General Medical Council

Supporting vulnerable doctors programme

Changes to better support doctors under investigation

December 2020

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Foreword

In 2015, Professor Louis Appleby began working with us to review our fitness to practise process. The aim of the review was to identify what changes we could make to our investigation process to reduce the stress and impact it had on doctors – particularly those with health concerns. In a blog, Professor Appleby explained how he drew on his experience in suicide research, including the fact that suicides often occur in people not thought to be at risk. He emphasised that suicide was rarely caused by one thing and that prevention would require a comprehensive look at how investigations worked.

> "The GMC can now turn a tragic problem into positive steps that others can follow. It can make mental health safety a thread that runs throughout the organisation, influencing training, standards, leadership & culture. A permanent focus on mental health safety will help doctors who might otherwise be at risk of suicide but it can go further – in time it can extend the potential benefits of these proposals to patients and staff" **- Professor Louis Appleby**

Professor Appleby worked closely with policy teams, looking at each step of the investigation process from when a complaint is received to when the case closes or, in a minority of cases, gets referred to tribunal.

This review resulted in a set of proposals for improvement, in total over twenty-five changes to our investigation process which have now all been fully implemented. In a subsequent blog in May 2018, Professor Appleby acknowledged the positive impact of these changes commenting "Some of the processes have seen real improvements that I feel confident will make a difference."

This report aims to highlight the key changes following this programme of work and the positive impact the changes have had on doctors under investigation. It is important that this is not the end of the process however and, going forward, we will continue to seek and act on feedback on how our investigation procedures can be further improved to reduce their impact on vulnerable doctors.

Professor Louis Appleby is a Professor of Psychiatry at the University of Manchester and Director of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. He leads the National Suicide Prevention Strategy for England and is a Non-Executive Director of the Care Quality Commission.

Why we commissioned Professor Appleby

In 2014 we commissioned an independent review* to look into cases where doctors had died by suicide whilst under our fitness to practise processes. The review identified that doctors in our procedures were often subject to a range of stressors such as employer disciplinary procedures, mental health issues, financial pressures, relationship breakdown and criminal proceedings. But it was clear that our investigation was a very significant additional stressor.

The review highlighted the stigma of a GMC investigation, the formal legalistic tone of correspondence with doctors under investigation which made them feel prejudged, and the time that investigations can take as factors that add significantly to stress. It was recommended that we undertake a review of our investigation processes with this in mind.

In 2015 we appointed Professor Louis Appleby, a leading UK mental health expert, as an independent adviser to guide us on how we could reduce the impact of our investigatory role.

The difference we wanted to make

The requirement to investigate an allegation, the threshold for when we must do so and the steps that must be carried out during an investigation, are laid down in legislation. We have been asking for changes to legislation for some years in order to enable us to be more flexible about what we investigate. However, with this programme we recognised that there were opportunities within the current legislation for us to make improvements. In particular, we have tried to balance effective regulation to protect the public with a sensitive approach in our investigation of doctors.

Professor Appleby talked about the significant risks connected with the stigma of a GMC investigation for doctors who have always been high achievers, particularly if they can see no end to or no way out of their predicament. He worked with us to examine each stage of the fitness to practise process to identify ways in which we could reduce the impact of investigations for all doctors, and particularly for doctors who may be vulnerable.

This review resulted in a set of proposals** for improvement, in total over twenty-five changes that were made to our fitness to practise procedures. A summary of the changes and their impact can be found at Annex B.

> “Investigations can be punitive in effect, even if that is not the intention. Being able to see things from the point of view of the hardworking, perfectionist, sometimes distressed and probably remorseful doctor was key to reforming the process **- Professor Louis Appleby**”

Striking a balance

Throughout this programme we were mindful of striking a balance between providing support and being sensitive to a potentially vulnerable doctor and protecting the safety of the public. We have ensured that we continue to take robust action to protect patients, whilst also being compassionate in our communication with doctors. We have developed guidance for staff on handling cases that involve both health concerns and serious misconduct and/or performance issues, and we've provided training to our teams about how to balance sensitive communication with doctors with robust public protection.

Key changes

Following the review with Professor Appleby we carried out a programme of work over 18 months involving over 25 different projects.

Each of these projects fell under one of the three overarching aims shown in the diagram.

