an investigation.

We may conduct a provisional enquiry, which is a limited, initial enquiry at the triage stage of the fitness to practise process to help us decide whether to close the complaint or open a full investigation.

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](#).

When we are aware that a doctor has died by suicide while under investigation or monitoring, we conduct a significant event review (SER) to review our interaction with the doctor. This allows us to identify any lessons to be learned or changes to be made to our processes or interactions.

The following [support is available for doctors who are in our fitness to practise processes](#).

2018 – 2020 data

When we are notified of a doctor's death, we request a copy of the death certificate from either the individual notifying us of the death or the relevant coroners' office. Once this is received, we record the cause and date of death on our system (using the cause of death stated by the coroner). We've used the data recorded on our system to produce this report.

The data used in this report covers a three-year period from 1 January 2018 – 31 December 2020. We will 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 publish the data at least 12 months in arrears 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.

Over the three-year period (1 Jan 2018 – 31 Dec 2020) our records show that 29 doctors died while under GMC investigation or monitoring. This is broken down as follows:

Number of investigations opened between 1 Jan 2018 – 31 Dec 2020:	5,370
<i>Provisional</i>	<i>1536</i>
<i>Full</i>	<i>3834</i>
Doctors who died while under investigation during this period	19
Doctors who died while being monitored during this period	10
Total	29

Number of doctors who died while under investigation or monitoring between 1 January 2018 and 31 December 2020.

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 which are recorded in a category of 'other/unspecified'.

In order to mitigate the risk of identifying sensitive information about doctors who have died, we have broken the causes of death down into two broad categories: natural, and deaths from external cause(s) (including suicide). We've used the term 'deaths from external cause(s)' based on advice about terms used by the Office for National Statistics (ONS).

Those where we are unable to obtain coronial records or have yet to receive confirmation of cause of death are recorded in the 'other/unspecified' category.

We rely on the cause of death recorded on the death certificate for our data on cause of death of doctors who have died while under investigation or during a period of monitoring. Where a doctor's cause of death is undetermined or where the coroner issues an open or narrative verdict, we have recorded the deaths in the 'other/unspecified' category. There is therefore a possibility that we may be unaware that a doctor has died by suicide and that the figures we hold may be an underestimate.

Cause of death	Number of doctors
Natural	20
Deaths from external cause(s)	6
<i>Number of which were confirmed as suicide</i>	<i>5</i>
Other/unspecified	3

Cause of death of doctors under investigation/monitoring for the three-year period between 1 January 2018 and 31 December 2020.

Note: for any causes of death where less than three deaths have occurred during a three-year rolling period, we will record this as '< 3' to avoid any risks of identification.

Ongoing work and future reporting

We will continue to listen to feedback to identify further improvements that we can make to our processes or how we communicate with doctors. If any improvements can be made, we will move with pace to implement them.

We have committed to routinely collect and publish this data and, in future, this will be included alongside the fitness to practise annual statistics.