Reduce impact

A fundamental way to reduce the impact on doctors is to ensure that only complaints that may require GMC action are referred to us in the first place. To help achieve this:

- we updated our guidance to support our employer liaison advisers and our decision makers to understand which concerns can and should be managed locally rather than come to us. This ensures we only investigate where the concerns about the doctor are unmanaged and pose a risk to the public.

- the pages attached to our online complaint form have been improved. The types of concerns we can and can't investigate are clearer and we've improved signposting for patients to other organisations who may be able to help them.

Another key way to reduce the impact on doctors is, when we do receive a complaint or referral, to ensure we only launch a full investigation where necessary. Professor Appleby was very supportive of an approach we were piloting at the time of his review, called provisional enquiries, which involves early informal enquiries to obtain more information at the outset to help us decide whether a full investigation is needed. He recommended that we extend this approach to more cases. We now undertake provisional enquiries in cases where:

- it is likely that one or two pieces of information can be swiftly obtained which will clarify the seriousness of the matters raised;

- the concerns relate to a single clinical incident or a single clinical concern;
- the doctor has a history of whistleblowing;
- there are concerns about a doctor's health, or;
- the events arose during the Covid-19 pandemic.

The use of provisional enquiries enables us to obtain information to determine whether there are any ongoing risks to patients or the public. In 2019 the total number of cases where information obtained by provisional enquiries enabled us to resolve the matter without the need for a full investigation was 404. We have since extended this approach to cases involving single clinical concerns (more than one procedure or consultation but confined to a single condition and course of treatment) and to complaints about issues arising during the COVID-19 pandemic.

> "I really appreciate your help and support along this process **– doctor under investigation**"

> "Many thanks for your continuing kindness, because this has come over in our few telephone queries **– doctor under investigation**"

We also looked at ways in which we could reduce the impact on doctors who we do have to investigate.

The most significant change is the creation of a specialist team who manage cases where the doctor has a known vulnerability. This team provide enhanced communication and use bespoke communication plans to support a sensitive approach. Where a doctor is experiencing a serious phase of an illness, the specialist team are able to pause an investigation for a short period of time (up to six months) to allow the doctor space to seek treatment without being contacted by us.

Some of the changes we have made to reduce the impact of an investigation on all doctors, not just those that have health concerns, include:

- creating a single point of contact for doctors under investigation to reduce any anxiety caused by receiving correspondence from different members of staff and looking at how the whole of the GMC communicates with doctors during an investigation;

> "I think doctors had previously been nervous about contacting us, but now they have a single point of contact, they feel far more confident to just give us a call if they have a question **– Investigation Officer, GMC**"

- frontloading our investigation process in order to speed it up by identifying and recording allegations at the outset of the process, and;
- reducing the time between an investigation decision being made and the decision being notified to the doctor.

From time to time a doctor will die while under investigation. We've introduced a system to obtain information about the cause of death to ensure that, when a doctor dies by suicide during our investigations, we can conduct a review of our interaction with them and identify where improvements may be needed. In future, we will publish these statistics.

Increase support

Increasing support took two main forms in this programme of change. We increased support for doctors but also for our staff in order to equip them with the skills to support the doctors that they interact with.

Support for doctors:

The reviews that we commissioned identified that doctors under investigation can be left feeling marginalised and unable to confide in family or friends. We commission an independent provider (currently the BMA's Wellbeing Support Service) to offer every doctor under investigation free and confidential emotional support from a fellow doctor throughout our investigation (the GMC Doctors' Support Service). Around 100 doctors access the service every year. We worked with the BMA to train investigation and tribunal teams to improve how they promote the service to doctors. Through this training, staff explored doctors' experiences, the stressors they face and the experience of being under investigation.

Professor Appleby was struck by the number of doctors who attended MPTS hearings alone without support. The MPTS now runs a service that provides pastoral support to all doctors at the hearing centre (the MPTS Doctor Contact Service). This is particularly beneficial to unrepresented or unsupported doctors who have rated the service 4.9 out of 5. Should a doctor need further support following a tribunal, staff are able to signpost them to national organisations, such as the Samaritans, BMA Counselling and BMA Wellbeing.

> "I'm unrepresented, so it was lovely to have someone to talk to and to clarify the procedures. It was good to be able to raise one or two points in my case. An invaluable service – **doctor following a tribunal**"

Throughout this programme of work, we championed the need for mental health services for doctors in view of their difficulties accessing mainstream services. We are pleased to note that, in England, a national service for GPs was established in 2017 and was expanded in October 2019 to provide access to mental health services for all doctors in England.

Support for staff

We provide mental health awareness training for all our staff, but we also wanted to prepare our staff to be better equipped to handle calls with distressed doctors. We have developed a range of guidance and training for staff (with input from some of our staff who are trained psychiatrists and doctors) on spotting signs a doctor under investigation may be unwell, and how to handle cases involving vulnerable and suicidal doctors sensitively and safely. We have also introduced a process for staff to get specialist advice about such cases when they need to. Examples of this include seeking advice from the specialist team who manage cases involving doctors with a known vulnerability either via phone, email or face to face on the best way to handle subsequent interactions with the doctor. Staff will also be able to seek specialist advice from a medical case examiner, or if needed, a consultant psychiatrist on the best way to communicate with a doctor.

Be more sensitive

In the independent review* we heard that doctors felt our correspondence had an accusatory tone. Since then we have completed a large-scale review of all the letters we send to doctors under investigation, to make sure the tone and language are appropriate and more sympathetic to the stress that recipients are under. We identified that the volume of legal material in our letters was contributing to the tone that doctors found uncomfortable, and we have changed our approach so that we provide any legal information separately and not in the body of our letters. We have received positive feedback on the changes made to the letters from doctors, medical defence organisations (MDOs) and the BMA.

We've also made further changes to the letters we send to doctors with health concerns, so that they're more sensitive to the circumstances that they are in. In those cases, our specialist team call each doctor at the start of the investigation to ask how they prefer to be contacted throughout the process.

Our specialist team also have a role in supporting the wider teams on how to deliver enhanced communication; this means that if a doctor becomes vulnerable, they will have the same support as if they were in the specialist team.

We have received feedback from MDOs that the change in our communication style has made a real difference to doctors. By taking a kinder, more empathetic approach, we have helped to reduce the stress caused by our investigation.

> Since we've started to think about these things more carefully and working with Professor Appleby, what I've seen and what I've observed is a real culture change within the organisation when it comes to recognising the effect that the investigation process has on doctors **– Dr John Smyth, Assistant Director of Case Examiner Team, GMC**

The impact of these changes

Here is an example of how the changes that we have made impact on a doctor who is going through our fitness to practise procedure.

Previous approach: Doctor A self-referred to the GMC following a diagnosis of bi-polar disorder after a period during which she had been very depressed and had suffered a psychotic episode, although not on duty. Due to there being insufficient information to assess the level of risk this might pose to patients, we opened a full investigation. We carried out a health assessment and received reports from two independent psychiatrists. This confirmed that, since the diagnosis, the doctor had been receiving treatment, following medical advice and, on the advice of occupational health, reduced her working hours to ensure that she was able to care safely for patients while she worked with her treating doctor to manage her condition. Both psychiatrists found that the doctor was fit to practise without restrictions being put in place. This process took six months to complete.

Current approach: Doctor A's self-referral triggered early enquiries (provisional enquiries) from our triage team. We asked the doctor for information from her treating psychiatrist and occupational health team. This information gave us the assurance that her mental health condition was being treated, the doctor was fully engaged with that treatment and any potential risk to patients was being well managed locally. We closed the enquiry within nine weeks, without the need for a full investigation.

Evaluating our success

After an 18-month programme of change, it was important for us to evaluate its success. We conducted a staff survey, a wide range of audits, and staff focus groups to seek feedback. Staff reported a positive, noticeable and measurable culture change in how we conduct investigations. They feel that the way we communicate with doctors has shifted to be more supportive where possible and are positive about this change in approach. The data shows that investigations are generally shorter which is a measurable benefit to doctors in our processes. We have received positive feedback from doctors who have been investigated since we made the changes, and plan to continue to seek that feedback.

> Thank you for your kindness in how you spoke to me yesterday – **doctor under investigation**

> Thank you so much for all of the assistance that you have given me throughout this process. I am pleased to hear that the matter is closed – **doctor under investigation**

> Many thanks for all your support in the last few months. I am very grateful for all your help and your prompt and kind responses to my queries – **doctor under investigation**

The future

We believe that a focus on support for vulnerable doctors should be our approach for the long term and not just connected to a one-off programme of work.

To help us continue to support vulnerable doctors, we have set up an advisory forum comprised of representatives from the Royal College of General Practitioners, the Royal College of Psychiatrists, the Faculty of Occupational Medicine and a practising doctor.

We will continue to listen to feedback to identify further improvements that we can make to our processes or how we communicate with doctors.

While the focus of this work programme has been to improve the experience of doctors who are referred to us, and to reduce the impact of our investigations, we are also aware of the increased pressures on healthcare environments in which doctors train and work.

In 2018, we commissioned Professor Michael West, Senior Fellow at The King's Fund and Dame Denise Coia, Chair of Health Improvement Scotland to chair a review of the impact that these pressures have on the mental health and wellbeing of medical students and doctors across the UK and how to tackle them to bring improvement.

Their report, *Caring for doctors Caring for patients* identified the causes of pressures on doctors in the environments in which they work, and provided evidence of how to address them. We are taking forward the recommendations for us and have discussed the wider recommendations with healthcare leaders across the UK. We'll continue to use our influence to support positive change.

> The pressures on medical students, doctors in training and the profession as a whole are huge. We know that tiredness, stress and health problems can impact safe patient care and also cause doctors to leave the profession early or during training.
>
> A lot of initiatives are already underway, but we all recognise that more can be done to improve the wellbeing of doctors especially in the workplace. We are committed to working together with key organisations to achieve this.
>
> The dedication of doctors is hugely valuable to the UK workforce. Listening to their concerns, acting on them and making sure they get the support they need and deserve are important priorities for us **- Charlie Massey, Chief Executive of the GMC**

Acknowledgements

This programme of work would not have been possible without the support, contributions and dedication of many. We'd particularly like to thank; Professor Louis Appleby for sharing his expertise and overseeing our review; the British Medical Association's Wellbeing Support Services for offering confidential emotional support to any doctor involved in a fitness to practise case; feedback from the medical defence organisations that represent investigated doctors, staff from the Practitioner Health Programme and National GP service for advice throughout our reform programme and the advisory forum members who continue to support us in our work in this important area.

Annex A – Further Reading

1 *Doctors who commit suicide while under GMC fitness to practise investigation, Sarndrah Horsfall, Chief Executive for the National Patient Safety Agency (NPSA) the UK , 14 December 2014

This report was commissioned by the GMC to review those cases where doctors had taken their own life while under the fitness to practise procedures over an eight year period. The report addresses lessons that can be learnt from these deaths, as well as any changes the GMC could make in the way it handles vulnerable doctors.

2 **Proposals to reduce the impact of our fitness to practise processes

Professor Appleby worked closely with investigation and adjudication staff to review every stage of the fitness to practise and MPTS process and identify what changes we could make. We developed and have now implemented the proposals outlined in this document.

3 Our webpage "reducing stress for doctors going through investigation" has further information on this programme of work, including this summary of changes.

4 Information for doctors under investigation

If you would like more information on our investigations process these webpages outline what we do and what action we may take.

Annex B – Summary of individual projects

Communicating with doctors at risk of self harm

From time to time staff would be contacted by doctors at risk of self harm and would do their best to manage those interactions sensitively. We have provided training, including interactive case studies and guidance for staff on managing interactions with individuals at risk of self harm. This is supported by an interactive desktop tool to make it easy for staff to quickly access help during interactions. Feedback from staff has been very positive.

Deciding whether to investigate health concerns

We are conscious that the stress of an investigation can be even more stressful for doctors who are unwell and we have guidance to help staff decide if we need to investigate health concerns. We have reviewed the guidance to emphasise the importance of exploring any local arrangements that might be in place to manage potential risks to patients to ensure we only conduct a GMC investigation relating to a doctor's health where necessary.
We have also expanded the existing Provisional Enquiry (PE) process to include certain types of cases involving doctors with health concerns.

This change has been made to improve the information available to us at the triage stage, in turn, helping to reduce the number of full investigations that we open about matters relating to a doctor's health. We are also expanding this approach in other types of cases.

Handling interactions with doctors in distress and recognising signs a doctor may be unwell

GMC staff sometimes interact with doctors where we may be unaware that they are unwell which may affect how they interact with us and staff do their best to manage these interactions as effectively as possible. We have developed guidance for staff, with input from the Royal College of Psychiatrists, to help them manage interactions with doctors in distress and to identify where a doctor may be suffering from an underlying mental health issue that may be impacting on their interactions with us. Staff have provided positive feedback about how this supports them in their role, but they also report that this has improved their support for the doctors they interact with.

Improving how we correspond with doctors who are under investigation

Doctors who are under investigation can sometimes receive automated email correspondence from different GMC departments that may be unrelated to their GMC investigation (such as about their registration). With input from the BMA and Medical Defence Organisations, we have improved the tone of voice of automated emails and clarity of email subject headings to reduce any anxiety for doctors receiving such correspondence during an investigation; we have received positive feedback on these changes.

A single point of contact for doctors under investigation

During an investigation, a doctor's case may be dealt with by a range of GMC fitness to practise teams who may all need to correspond with the doctor. We have changed our approach so that we now allocate a single point of contact to a doctor to co-ordinate communication with them during the investigation. In cases relating to health, the single point of contact will correspond in line with a bespoke communication plan for the doctor that meets their preferred communication style and we have received positive feedback about the changes from those who represent doctors.

The GMC Doctor Support Service

Any doctor under investigation is offered access to free, emotional confidential support throughout a GMC investigation which is provided by an external provider – currently the BMA Wellbeing Support Service. The BMA Wellbeing Support Service have worked with us to train our staff to help them to promote the service to doctors.

The MPTS Doctor Contact Service

Despite the availability of the GMC Doctor Support Service, some doctors do not opt for that support and attend the hearing centre alone. The MPTS has established a support service to ensure that all doctors are supported when at the hearing centre.

A specialist team to handle cases involving doctors with a known vulnerability

Sometimes we know that a doctor under investigation has a known vulnerability because there is an allegation about their health posing a risk to the public (often alongside other allegations). We have established a specialist team of investigators to handle those cases who have had additional training to help them to be as sensitive and supportive as possible to a vulnerable doctor while we carry out our role to ensure that the public is protected. Staff also have access to specialist psychiatric advice about a doctor's health during an investigation or a hearing – staff have provided positive feedback on this approach.

Pausing investigations

Sometimes doctors that are in our investigation process experience an acute phase of an illness and teams have in the past tried to avoid putting extra stress on them at this time by only contacting them if necessary. We have introduced a process to enable the specialist team to pause an investigation that is solely related to the doctor's health for doctors who are seriously unwell to enable us to stop contact with them while they seek treatment.

The tone of our correspondence

We have had feedback that the tone of our correspondence can make doctors under investigation feel prejudged. We have worked with the BMA, the medical defence organisations and other groups that support doctors to make significant amendments to our template letters to improve their tone and have had positive feedback on the new approach.

Sharing health assessment reports where opinions differ

We have introduced a process for health examiners to discuss their reports with each other in cases where there are differing diagnoses or recommendations about a doctor's health, to see if they can reach consensus where their opinions differ, or to confirm that there is a definite difference of opinion. This new process has helped avoid uncertainty for doctors caused by the health examiners reaching different conclusions and has reduced delays.

Providing guidance for Medical Supervisors who do not believe a Doctor is receiving appropriate medical treatment

There are occasional instances where a Medical Supervisor identifies a risk that the doctor they are supervising is not receiving appropriate medical treatment. We have developed new guidance in this area, to support medical supervisors carry out their role.

Improving information leading to the online complaint form

The pages leading up to our online complaint form have been improved to clarify the types of concerns we can or cannot investigate and we've improved signposting for patients to other organisations.

Meeting with Royal Colleges

An Advisory Forum was established in 2018, consisting of representatives from the Royal College of Psychiatrists, the Royal College of General Practitioners, the Faculty of Occupational Medicine and a doctor representative. The Forum meets twice a year and provides the GMC with specialist advice on its approach to vulnerable doctors involved in GMC processes.

Recording information about the cause of doctor deaths, during and after a GMC investigation

Since 2018 we systematically gather and record information about the cause of death for doctors who die while under GMC investigation.